

111TH CONGRESS
1ST SESSION

H. R. 1321

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

IN THE HOUSE OF REPRESENTATIVES

MARCH 5, 2009

Ms. ESHOO (for herself, Ms. HARMAN, Ms. WASSERMAN SCHULTZ, Mr. COOPER, Mrs. EMERSON, Mr. CASTLE, and Mr. WELCH) introduced the following bill; which was referred to the Committee on Energy and Commerce, and in addition to the Committees on Ways and Means, Education and Labor, and Oversight and Government Reform, for a period to be subsequently determined by the Speaker, in each case for consideration of such provisions as fall within the jurisdiction of the committee concerned

A BILL

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

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

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

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

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

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

TITLE I—HEALTHY AMERICANS PRIVATE INSURANCE PLANS

Subtitle A—Guaranteed Private Coverage

- Sec. 101. Guarantee of Healthy Americans Private Insurance coverage.
- Sec. 102. Individual responsibility to enroll in a Healthy Americans Private Insurance plan.
- Sec. 103. Health coverage plans offered by employers.
- Sec. 104. Coordination of supplemental coverage under the Medicaid program to HAPI plan coverage for nondisabled, nonelderly adult individuals.

Subtitle B—Standards for Healthy Americans Private Insurance Coverage

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

Subtitle C—Eligibility for Premium and Personal Responsibility Contribution Subsidies

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

Subtitle D—Wellness Programs

- Sec. 131. Requirements for wellness programs.

TITLE II—HEALTHY START FOR CHILDREN

Subtitle A—Benefits and Eligibility

- Sec. 201. HAPI plan coverage for children.
- Sec. 202. Coordination of supplemental coverage under the Medicaid program with HAPI plan coverage for children.

Subtitle B—Service Providers

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

TITLE III—BETTER HEALTH FOR OLDER AND DISABLED AMERICANS

Subtitle A—Assurance of Supplemental Medicaid Coverage

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

Subtitle B—Empowering Individuals and State To Improve Long-Term Care Choices

- Sec. 311. New, automatic Medicaid option for State choices for long-term care program.

Sec. 312. Simpler and more affordable long-term care insurance coverage.

TITLE IV—HEALTHIER MEDICARE

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

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

Subtitle B—Promoting Primary Care for Medicare Beneficiaries

Sec. 411. Primary care services management payment.

Subtitle C—Chronic Care Disease Management

Sec. 421. Chronic care disease management.

Sec. 422. Chronic Care Education Centers.

Subtitle D—Improving Quality in Hospitals for All Patients

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

Subtitle E—Additional Provisions

Sec. 441. Additional cost information.

Sec. 442. Reducing Medicare paperwork and regulatory burdens.

TITLE V—STATE HEALTH HELP AGENCIES

Sec. 501. Establishment.

Sec. 502. Responsibilities and authorities.

Sec. 503. Appropriations for Transition to State Health Help Agencies.

TITLE VI—SHARED RESPONSIBILITIES

Subtitle A—Individual Responsibilities

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

Subtitle B—Employer Responsibilities

Sec. 611. Health care responsibility payments.

Sec. 612. Distribution of individual responsibility payments to HHAs.

Subtitle C—Insurer Responsibilities

Sec. 621. Insurer responsibilities.

Subtitle D—State Responsibilities

Sec. 631. State responsibilities.

Sec. 632. Empowering States to innovate through waivers.

Subtitle E—Federal Fallback Guarantee Responsibility

Sec. 641. Federal guarantee of access to coverage.

Subtitle F—Federal Financing Responsibilities

Sec. 651. Appropriation for subsidy payments.

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

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

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

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

Sec. 662. Exclusion for limited employer-provided health care fringe benefits.

Sec. 663. Limited employer deduction for employer shared responsibility payments, historic retiree health contributions, and other health care expenses.

Sec. 664. Refundable credit for individual shared responsibility payments.

Sec. 665. Modification of other tax incentives to complement Healthy Americans program.

Sec. 666. Termination of certain employer incentives when replaced by lower health care costs.

PART 2—CLARIFICATION OF ERISA TREATMENT; TERMINATION OF COVERAGE UNDER OTHER GOVERNMENTAL PROGRAMS AND TRANSITION RULES FOR MEDICAID AND CHIP

Sec. 671. Clarification of ERISA applicability to employer-sponsored HAPI plans.

Sec. 672. Federal Employees Health Benefits Plan.

Sec. 673. Medicaid and SCHIP.

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

Sec. 701. One time disallowance of deduction for advertising and promotional expenses for certain prescription pharmaceuticals.

Sec. 702. Enhanced new drug and device approval.

Sec. 703. Medical schools and finding what works in health care.

Sec. 704. Finding affordable health care providers nearby.

TITLE VIII—ENHANCED HEALTH CARE VALUE

Sec. 801. Research on comparative effectiveness of health care items and services.

Sec. 802. Health Care Comparative Effectiveness Research Trust Fund; financing for Trust Fund.

Sec. 803. Improved coordination of health services research.

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

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

1 **SEC. 2. FINDINGS.**

2 Congress makes the following findings:

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

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

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

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

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

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

14 **SEC. 3. DEFINITIONS.**

15 In this Act:

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

18 (A) is—

19 (i) age 19 or older;

20 (ii) a resident of a State;

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

22 (II) an alien with permanent resi-
23 dence;

24 (iv) not a dependent child; and

1 (v) not an alien unlawfully present in
2 the United States; and

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

6 (2) ALIEN WITH PERMANENT RESIDENCE.—
7 The term “alien with permanent residence” has the
8 meaning given the term “qualified alien” in section
9 431 of the Personal Responsibility and Work Oppor-
10 tunity Reconciliation Act of 1996 (8 U.S.C. 1641).

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

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

18 (5) HAPI PLAN.—The term “HAPI plan”
19 means a Healthy Americans Private Insurance plan
20 described under subtitle B of title I or an employer-
21 sponsored health coverage plan described under sec-
22 tion 103 offered by an employer.

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

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

11 (8) HEALTH MAINTENANCE ORGANIZATION.—
12 The term “health maintenance organization”
13 means—

14 (A) a federally qualified health mainte-
15 nance organization (as defined in section
16 1301(a)),

17 (B) an organization recognized under State
18 law as a health maintenance organization, or

19 (C) a similar organization regulated under
20 State law for solvency in the same manner and
21 to the same extent as such a health mainte-
22 nance organization.

23 (9) PERSONAL RESPONSIBILITY CONTRIBU-
24 TION.—The term “personal responsibility contribu-
25 tion” means a payment made by a covered individual

1 to a health care provider or a health insurance
2 issuer with respect to the provision of health care
3 services under a HAPI plan, not including any
4 health insurance premium payment.

5 (10) QUALIFIED COLLECTIVE BARGAINING
6 AGREEMENT.—

7 (A) IN GENERAL.—The term “qualified
8 collective bargaining agreement” means an
9 agreement between a qualified collective bar-
10 gaining employer and an employee organization
11 that represents the employees of such employer,
12 including an agreement under section 302(c)(5)
13 of the Labor-Management Relations Act, 1947,
14 that is entered into before the date of the en-
15 actment of this Act and that is in effect until
16 the date that is the earlier of—

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

20 (ii) the date the agreement expires.

21 (B) QUALIFIED COLLECTIVE BARGAINING
22 EMPLOYER.—The term “qualified collective bar-
23 gaining employer” means an employer who pro-
24 vides health insurance to employees under the
25 terms of a collective bargaining agreement

1 which is entered into before the date of the en-
2 actment of this Act.

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

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

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

15 **TITLE I—HEALTHY AMERICANS**
16 **PRIVATE INSURANCE PLANS**
17 **Subtitle A—Guaranteed Private**
18 **Coverage**

19 **SEC. 101. GUARANTEE OF HEALTHY AMERICANS PRIVATE**
20 **INSURANCE COVERAGE.**

21 Not later than the date that is 4 years after the date
22 of enactment of this Act, each adult individual shall have
23 the opportunity to purchase a Healthy Americans Private
24 Insurance plan that meets the requirements of subtitle B,

1 (referred to in this Act as “HAPI plan”) for such indi-
2 vidual and the dependent children of such individual.

3 **SEC. 102. INDIVIDUAL RESPONSIBILITY TO ENROLL IN A**
4 **HEALTHY AMERICANS PRIVATE INSURANCE**
5 **PLAN.**

6 (a) INDIVIDUAL RESPONSIBILITY.—

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

10 (A) provides evidence of receipt of coverage
11 under, or enrollment in a health plan offered
12 through—

13 (i) the Medicare program under title
14 XVIII of the Social Security Act;

15 (ii) a health insurance plan offered by
16 the Department of Defense;

17 (iii) an employee benefit plan through
18 a former employer;

19 (iv) a qualified collective bargaining
20 agreement;

21 (v) the Department of Veterans Af-
22 fairs; or

23 (vi) the Indian Health Service; or

24 (B) is opposed to health plan coverage for
25 religious reasons, including an individual who

1 declines health plan coverage due to a reliance
2 on healing using spiritual means through prayer
3 alone.

4 (2) DEPENDENT CHILDREN.—Each adult indi-
5 vidual shall have the responsibility to enroll each de-
6 pendent child of the adult individual in a HAPI
7 plan, unless the adult individual—

8 (A) provides evidence that the dependent
9 child is receiving coverage under any program
10 described in paragraph (1)(A); or

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

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

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

18 (1) PENALTY.—

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

24 (B) INDIVIDUALS SUBJECT TO PENALTY.—

25 An individual described in this subparagraph is

1 an adult individual for whom there is a contin-
2 uous period of 63 days or longer, beginning on
3 the applicable date (as defined in subparagraph
4 (E)) and ending on the date of enrollment in a
5 HAPI plan, during all of which the individual—

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

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

12 (C) AMOUNT OF PENALTY.—

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

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

1 (II) 15 percent of the amount de-
2 termined under subclause (I).

3 (ii) UNCOVERED MONTH DEFINED.—

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

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

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

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

24 (D) PAYMENT.—Payment of any late en-
25 rollment penalty by an individual under this

1 subsection shall be made to the HHA of the in-
2 dividual’s State of residence under procedures
3 established by the State.

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

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

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

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

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

1 such individual and any dependent children of such
2 individual under subsection (a).

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

6 **SEC. 103. HEALTH COVERAGE PLANS OFFERED BY EMPLOY-**
7 **ERS.**

8 (a) PLAN REQUIREMENTS.—

9 (1) IN GENERAL.—A health coverage plan de-
10 scribed in section 105(h)(6) of the Internal Revenue
11 Code of 1986 (relating to self-insured plans) that is
12 offered by an employer shall be subject to—

13 (A) the requirements of subtitle B, other
14 than subsections (a), (d)(2), and (d)(4) of sec-
15 tion 111; and

16 (B) a risk-adjustment mechanism used to
17 spread risks across all health plans.

18 (2) OTHER PLANS.—A health coverage plan
19 that is not described in section 105(h)(6) of the In-
20 ternal Revenue Code of 1986 that is offered by an
21 employer shall be subject to the requirements of sub-
22 title B, other than section 111(a).

23 (b) DISTRIBUTION OF INFORMATION.—Employers
24 that offer an employer-sponsored health coverage plan
25 shall distribute to employees standardized, unbiased infor-

1 mation on HAPI plans and supplemental health insurance
 2 options provided by the State HAA under section 502(b).

3 (c) PLANS OFFERED THROUGH EMPLOYERS.—An
 4 employer-sponsored health coverage plan shall be offered
 5 by an employer and not through the applicable State
 6 HHA.

7 **SEC. 104. COORDINATION OF SUPPLEMENTAL COVERAGE**
 8 **UNDER THE MEDICAID PROGRAM TO HAPI**
 9 **PLAN COVERAGE FOR NONDISABLED, NON-**
 10 **ELDERLY ADULT INDIVIDUALS.**

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

21 (1) is provided in coordination with, and as a
 22 supplement to, the coverage provided the non-
 23 disabled, nonelderly adult individual under the
 24 HAPI plan in which the individual is enrolled;

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

4 (3) ensures that the nondisabled, nonelderly
5 adult individual receives all items or services that
6 are not available (or are otherwise limited) under the
7 HAPI plan in which they are enrolled but that is
8 provided under the State plan (or provided to a
9 greater extent or in a less restrictive manner) under
10 title XIX of the Social Security Act (including any
11 waiver under such title or under section 1115 of
12 such Act (42 U.S.C. 1315)) of the State in which
13 the nondisabled, nonelderly adult individual resides;
14 and

15 (4) ensures that the family of the nondisabled,
16 nonelderly adult individual is not charged premiums,
17 deductibles, or other cost-sharing that is greater
18 than would have been charged under the State plan
19 under title XIX of the Social Security Act of the
20 State in which the nondisabled, nonelderly adult in-
21 dividual resides if such coverage was not provided as
22 a supplement to the coverage provided the child
23 under the HAPI plan in which the nondisabled, non-
24 elderly adult individual is enrolled.

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

6 **Subtitle B—Standards for Healthy**
7 **Americans Private Insurance**
8 **Coverage**

9 **SEC. 111. HEALTHY AMERICANS PRIVATE INSURANCE**
10 **PLANS.**

11 (a) OPTIONS.—A State HHA—

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

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

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

24 (B) a list of such additional benefits,
25 items, or services, and the prices applicable to

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

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

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

17 (b) STANDARDIZED COVERAGE REQUIREMENTS FOR
18 HAPI PLANS.—

19 (1) IN GENERAL.—Each HAPI plan offered
20 through an HHA shall—

21 (A) provide benefits for—

22 (i) health care items and services that
23 are actuarially equivalent or greater in
24 value than the benefits offered as of Janu-
25 ary 1, 2009, under the Blue Cross/Blue

1 Shield Standard Plan provided under the
2 Federal Employees Health Benefit Pro-
3 gram under chapter 89 of title 5, United
4 States Code, including coverage of an ini-
5 tial primary care assessment and annual
6 physical examinations;

7 (ii) catastrophic medical events that
8 result in out-of-pocket costs for an indi-
9 vidual or family if lifetime limits are ex-
10 hausted; and

11 (iii) comprehensive disease prevention,
12 early detection, disease management, and
13 chronic condition management that meets
14 minimum standards developed by the Sec-
15 retary;

16 (B) designate a health care provider, such
17 as a primary care physician, nurse practitioner,
18 or other qualified health provider, to monitor
19 the health and health care of a covered individ-
20 uals (such provider shall be known as the
21 “health home” of the covered individual);

22 (C) ensure that, as part of the first visit
23 with a primary care physician or the health
24 home of a covered individual, such provider and
25 individual determine a care plan to maximize

1 the health of the individual through wellness
2 and prevention activities;

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

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

17 (E) provide benefits for family planning
18 services (as defined for purposes of title X of
19 the Public Health Service Act); and

20 (F) comply with the requirements of sec-
21 tion 112.

22 (2) DETERMINATION OF BENEFITS BY SEC-
23 RETARY.—Not later than 1 year after the date of
24 enactment of this Act, the Secretary shall promul-

1 gate guidelines concerning the benefits, items, and
2 services that are covered under paragraph (1).

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

11 (c) ACTUARIALY EQUIVALENT HEALTHY AMERICAN
12 PLANS.—Each actuarially equivalent HAPI plan offered
13 through an HHA—

14 (1) shall cover all treatments, items, services,
15 and providers at least to the same extent as those
16 covered under a HAPI plan that—

17 (A) preventive items and services (includ-
18 ing well baby care and well child care and ap-
19 propriate immunizations);

20 (B) disease management services;

21 (C) inpatient and outpatient hospital serv-
22 ices;

23 (D) physicians' surgical and medical serv-
24 ices; and

25 (E) laboratory and x-ray services;

1 (2) may include additional supplemental bene-
2 fits to the extent approved by the State and provided
3 for in advance in the plan contract; and

4 (3) ensure that no personal responsibility con-
5 tribution requirements are applied for prevention
6 and chronic disease management benefits, items, or
7 services.

8 (d) CLASSES OF COVERAGE.—With respect to a
9 HAPI plan, a health insurance issuer shall provide for the
10 following classes of coverage:

11 (1) Coverage of an individual.

12 (2) Coverage of a married couple or domestic
13 partnership (as determined by a State) without de-
14 pendent children.

15 (3) Coverage of an adult individual with 1 or
16 more dependent children.

17 (4) Coverage of a married couple or domestic
18 partnership (as determined by a State) with 1 or
19 more dependent children.

20 (e) PREMIUMS AND RATING REQUIREMENTS.—

21 (1) DETERMINATIONS OF PREMIUMS.—With re-
22 spect to each class of coverage described in sub-
23 section (d), a health insurance issuer shall determine
24 the premium amount for a HAPI plan using ad-
25 justed community rating principles, including a risk-

1 adjustment mechanism, as described in paragraphs
2 (2) and (3) established by the State. States may
3 permit premium variations based only on geography,
4 tobacco use, and family size. A State may determine
5 to have no variation.

6 (2) REWARDS.—A State shall permit a health
7 insurance issuer to provide premium discounts and
8 other incentives to enrollees based on the participa-
9 tion of such enrollees in wellness, chronic disease
10 management, and other programs designed to im-
11 prove the health of the enrollees.

12 (3) LIMITATION.—A health insurance issuer
13 shall not consider age, gender, industry, health sta-
14 tus, or claims experience in determining premiums
15 under this subsection.

16 (f) APPLICATION OF STATE MANDATE LAWS.—State
17 benefit mandate laws that would otherwise be applicable
18 to HAPI plans shall be preempted.

19 (g) DEFINITION OF PREVENTIVE ITEMS OR SERV-
20 ICES.—In this section, the term “preventive items or serv-
21 ices” means clinical activities that help prevent or detect
22 disease, illness, or disability and may include—

23 (1) immunizations and preventive physical ex-
24 aminations;

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

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

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

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

9 (1) provide for increased portability through
10 limitations on the application of preexisting condi-
11 tion exclusions, consistent with that provided for
12 under section 2701 of the Public Health Service Act
13 (42 U.S.C. 300gg), as such section existed on the
14 day before the date of enactment of this Act, except
15 that the State shall develop procedures to ensure
16 that preexisting exclusion limitations do not apply to
17 new enrollees who had no applicable creditable cov-
18 erage immediately prior to the first enrollment pe-
19 riod;

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

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

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

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

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

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

7 (8) prohibit discrimination on the basis of ge-
8 netic information, as provided for under the amend-
9 ments made by the Genetic Information Non-
10 discrimination Act of 2008 (Public Law 110–233),
11 as such amendments were in effect on the day before
12 the date of enactment of this Act.

13 (b) GUIDELINES.—Not later than 1 year after the
14 date of enactment of this Act, the Secretary shall develop
15 guidelines for the application of the requirements of this
16 section.

17 **SEC. 113. UPDATING HEALTHY AMERICANS PRIVATE IN-**
18 **SURANCE PLAN REQUIREMENTS.**

19 (a) IN GENERAL.—The Secretary shall establish the
20 Healthy America Advisory Committee (referred to in this
21 section as the “Advisory Committee”) to provide rec-
22 ommendations to the Secretary and Congress concerning
23 modifications to the benefits, items, and services required
24 under section 111(a)(1).

25 (b) COMPOSITION.—

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

4 (A) at least 1 such member shall be a
5 health economist;

6 (B) at least 1 such member shall be an
7 ethicist;

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

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

13 (E) at least 1 such member shall be a
14 health care consumer;

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

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

20 (2) GEOGRAPHIC BALANCE.—The Comptroller
21 General shall ensure the geographic diversity of the
22 members appointed under paragraph (1).

23 (c) TERMS, VACANCIES.—Members of the Advisory
24 Committee shall be appointed for a term of 3 years and
25 may be reappointed for 1 additional term. In appointing

1 members, the Comptroller General shall stagger the terms
2 of the initial members so that the terms of one-third of
3 the members expire each year. Vacancies in the member-
4 ship of the Advisory Committee shall not affect the Com-
5 mittee's ability to carry out its functions. The Comptroller
6 General shall appoint an individual to fill the remaining
7 term of a vacant member within 2 months of being noti-
8 fied of such vacancy.

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

23 (e) REPORTS.—

24 (1) ANNUAL REPORTS.—Not later than Decem-
25 ber 31 of the fourth full calendar year following the

1 date of enactment of this Act, and each December
2 31 thereafter, the Advisory Committee shall provide
3 to Congress and the Secretary a report that—

4 (A) describes any recommendations for
5 modifications to the benefits, items, and serv-
6 ices that are required to be covered under a
7 HAPI plan; and

8 (B) includes any recommendations to mod-
9 ify HAPI plans to improve the quality of life for
10 United States citizens and to ensure that bene-
11 fits in such plans are medically- and cost-effec-
12 tive.

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

24 (f) APPLICATION OF FACA.—The Federal Advisory
25 Committee Act (5 U.S.C. App.) shall apply to the Advisory

1 Committee, except that section 14 of such Act shall not
2 apply.

3 **Subtitle C—Eligibility for Premium**
4 **and Personal Responsibility**
5 **Contribution Subsidies**

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

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

15 (b) PARTIAL SUBSIDY FOR OTHER INDIVIDUALS AND
16 FAMILIES.—

17 (1) IN GENERAL.—For any calendar year, in
18 the case of a covered individual who is determined
19 to have a modified adjusted gross income that is
20 greater than 100 percent of the poverty line, as ap-
21 plicable to a family of the size involved, but below
22 400 percent of the poverty line, as applicable to a
23 family of the size involved, the covered individual is
24 entitled under this section to an income-related pre-
25 mium subsidy equal to the basic premium subsidy

1 amount reduced by the amount determined under
2 paragraph (2).

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

7 (A) the excess of—

8 (i) such individual’s modified adjusted
9 gross income, over

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

13 (B) the excess of—

14 (i) an amount equal to 400 percent of
15 the poverty line as applicable to a family of
16 the size involved, over

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

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

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

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

5 (d) CHANGE IN STATUS NOTIFICATION.—

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

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

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

1 **SEC. 122. ELIGIBILITY FOR PERSONAL RESPONSIBILITY**
2 **CONTRIBUTION SUBSIDIES.**

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

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

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

21 (a) DETERMINATION OF MODIFIED ADJUSTED
22 GROSS INCOME.—

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

1 (A) determined without regard to sections
2 86, 135, 137, 199, 221, 222, 911, 931, and
3 933 of such Code; and

4 (B) increased by—

5 (i) the amount of interest received or
6 accrued during the taxable year which is
7 exempt from tax under such Code; and

8 (ii) the amount of any social security
9 benefits (as defined in section 86(d) of
10 such Code) received or accrued during the
11 taxable year.

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

20 (b) POVERTY LINE.—In this subtitle, the term “pov-
21 erty line” has the meaning given such term in section
22 673(2) of the Community Health Services Block Grant
23 Act (42 U.S.C. 9902(2)), including any revision required
24 by such section.

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

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

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

19 (1) a premium payment for a HAPI plan that
20 is past due; or

21 (2) a penalty incurred for failing to pay such a
22 premium.

23 (f) NO DISCHARGE IN BANKRUPTCY.—In the case of
24 any bankruptcy filed by or on behalf of any person after
25 the date that is 4 years after the date of enactment of

1 this Act, under title 11, United States Code, any penalty
2 imposed with respect to such person for failure to pay a
3 HAPI plan premium shall not be subject to discharge
4 under such title.

5 **Subtitle D—Wellness Programs**

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

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

15 (b) DISCOUNTS.—

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

23 (A) the enrollee, or the dependent child of
24 the enrollee, is participating in an approved
25 wellness program; and

1 (B) the wellness program meets the re-
2 quirements of this subsection.

3 (2) REQUIREMENTS.—A wellness program
4 meets the requirements of this paragraph if such
5 program—

6 (A) is reasonably designed (as determined
7 by the HAPI plan) to promote good health and
8 prevent disease for program participants;

9 (B) has been determined by the HAPI
10 plan to be eligible for participation discounts;

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

13 (D) permits any enrollee for whom it is un-
14 reasonably difficult to meet the initial program
15 standard for participation due to a medical con-
16 dition, or for whom it is medically inadvisable
17 to attempt, an opportunity to meet a reasonable
18 alternative participation standard—

19 (i) that is developed prior to enroll-
20 ment of the enrollee or, after a determina-
21 tion has been made that the enrollee can-
22 not safely meet the program participation
23 standard, in consultation with the enrollee
24 after enrollment of the enrollee; and

1 (ii) the availability of which is dis-
2 closed in the original documents relating to
3 participation in the program;

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

10 (F) meets any other requirements imposed
11 by the HAPI plan.

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

16 (4) AVAILABILITY OF DISCOUNTS.—

17 (A) OFFERING OF ENROLLMENT.—A
18 HAPI plan shall provide enrollees with the op-
19 portunity to participate in a wellness program
20 (for purposes of qualifying for premium dis-
21 counts) at least once each year.

22 (B) DETERMINATIONS.—Determinations
23 with respect to the successful participation by
24 an enrollee in a wellness program for purposes
25 of qualifying for premium discounts shall be

1 made by the HAPI plan based on a retrospec-
2 tive review of the scope of activities of the en-
3 rollee under the program. The HAPI plan may
4 require a minimum level of successful participa-
5 tion in such a program prior to applying any
6 premium discount.

7 (C) PARTICIPATION IN MULTIPLE PRO-
8 GRAMS.—An enrollee may participate in mul-
9 tiple wellness programs to reach the maximum
10 premium discount permitted by the HAPI plan
11 under applicable State law.

12 (5) PERSONAL RESPONSIBILITY CONTRIBUTION
13 DISCOUNT.—A HAPI plan may elect to provide dis-
14 counts in the amount of the personal responsibility
15 contribution that is required of an enrollee if the en-
16 rollee participates in an approved wellness program.

17 (c) EMPLOYER INCENTIVE FOR WELLNESS PRO-
18 GRAMS.—For provisions relating to employers deducting
19 the costs of offering wellness programs or worksite health
20 centers see section 162(l) of the Internal Revenue Code
21 of 1986.

1 **TITLE II—HEALTHY START FOR**
2 **CHILDREN**
3 **Subtitle A—Benefits and Eligibility**

4 **SEC. 201. HAPI PLAN COVERAGE FOR CHILDREN.**

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

16 (b) **POLICIES AND PROCEDURES.**—The Secretary
17 shall develop policies and procedures to be applied by the
18 States to identify children described in subsection (a) and
19 to provide such children with coverage under a HAPI plan.
20 States shall determine, in consultation with health insur-
21 ance issuers, a separate class of coverage to assure afford-
22 able child coverage.

23 (c) **DEFINITION.**—In this title, the term “child”
24 means an individual who is under the age of 19 years or,

1 in the case of an individual in foster care, under the age
2 of 21 years.

3 **SEC. 202. COORDINATION OF SUPPLEMENTAL COVERAGE**
4 **UNDER THE MEDICAID PROGRAM WITH HAPI**
5 **PLAN COVERAGE FOR CHILDREN.**

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

15 (1) is provided in coordination with, and as a
16 supplement to, the coverage provided the child under
17 the HAPI plan in which the child is enrolled;

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

20 (3) ensures that the child receives all items or
21 services that are not available (or are otherwise lim-
22 ited) under the HAPI plan in which they are en-
23 rolled but that is provided under the State plan (or
24 provided to a greater extent or in a less restrictive
25 manner) under title XIX of the Social Security Act

1 (including any waiver under such title or under sec-
2 tion 1115 of such Act (42 U.S.C. 1315)) of the
3 State in which the child resides; and

4 (4) ensures that the family of the child is not
5 charged premiums, deductibles, or other cost-sharing
6 that is greater than would have been charged under
7 the State plan under title XIX of the Social Security
8 Act of the State in which the child resides if such
9 coverage was not provided as a supplement to the
10 coverage provided the child under the HAPI plan in
11 which the child is enrolled.

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

17 (c) RULE OF CONSTRUCTION.—Nothing in this sec-
18 tion shall be construed as affecting a State’s requirement
19 to provide items and services described in section
20 1905(a)(4)(B) of the Social Security Act (relating to early
21 and periodic screening, diagnostic, and treatment services
22 defined in section 1905(r) of such Act and provided in
23 accordance with the requirements of section 1902(a)(43)
24 of such Act).

1 (d) CHILD.—In this section, the term “child” has the
2 meaning given that term under section 201(c) and may
3 include, upon application by a State to the Secretary and
4 with the approval of the Secretary on a budget neutral
5 basis, any individual who would be considered a child
6 under the Medicaid program of the State as of the date
7 of the enactment of this Act.

8 **Subtitle B—Service Providers**

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

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

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

19 (1) A school-based health center (in accordance
20 with section 212).

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

23 (3) A federally qualified health center.

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

1 (5) An Indian Health Service facility.

2 **SEC. 212. USE OF, AND GRANTS FOR, SCHOOL-BASED**
3 **HEALTH CENTERS.**

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

6 (1) is located within an elementary or secondary
7 school facility;

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

10 (3) is administered by a community-based orga-
11 nization including a hospital, public health depart-
12 ment, community health center, or nonprofit health
13 care agency;

14 (4) at a minimum, provides to school-aged chil-
15 dren—

16 (A) primary health care services, including
17 comprehensive health assessments, and diag-
18 nosis and treatment of minor, acute, and chron-
19 ic medical conditions and Healthy Start bene-
20 fits;

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

24 (C) the availability of services at the school
25 when the school is open and 24-hour coverage

1 through an on-call system with other providers
2 to ensure access when the school or health cen-
3 ter is closed;

4 (D) services through the use of a qualified
5 and appropriately credentialed individual, in-
6 cluding a nurse practitioner or physician assist-
7 ant, a mental health professional, a physician,
8 and a health assistant; and

9 (E) by not later than January 1, 2018, an
10 electronic medical record relating to the indi-
11 vidual; and

12 (5) may provide optional preventive dental serv-
13 ices, consistent with State licensure law, through the
14 use of dental hygienists or dental assistants that
15 provide preventive services such as basic oral exams,
16 cleanings, and sealants.

17 (b) ACCESS TO SCHOOL-BASED HEALTH CEN-
18 TERS.—

19 (1) IN GENERAL.—A school-based health center
20 may provide services to students in more than 1
21 school if the school district or other supervising
22 State entity determine that capacity and geographic
23 location make such provision of services appropriate.

24 (2) ENROLLMENT.—Upon the enrollment of a
25 student in a school with a school-based health cen-

1 ter, the center will provide the student with the op-
2 portunity to enroll, after parental consent, to receive
3 health care from the center.

4 (3) REIMBURSEMENT FOR SERVICES.—

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

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

17 (c) DEVELOPMENTAL GRANTS.—

18 (1) IN GENERAL.—The Secretary shall award
19 grants to local school districts and communities for
20 the establishment and operation of school-based
21 health centers.

22 (2) ELIGIBILITY.—To be eligible for a grant
23 under paragraph (1), a local school district or local
24 community shall submit to the Secretary an applica-

1 tion at such time, in such manner, and containing
2 such information as the Secretary may require.

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

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

13 (B) an applicant that will use amounts
14 under the grant to establish a school-based
15 health center in a school that serves students
16 with the highest incidence of unmet medical
17 and psycho-social needs; and

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

24 (4) USE OF FUNDS.—A grantee shall use
25 amounts received under a grant under this sub-

1 section to establish and operate a school-based
 2 health center. Not less than 50 percent of the
 3 amounts received under the grant shall be used for
 4 the ongoing operations of the center.

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

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

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

18 **SEC. 301. COORDINATION OF SUPPLEMENTAL COVERAGE**
 19 **UNDER THE MEDICAID PROGRAM FOR EL-**
 20 **DERLY AND DISABLED INDIVIDUALS.**

21 (a) ASSURANCE OF SUPPLEMENTAL COVERAGE.—
 22 Subject to section 631(d), the Secretary, States, and
 23 health insurance issuers shall ensure that any elderly or
 24 disabled individual eligible under title XIX of the Social
 25 Security Act (including any such individual eligible pursu-

1 ant to a waiver under such title or under section 1115
2 of such Act (42 U.S.C. 1315)) covered under a HAPI plan
3 provided through the State HHA receives medical assist-
4 ance under State Medicaid plans in a manner that—

5 (1) is provided in coordination with, and as a
6 supplement to, the coverage provided the individual
7 under the HAPI plans in which the individual is en-
8 rolled;

9 (2) does not supplant the individual’s coverage
10 under a HAPI plan;

11 (3) ensures that the elderly or disabled indi-
12 vidual receives all items or services, including insti-
13 tutional care or home and community-based services
14 that are not available (or are otherwise limited)
15 under the HAPI plan in which they are enrolled but
16 that is provided (or provided to a greater extent or
17 in a less restrictive manner) under the State plan
18 under title XIX of the Social Security Act (including
19 through any waiver under such title or under section
20 1115 of such Act (42 U.S.C. 1315)) of the State in
21 which the individual resides; and

22 (4) ensures that the elderly or disabled indi-
23 vidual is not charged premiums, deductibles and
24 other cost-sharing that is greater than would have
25 been charged under the State plan under title XIX

1 of the Social Security Act (including any waiver
2 under such title or under section 1115 of such Act
3 (42 U.S.C. 1315)) of the State in which the indi-
4 vidual resides if such coverage was not provided as
5 a supplement to the coverage provided the individual
6 under the HAPI plan in which the individual is en-
7 rolled.

8 (b) GUIDANCE TO STATES AND HEALTH INSURANCE
9 ISSUERS.—The Secretary shall issue regulations and guid-
10 ance to States and health insurance issuers implementing
11 this section that takes into account the special health care
12 needs of elderly and disabled individuals who are eligible
13 for medical assistance under State Medicaid programs,
14 particularly with respect to institutionalized care or home
15 and community-based services, not later than 6 months
16 prior to the date on which coverage under a HAPI plan
17 first begins.

18 (c) DEFINITIONS.—In this section—

19 (1) the term “institutionalized care” means the
20 health care provided under the Medicaid plan of the
21 State of residence of an elderly or disabled individual
22 who is a patient in a hospital, nursing facility, inter-
23 mediate care facility for the mentally retarded, or an
24 institution for mental diseases (as such terms are
25 defined for purposes of such plan); and

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

9 **Subtitle B—Empowering Individ-**
10 **uals and State To Improve**
11 **Long-Term Care Choices**

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

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

17 **“SEC. 1943. STATE CHOICES FOR LONG-TERM CARE PRO-**
18 **GRAM.**

19 “(a) IN GENERAL.—Notwithstanding any other pro-
20 vision of this title, the Secretary shall permit a State to
21 establish and operate under the State plan under this title
22 (including such a plan operating under a statewide waiver
23 under section 1115) a State Choices for Long-Term Care
24 Program in accordance with this section.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

22 “(e) INDEPENDENT EVALUATION AND REPORT.—

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

1 PLAN REQUIREMENTS.—Section 7702B(b)(1)(A) of the
2 Internal Revenue Code of 1986 (defining qualified long-
3 term care insurance contract) is amended by inserting
4 “through a qualified long-term care plan” after “qualified
5 long-term care services”.

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

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

11 “(1) IN GENERAL.—The term ‘qualified long-
12 term care plan’ means an insurance plan that meets
13 the standards and requirements set forth in para-
14 graph (2) (including the 2009–2010 NAIC Model
15 Regulation or 2009–2010 Federal Regulation (as
16 the case may be)) on or after the date specified in
17 paragraph (5).

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

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

1 this section referred to as the ‘2009–2010
2 NAIC Model Regulation’) to incorporate—

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

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

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

11 “(iv) other standards required by the
12 Secretary of Health and Human Services
13 paragraph (1) shall be applied in each State, ef-
14 fective for policies issued to policyholders on
15 and after the date specified in paragraph (5).

16 “(B) SECRETARIAL RESPONSIBILITY.—If
17 the Association does not adopt the 2009–2010
18 NAIC Model Regulation within the 9-month pe-
19 riod specified in subparagraph (A), the Sec-
20 retary shall promulgate, not later than 9
21 months after the end of such period, a regula-
22 tion (in this section referred to as the ‘2009–
23 2010 Federal Regulation’) and paragraph (1)
24 shall be applied in each State, effective for poli-

1 cies issued to policyholders on and after the
2 date specified in paragraph (5).

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

13 “(3) LIMITATIONS OF GROUPS OR PACKAGES OF
14 BENEFITS.—The benefits under the 2009–2010
15 NAIC Model Regulation or 2009–2010 Federal Reg-
16 ulation shall provide—

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

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

24 “(C) that the total number of different
25 benefit packages (counting the core group of

1 basic benefits described in subparagraph (B)
2 and each other combination of benefits that
3 may be offered as a separate benefit package)
4 that may be established in all the States and by
5 all issuers shall not exceed 10.

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

8 “(A) provide for benefits that offer con-
9 sumers the ability to purchase the benefits that
10 are available in the market as of November 5,
11 2009, and

12 “(B) balance the objectives of—

13 “(i) simplifying the market to facili-
14 tate comparisons among policies,

15 “(ii) avoiding adverse selection,

16 “(iii) providing consumer choice,

17 “(iv) providing market stability, and

18 “(v) promoting competition.

19 “(5) EFFECTIVE DATE.—

20 “(A) IN GENERAL.—Subject to subpara-
21 graph (B), the date specified in this paragraph
22 shall be the date the State adopts the 2009–
23 2010 NAIC Model Regulation or 2009–2010
24 Federal Regulation or 1 year after the date the

1 Association or the Secretary first adopts such
2 standards, whichever is earlier.

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

6 “(i) requiring State legislation (other
7 than legislation appropriating funds) in
8 order for long-term care insurance policies
9 to meet the 2009–2010 NAIC Model Regu-
10 lation or 2009–2010 Federal Regulation,
11 but

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

16 the date specified in this paragraph is the first
17 day of the first calendar quarter beginning after
18 the close of the first legislative session of the
19 State legislature that begins on or after Janu-
20 ary 1, 2011. For purposes of the preceding sen-
21 tence, in the case of a State that has a 2-year
22 legislative session, each year of such session
23 shall be deemed to be a separate regular session
24 of the State legislature.”.

25 (c) ADDITIONAL CONSUMER PROTECTIONS.—

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

4 (A) by striking subparagraph (A) and in-
5 serting the following new paragraph:

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

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

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

14 (D) by adding at the end the following new
15 subparagraph:

16 “(D) the requirements relating to manda-
17 tory offer and information under paragraph
18 (6).”.

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

21 (A) by inserting “1993 NAIC” after “RE-
22 QUIREMENTS OF” in the heading for paragraph
23 (2),

24 (B) by redesignating paragraph (5) as
25 paragraph (7), and

1 (C) by inserting after paragraph (4) the
2 following new paragraph:

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

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

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

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

15 “(II) Section 6B (other than
16 paragraph (7) thereof).

17 “(III) Sections 6C, 6D, 6E, and
18 7.

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

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

23 “(VI) Section 23, including inac-
24 curate completion of medical histories

1 (other than paragraphs (1), (6), and
2 (9) of section 23C).

3 “(VII) Sections 24 and 25.

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

9 “(IX) Sections 29 and 30.

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

12 “(I) Sections 6C and 6D.

13 “(II) The provisions of section 8
14 relating to contingent nonforfeiture
15 benefits.

16 “(III) Sections 6F, 6G, 6H, 6J,
17 6K, and 7.

18 “(B) DEFINITIONS.—For purposes of this
19 paragraph—

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

1 Commissioners (as adopted as of October
2 2000).

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

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

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

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

21 “(A) MANDATORY OFFER.—Any person
22 who sells a long-term care insurance policy to
23 an individual shall make available for sale to
24 the individual a long-term care insurance policy

1 with only the core group of basic benefits (de-
2 scribed in subsection (h)(3)(B)).

3 “(B) INFORMATION.—Any person who sells
4 a long-term care insurance policy to an indi-
5 vidual shall provide the individual, before the
6 sale of the policy, an outline of coverage which
7 describes the benefits under the policy. Such
8 outline shall be on a standard form approved by
9 the State regulatory program or the Secretary
10 (as the case may be) consistent with the 2009–
11 2010 NAIC Model Regulation or 2009–2010
12 Federal Regulation.”.

13 (e) STATE REGULATION OF OUT-OF-STATE CON-
14 TRACTS.—Section 7702B of such Code is amended by
15 adding at the end the following new subsection:

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

21 (f) EFFECTIVE DATE.—The amendments made by
22 this section shall apply to contracts issued after December
23 31, 2009.

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

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

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

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

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

16 “(j)(1) With respect to the monthly premium amount
17 for months after December 2010, the Secretary may ad-
18 just (under procedures established by the Secretary) the
19 amount of such premium for an individual based on
20 whether or not the individual participates in certain
21 healthy behaviors, such as weight management, exercise,
22 nutrition counseling, refraining from tobacco use, desig-
23 nating a health home, and other behaviors determined ap-
24 propriate by the Secretary.

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

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

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

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

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

17 “(a) PAYMENT.—

18 “(1) IN GENERAL.—Not later than January 1,
19 2010, the Secretary, subject to paragraph (2), shall
20 establish procedures for providing primary care and
21 participating providers with a management fee (as
22 determined appropriate by the Secretary, in con-
23 sultation with the Medicare Payment Advisory Com-
24 mission established under section 1805) that reflects
25 the amount of time spent with a Medicare bene-

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

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

11 “(b) DEFINITIONS.—In this section:

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

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

20 “(3) PRIMARY CARE PROVIDER.—

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

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

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

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

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

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

17 “(a) ESTABLISHMENT.—

18 “(1) IN GENERAL.—Not later than January 1,
19 2010, the Secretary shall develop and implement a
20 chronic care disease management program (in this
21 section referred to as the ‘program’). The program
22 shall be designed to provide chronic care disease
23 management to all Medicare beneficiaries with re-
24 spect to at least the 5 most prevalent diseases within

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

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

6 “(A) take into consideration—

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

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

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

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

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

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

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

17 “(d) DEFINITIONS.—In this section:

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

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

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

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

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

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

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

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

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

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

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

3 **SEC. 431. IMPROVING QUALITY IN HOSPITALS FOR ALL PA-**
4 **TIENTS.**

5 (a) IMPROVING HEALTH CARE QUALITY FOR ALL
6 PATIENTS.—

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 4 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 E—Additional Provisions**

2 **SEC. 441. ADDITIONAL COST INFORMATION.**

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

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

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

17 **SEC. 442. REDUCING MEDICARE PAPERWORK AND REGU-** 18 **LATORY BURDENS.**

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

1 **TITLE V—STATE HEALTH HELP**
2 **AGENCIES**

3 **SEC. 501. ESTABLISHMENT.**

4 As a condition of receiving payment under section
5 503, a State shall, not later than the date that is 4 years
6 after the date of enactment of this Act, establish or des-
7 ignate a State agency, to be known as the “Health Help
8 Agency” (referred to in this Act as a “HHA”) to—

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

11 (2) carry out the functions described in section
12 502.

13 **SEC. 502. RESPONSIBILITIES AND AUTHORITIES.**

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

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

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

23 (3) make available to the public, with respect to
24 each health insurance issuer and each HAPI plan,
25 the number of covered individuals who have des-

1 ignated a health home described in section 111(b);
2 and

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

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

7 (1) providing standardized, unbiased informa-
8 tion on HAPI plans and supplemental health insur-
9 ance options;

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

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

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

22 (5) establish procedures for default enrollment
23 of uninsured individuals into low-cost HAPI plans
24 for individuals or families who do not enroll, are not
25 covered under a health plan offered through a pro-

1 gram described in paragraphs (1)(A) of section
2 102(a), and are not described in paragraph (1)(B)
3 of such section;

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

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

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

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

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

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

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

7 (2) obtaining necessary information about in-
8 come from individuals and Federal and State agen-
9 cies;

10 (3) making eligibility determinations on an indi-
11 vidual basis and informing individuals of such deter-
12 minations;

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

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

18 (6) collecting premium payments made by, or
19 on behalf of, covered individuals, and remitting such
20 payments to the HAPI plans; and

21 (7) collecting Federal premium subsidies for
22 covered individuals and remitting such subsidies to
23 HAPI plans.

24 (d) PREMIUM RATING RULES.—Each HHA shall en-
25 sure that the premium payments for each HAPI plan are

1 determined in accordance with the rating rules described
2 in section 111(e).

3 (e) DETERMINATION OF PLAN COVERAGE AREAS.—

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

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

8 (f) COOPERATION AMONG STATES.—States that
9 share 1 or more metropolitan statistical area may enter
10 into agreements to share administrative responsibilities
11 described under this section.

12 (g) TRANSITION FROM MEDICAID AND SCHIP; CO-
13 ORDINATION OF SUPPLEMENTAL MEDICAL ASSISTANCE
14 FOR ELDERLY AND DISABLED MEDICAID ELIGIBLES.—

15 Each HHA shall work with the Secretary to ensure that
16 the requirements of section 301 of this Act, section 1944
17 of the Social Security Act (as added by section 673(a) of
18 this Act), and subsections (a) and (b) of section 1943 of
19 the Social Security Act (as added by section 311 of this
20 Act) are met.

21 **SEC. 503. APPROPRIATIONS FOR TRANSITION TO STATE**

22 **HEALTH HELP AGENCIES.**

23 (a) APPROPRIATION.—There is authorized to be ap-
24 propriated and there is appropriated, for each of the 4
25 full fiscal years immediately following the date of enact-

1 ment of this Act, such sums as may be necessary for the
2 purpose of enabling each State to carry out the purposes
3 of this title. The sums made available under this section
4 shall be used for making payments to States that have
5 submitted, and had approved by the Secretary, an HHA
6 plan under this section.

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

9 (1) the establishment of an HHA within such
10 State by the date that is 4 years after the date of
11 enactment of this Act;

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

6 (a) PAYMENT REQUIREMENTS.—

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

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

“SUBCHAPTER A—EMPLOYER SHARED RESPONSIBILITY PAYMENTS

“SUBCHAPTER B—INDIVIDUAL SHARED RESPONSIBILITY PAYMENTS

“SUBCHAPTER C—GENERAL PROVISIONS

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

“Sec. 3411. Payment requirement.

“Sec. 3412. Instrumentalities of the United States.

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

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

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

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

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

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

“Revenue per employee national percentile of the taxpayer for the preceding calendar year:	Large employer:	Small employer:
0–20th percentile	18%	3%
21st–40th percentile	20%	5%
41st–60th percentile	22%	7%
61st–80th percentile	24%	9%
81st–99th percentile	26%	11%.

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

14 “(A) in the case of a large employer, 18
 15 percent, and

16 “(B) in the case of a small employer, 3
 17 percent.

18 “(3) APPLICABLE PERCENTAGE FOR CERTAIN
 19 LARGE EMPLOYERS.—In the case of any large em-
 20 ployer which did not provide health insurance cov-
 21 erage for employees on the day before the date of

1 enactment of the Healthy Americans Act, the table
2 contained in paragraph (1) shall be applied by sub-
3 stituting ‘30%’ for ‘24%’ and by substituting ‘32%’
4 for ‘26%’ with respect the each of the first 4 cal-
5 endar years to which this section applies.

6 “(4) ADDITIONAL RATE FOR CERTAIN SMALL
7 EMPLOYERS.—

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

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

18 “(5) REVENUE PER EMPLOYEE NATIONAL PER-
19 CENTILE RANK.—At the beginning of each calendar
20 year, the Secretary, in consultation with the Sec-
21 retary of Labor, shall publish a table, based on sam-
22 pling of employers, to be used in determining the na-
23 tional percentile for revenue per employee amounts
24 for the preceding calendar year.

25 “(c) TRANSITION RATES.—

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

3 “(A) IN GENERAL.—In the case of the first
4 four calendar years to which this section ap-
5 plies, in the case of any employer who provided
6 health insurance coverage for employees on the
7 day before the date of enactment of the Healthy
8 Americans Act, the employer shared responsi-
9 bility payment shall be, in lieu of the amount
10 determined under subsection (a), an amount
11 equal to—

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

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

17 “(B) EMPLOYEE SALARY INVESTMENT
18 AMOUNT.—For purposes of this paragraph—

19 “(i) IN GENERAL.—The term ‘em-
20 ployee salary investment amount’ means
21 the lesser of—

22 “(I) the excess of the amount of
23 average yearly wages paid to all em-
24 ployees for such year over the amount
25 of average yearly wages paid to such

1 employee for the year before the first
2 year this section applies, or

3 “(II) the designated employee
4 health insurance premium amount of
5 such employer.

6 “(ii) NONDISCRIMINATION RULES.—
7 No amount paid by an employer shall be
8 treated as an employee salary investment
9 amount unless such amount is distributed
10 to all employees on a basis that is propor-
11 tional to the designated employee health
12 insurance premium amount paid with re-
13 spect to such employee before such dis-
14 tribution.

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

23 “(iv) TREATMENT OF AMOUNT.—An
24 employee salary investment amount shall
25 not be treated as income or otherwise

1 taken into account for purposes of deter-
2 mining any individual’s eligibility for bene-
3 fits or assistance under any governmental
4 assistance program.

5 “(C) EMPLOYER SHARED RESPONSIBILITY
6 CREDIT.—The Secretary may provide a credit
7 to private employers who provided health insur-
8 ance benefits greater than the 80th percentile
9 of the national average in the 2 years prior to
10 enactment of the Healthy Americans Act, if
11 such employer can demonstrate the benefits
12 provided encouraged prevention and wellness
13 activities as defined in such Act, and that the
14 employer continues to provide wellness pro-
15 grams.

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

1 “(E) REGULATIONS.—The Secretary may
2 establish such rules and regulations as nec-
3 essary to carry out the purposes of this para-
4 graph.

5 “(2) TRANSITION RATE FOR OTHER EMPLOY-
6 ERS.—

7 “(A) IN GENERAL.—In the case of an em-
8 ployer who did not provide health insurance to
9 employees on the day before the date of enact-
10 ment of the Healthy Americans Act—

11 “(i) the employer shared responsibility
12 payment for the first year this section ap-
13 plies shall be an amount equal to $\frac{1}{3}$ of the
14 amount otherwise required under this sec-
15 tion (determined without regard to this
16 subsection), and

17 “(ii) the employer shared responsi-
18 bility payment for the second year this sec-
19 tion applies shall be an amount equal to $\frac{2}{3}$
20 of the amount otherwise required under
21 this section (determined without regard to
22 this subsection).

23 “(B) TRANSITION RATE DOES NOT APPLY
24 TO CERTAIN LARGE EMPLOYERS.—Subpara-

1 graph (A) shall not apply to any large employer
2 covered by subsection (b)(3).

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

4 “Notwithstanding any other provision of law (wheth-
5 er enacted before or after the enactment of this section)
6 which grants to any instrumentality of the United States
7 an exemption from taxation, such instrumentality shall
8 not be exempt from the payment required by section 3411
9 unless such provision of law grants a specific exemption,
10 by reference to section 3111 from the payment required
11 by such section.

12 **“Subchapter B—Individual Shared**
13 **Responsibility Payments**

“Sec. 3421. Amount of payment.

“Sec. 3422. Deduction of tax from wages.

14 **“SEC. 3421. AMOUNT OF PAYMENT.**

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

18 “(b) EXCEPTION.—This section shall not apply to
19 any individual—

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

22 “(2) who provides such documentation as re-
23 quired by the Secretary demonstrating that such in-
24 dividual has paid such HAPI plan premium amount,

1 but only for the period with respect to which such
2 amount is shown to be paid.

3 **“SEC. 3422. DEDUCTION OF INDIVIDUAL SHARED RESPON-**
4 **SIBILITY PAYMENT FROM WAGES.**

5 “(a) IN GENERAL.—The individual shared responsi-
6 bility payment imposed by section 3421 shall be collected
7 by the employer by deducting the amount of the payment
8 from the wages as and when paid. The preceding sentence
9 shall not apply to any employer who has fewer than 10
10 employees.

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

16 “(c) INDEMNIFICATION OF EMPLOYER; SPECIAL
17 RULE FOR TIPS.—Rules similar to the rules of subsections
18 (b) and (c) of section 3102 shall apply for purposes of
19 this section.

20 **“Subchapter C—General Provisions**

“Sec. 3431. Definitions and special rules.

“Sec. 3432. Labor contracts.

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

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

23 “(1) AVERAGE HAPI PLAN PREMIUM
24 AMOUNT.—The term ‘average HAPI plan premium

1 amount' means the national average yearly premium
2 for HAPI plans with standard coverage (as deter-
3 mined under section 111(b) of the Healthy Ameri-
4 cans Act), determined without regard to differing
5 classes of coverage.

6 “(2) DESIGNATED EMPLOYEE HEALTH INSUR-
7 ANCE PREMIUM AMOUNT.—The term ‘designated
8 employee health insurance premium amount’ means
9 the greater of—

10 “(A) the yearly premium paid by an em-
11 ployer for health insurance coverage for employ-
12 ees for the most recent calendar year ending be-
13 fore the date of enactment of the Healthy
14 Americans Act, or

15 “(B) the yearly premium paid by an em-
16 ployer for health insurance coverage for employ-
17 ees for the year before the first year this section
18 applies.

19 “(3) EMPLOYER.—

20 “(A) IN GENERAL.—The term ‘employer’
21 has the meaning given such term under section
22 3401(d).

23 “(B) AGGREGATION RULES.—For purposes
24 of this chapter, all persons treated as a single

1 employer under subsection (a) or (b) of section
2 52 shall be treated as 1 person.

3 “(4) EMPLOYMENT.—The term ‘employment’
4 has the meaning given such term under section
5 3121(b).

6 “(5) FULL-TIME EQUIVALENT EMPLOYEE.—
7 The term ‘full-time equivalent employee’ means the
8 equivalent number of full-time employees of an em-
9 ployer determined for any year under the following
10 formula:

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

14 “(B) The quotient of—

15 “(i) the sum of the average weekly
16 hours worked during such year for each
17 employee of the employer (including com-
18 mon law employees) who—

19 “(I) was employed by such em-
20 ployer during such year for more than
21 3 months, and

22 “(II) is not a full-time employee,
23 divided by

24 “(ii) 40.

1 “(6) FULL-TIME EMPLOYEE.—The term ‘full-
2 time employee’ means an employee (including a com-
3 mon law employee) who during an average workweek
4 performs, or can reasonably be expected to perform,
5 at least 40 hours of work. The Secretary may pre-
6 scribe alternative rules for determining full-time
7 equivalent employees in occupations or industries not
8 using a standard workweek.

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

12 “(8) HAPI PLAN PREMIUM AMOUNT.—The
13 term ‘HAPI plan premium amount’ means, with re-
14 spect to any individual, the monthly premium for the
15 HAPI plan under which such individual is enrolled,
16 determined after taking into account any subsidy
17 provided to such individual under section 131 of the
18 Healthy Americans Act.

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

23 “(10) REVENUE PER EMPLOYEE.—The term
24 ‘revenue per employee’ means, with respect to any
25 employer for any year, the gross receipts of the em-

1 employer for such year divided by the number of full-
2 time equivalent employees employed by such em-
3 ployer for such year.

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

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

10 “(b) SPECIAL RULES.—

11 “(1) SPECIAL RULE FOR SELF-EMPLOYED INDI-
12 VIDUALS.—For purposes of this chapter, a self-em-
13 ployed individual (as defined by section
14 401(c)(1)(B)) shall be treated as both a full-time
15 equivalent employee and as an employer.

16 “(2) TREATMENT OF PAYMENTS.—For pur-
17 poses of this title, the payments required by sections
18 3411 and 3421 shall be treated as a tax imposed by
19 such sections, respectively.

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

23 “(A) Section 3122 (relating to Federal
24 service).

1 “(B) Section 3123 (relating to deductions
2 as constructive payments).

3 “(C) Section 3125 (relating to returns in
4 the case of governmental employees in States,
5 Guam, American Samoa, and the District of
6 Columbia).

7 “(D) Section 3126 (relating to return and
8 payment by government employer).

9 “(E) Section 3127 (relating to exemption
10 for employers and their employees where both
11 are members of religious faiths opposed to par-
12 ticipation in Social Security Act programs).

13 **“SEC. 3432. LABOR CONTRACTS.**

14 “(a) IN GENERAL.—This chapter shall not apply with
15 respect to any qualified collective bargaining employee of
16 any qualified collective bargaining employer before the
17 earlier of—

18 “(1) January 1 of the first year which is more
19 than 9 years after the date of the enactment of this
20 chapter, or

21 “(2) the date the collective bargaining agree-
22 ment expires.

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

24 “(1) QUALIFIED COLLECTIVE BARGAINING EM-
25 PLOYER.—The term ‘qualified collective bargaining

1 employer' means an employer who provides health
 2 insurance to employees under the terms of a collec-
 3 tive bargaining agreement which is entered into be-
 4 fore the date of the enactment of this chapter.

5 “(2) QUALIFIED COLLECTIVE BARGAINING EM-
 6 PLOYEE.—The term ‘qualified collective bargaining
 7 employee’ means an employee of a qualified collec-
 8 tive bargaining employer who is covered by a collec-
 9 tive bargaining agreement governing the employee’s
 10 health insurance.”.

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

“CHAPTER 24A—HEALTH CARE RESPONSIBILITY PAYMENTS”.

15 (b) COLLECTION OF INDIVIDUAL SHARED RESPONSI-
 16 BILITY PAYMENTS THROUGH ESTIMATED TAXES.—Sec-
 17 tion 6654 of the Internal Revenue Code of 1986 (relating
 18 to failure by individual to pay estimated tax) is amended—

19 (1) in subsection (a), by striking “and the tax
 20 under chapter 2” and inserting “, the tax under
 21 chapter 2, and the individual shared responsibility
 22 payment required under subchapter B of chapter
 23 24A”, and

24 (2) in subsection (f)—

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

3 (B) by redesignating paragraph (3) as
4 paragraph (5), and

5 (C) by inserting after paragraph (2) the
6 following new paragraphs:

7 “(3) the individual shared responsibility pay-
8 ment required under subchapter B of chapter 24A,
9 minus

10 “(4) the amount withheld as an individual
11 shared responsibility payment under section 3422,
12 minus”.

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

16 **SEC. 612. DISTRIBUTION OF INDIVIDUAL RESPONSIBILITY**
17 **PAYMENTS TO HHAS.**

18 (a) IN GENERAL.—The Secretary of the Treasury
19 shall pay to the HHA in each State an amount equal to
20 the amount of individual shared responsibility payments
21 received under section 3421 of the Internal Revenue Code
22 of 1986 with respect to each individual residing in such
23 State.

24 (b) TREATMENT OF PAYMENTS.—Any amount paid
25 to a State under subsection (a) shall be treated as an

1 amount paid by the individual as a premium for the HAPI
2 plan in which such individual is enrolled.

3 **Subtitle C—Insurer** 4 **Responsibilities**

5 **SEC. 621. INSURER RESPONSIBILITIES.**

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

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

11 (1) implement and emphasize prevention, early
12 detection and chronic disease management;

13 (2) ensure that a wellness program as described
14 in section 131 is available to all covered individuals
15 so long as such a wellness program meets the re-
16 quirements of the health insurance issuers and other
17 relevant requirements;

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

23 (4) ensure enrollees have the opportunity to
24 designate a health home as described in section

1 111(b) and make public how many enrollees per pol-
2 icy have designated a health home;

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

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

10 (7) contribute to the financing of the HHAs by
11 incorporating into the administration component of
12 premiums an additional amount to reimburse HHAs
13 for administrative costs;

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

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

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

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

3 (A) for parents, if a covered child partici-
4 pates in wellness activities and the health of
5 such child improves; and

6 (B) for covered adults for participation in
7 prevention, wellness and chronic disease man-
8 agement programs;

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

15 (13) work with the Agency for Healthcare Re-
16 search and Quality, medical experts, and patient
17 groups to make information on high quality afford-
18 able health providers available to all Americans with-
19 in 4 years of the date of enactment of this Act
20 through a Web site searchable by zip code;

21 (14) provide to the HHA of each State in which
22 the issuer offers a HAPI plan, detailed information
23 on the HAPI plans offered by such issuer, using
24 standardized language as required by the HHA, so
25 that the HHA may compile a document that com-

1 pares the HAPI plans for use by prospective enroll-
2 ees;

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

8 (16) provide for prompt payment of providers
9 for claims received in accordance with State law, but
10 in no case later than 45 days after the date of re-
11 ceipt of a claim that has no defect or impropriety or
12 particular circumstance requiring special treatment
13 that prevents timely payment from being made on
14 the claim under the plan.

15 (c) UNIFORM BILLING PRACTICES.—

16 (1) IN GENERAL.—A health insurance issuer of-
17 fering a HAPI plan in a State shall agree to use
18 standardized common claim forms prescribed by the
19 applicable State HHA consistent with paragraph (2)
20 and to provide a copy of such form to the insured.

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

23 (A) the cost of the entire episode of care
24 provided to the insured;

1 (B) the percentage of the cost covered by
2 the issuer; and

3 (C) the percentage of the cost paid by the
4 insured.

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

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

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

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

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

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

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

9 (A) IN GENERAL.—Unless otherwise deter-
10 mined by an agreement between a State HHA
11 and a health insurance issuer, the administra-
12 tive expenses of an issuer shall—

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

23 (ii) not include the cost of personnel,
24 equipment, and facilities directly used in
25 the delivery of health care services (benefit

1 costs), payments to HHAs for establish-
2 ment and administration of HHAs, and
3 the cost of overseeing chronic disease man-
4 agement programs and wellness programs.

5 **Subtitle D—State Responsibilities**

6 **SEC. 631. STATE RESPONSIBILITIES.**

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

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

11 (2) ensure that the HAPI plans offered in the
12 State—

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

17 (B) comply with the requirements of this
18 Act;

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

22 (4) make risk-adjusted payments to all health
23 insurance issuers and employers offering a HAPI
24 plan in such State to account for the specific popu-

1 lation covered by the plan, in accordance with guide-
2 lines established by the Secretary;

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

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

10 (7) continue to apply State law with respect
11 to—

12 (A) solvency and financial standards for
13 health insurance issuers;

14 (B) fair marketing practices for health in-
15 surance issuers;

16 (C) grievances and appeals for covered in-
17 dividuals; and

18 (D) patient protection;

19 (8) ensure that providers receiving payment
20 from the State HHA, when appropriate, provide in-
21 formation to patients seeking treatment on the dif-
22 ferent treatment options, the costs of these treat-
23 ment options, and any comparative effectiveness in-
24 formation available through the research on com-

1 parative effectiveness conducted under the amend-
2 ments made by title VIII; and

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

4 (b) ENSURING MAXIMUM ENROLLMENT.—Each
5 State shall—

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

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

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

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

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

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

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

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 4 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 1944 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 1944 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) REDUCING THE FEDERAL BUDGET DEF-
10 ICIT.—The Secretary shall transfer any amounts in
11 the Trust Fund that are not expended as of Sep-
12 tember 30 of a fiscal year for a purpose described
13 in paragraph (1) to the general revenues account of
14 the Treasury.”.

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

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

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

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

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

16 (a) INCOME TAX EXCLUSION.—

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

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

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

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

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

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

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

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

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

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

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

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

9 (b) PAYROLL TAXES.—

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

14 (a) IN GENERAL.—Subpart C of part IV of sub-
15 chapter A of chapter 1 of the Internal Revenue Code of
16 1986 is amended by inserting after section 36A the fol-
17 lowing new section:

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

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

1 credit against the tax imposed by this chapter an amount
2 equal to the applicable fraction times, in the case of—

3 “(1) coverage of an individual, \$1,975,

4 “(2) coverage of a married couple or domestic
5 partnership (as determined by a State) without de-
6 pendent children, \$3,950,

7 “(3) coverage of an unmarried individual with
8 1 or more dependent children, \$3,660, plus \$600 for
9 each dependent child, and

10 “(4) coverage of a married couple or domestic
11 partnership (as determined by a State) with 1 or
12 more dependent children, \$4,860, plus \$600 for each
13 dependent child.

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

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

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

1 “(c) PHASEOUT OF CREDIT AMOUNT.—

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

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

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

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

16 Any amount determined under this paragraph which
17 is not a multiple of \$50 shall be rounded to the next
18 lowest \$50.

19 “(d) INFLATION ADJUSTMENT.—In the case of any
20 taxable year beginning in a calendar year after 2009, each
21 dollar amount contained in subsection (a) and subpara-
22 graphs (A) and (B) of subsection (c)(2) shall be increased
23 by an amount equal to—

24 “(1) such dollar amount, multiplied by

1 “(2) the cost-of-living adjustment determined
2 under section 1(f)(3) for the calendar year in which
3 the taxable year begins, determined by substituting
4 ‘calendar year 2009’ for ‘calendar year 1992’ in sub-
5 paragraph (B) thereof.

6 Any increase in a dollar amount contained in subsection
7 (a) that is determined under the preceding sentence shall
8 be rounded to the nearest multiple of \$5 and any increase
9 in a dollar amount contained in subparagraph (A) or (B)
10 of subsection 9c)(2) that is determined under the pre-
11 ceding sentence shall be rounded to the nearest multiple
12 of \$50.

13 “(e) DETERMINATION OF MODIFIED ADJUSTED
14 GROSS INCOME.—

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

18 “(A) determined without regard to this
19 section and sections 86, 135, 137, 199, 221,
20 222, 911, 931, and 933, and

21 “(B) increased by—

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

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

4 “(2) POVERTY LINE.—For purposes of this
5 paragraph, the term ‘poverty line’ has the meaning
6 given such term in section 673(2) of the Community
7 Health Services Block Grant Act (42 U.S.C.
8 9902(2)), including any revision required by such
9 section.”.

10 (b) CONFORMING AMENDMENTS.—

11 (1) Paragraph (2) of section 1324(b) of title
12 31, United States Code, is amended by inserting
13 “36B,” after “36A,”.

14 (2) The table of sections for subpart C of part
15 IV of subchapter A of chapter 1 of the Internal Rev-
16 enue Code of 1986 is amended by inserting after the
17 item relating to section 36A the following new item:

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

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

1 **SEC. 665. MODIFICATION OF OTHER TAX INCENTIVES TO**
2 **COMPLEMENT HEALTHY AMERICANS PRO-**
3 **GRAM.**

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

9 “(h) **TERMINATION.**—This section shall not apply to
10 payments made in any calendar year beginning at least
11 4 years after the date of the enactment of the Healthy
12 Americans Act.”.

13 (b) **TERMINATION OF HEALTH CARE EXPENSE RE-**
14 **IMBURSEMENT UNDER CAFETERIA PLANS.**—

15 (1) **IN GENERAL.**—Section 125 of the Internal
16 Revenue Code of 1986 (relating to cafeteria plans)
17 is amended by redesignating subsection (h) as sub-
18 section (i) and by inserting after subsection (g) the
19 following new subsection:

20 “(h) **TERMINATION.**—This section shall not apply to
21 health benefits coverage in any calendar year beginning
22 at least 4 years after the date of the enactment of the
23 Healthy Americans Act.”.

24 (2) **LONG-TERM CARE ALLOWED UNDER CAFE-**
25 **TERIA PLANS.**—

1 (A) IN GENERAL.—Section 125(f) of such
2 Code (defining qualified benefits) is amended by
3 striking the last sentence.

4 (B) EFFECTIVE DATE.—The amendment
5 made by this paragraph shall apply to contracts
6 issued with respect to any calendar year begin-
7 ning at least 4 years after the date of the en-
8 actment of this Act.

9 (c) TERMINATION OF ARCHER MSA CONTRIBU-
10 TIONS.—Section 220 of the Internal Revenue Code of
11 1986 (relating to Archer MSAs) is amended—

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

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

18 “(k) TERMINATION.—This section shall not apply to
19 contributions made in any calendar year beginning at least
20 4 years after the date of the enactment of the Healthy
21 Americans Act.”.

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

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

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

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

12 (C) by striking subparagraphs (B) and (C)
13 of subsection (c)(2) and by re-designating sub-
14 paragraph (D) of subsection (c)(2) as subpara-
15 graph (B), and

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

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

1 **SEC. 666. TERMINATION OF CERTAIN EMPLOYER INCEN-**
2 **TIVES WHEN REPLACED BY LOWER HEALTH**
3 **CARE COSTS.**

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

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

9 “The following provisions shall not apply to taxable
10 years beginning (or transactions in the case of sections
11 referred to in paragraph (3)) in any calendar year begin-
12 ning at least 4 years after the date of the enactment of
13 the Healthy Americans Act:

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

16 “(2) Section 501(c)(9) (relating to tax-exempt
17 status of voluntary employees’ beneficiary associa-
18 tions).

19 “(3) Sections 861(a)(6), 862(a)(6), 863(b)(2),
20 863(b)(3), and 865(b) (relating to inventory prop-
21 erty sales source rule exception).”.

22 (b) DEFERRAL OF ACTIVE INCOME OF CONTROLLED
23 FOREIGN CORPORATIONS.—Section 952 of the Internal
24 Revenue Code of 1986 (relating to subpart F income de-
25 fined) is amended by adding at the end the following new
26 subsection:

1 “(e) SPECIAL APPLICATION OF SUBPART.—

2 “(1) IN GENERAL.—For taxable years begin-
 3 ning in any calendar year beginning at least 4 years
 4 after the date of the enactment of the Healthy
 5 Americans Act, notwithstanding any other provision
 6 of this subpart, the term ‘subpart F income’ means,
 7 in the case of any controlled foreign corporation, the
 8 income of such corporation derived from any foreign
 9 country.

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

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

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

17 **PART 2—CLARIFICATION OF ERISA TREATMENT;**
 18 **TERMINATION OF COVERAGE UNDER OTHER**
 19 **GOVERNMENTAL PROGRAMS AND TRANSI-**
 20 **TION RULES FOR MEDICAID AND CHIP**

21 **SEC. 671. CLARIFICATION OF ERISA APPLICABILITY TO EM-**
 22 **PLOYER-SPONSORED HAPI PLANS.**

23 (a) ERISA.—Section 3(1) of Employee Retirement
 24 Income Security Act of 1974 (29 U.S.C. 1002(1)) is
 25 amended by adding at the end the following new sentence:

1 “Such terms include the provision of medical, surgical, or
2 hospital care or benefits through a HAPI plan described
3 under section 103 of the Healthy Americans Act.”.

4 (b) INTERNAL REVENUE CODE OF 1986.—Section
5 5000 of the Internal Revenue Code of 1986 (relating to
6 certain group health plans) is amended by adding at the
7 end the following new subsection:

8 “(e) HAPI PLANS.—For purposes of this section, the
9 terms ‘group health plan’ and ‘large group health plan’
10 include any HAPI plan described under section 103 of the
11 Healthy Americans Act.”.

12 (c) PUBLIC HEALTH SERVICE ACT.—Section
13 2791(b)(5) of the Public Health Service Act (42 U.S.C.
14 300gg–91(b)(5)) is amended by adding at the end the fol-
15 lowing new sentence: “Such term includes health insur-
16 ance coverage offered to individuals through a HAPI plan
17 described under section 103 of the Healthy Americans
18 Act.”.

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

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

23 **“§ 8915. Termination**

24 “No contract shall be entered into under this chapter
25 or chapters 89A and 89B with respect to any coverage

1 period occurring in any calendar year beginning at least
2 4 years after the date of the enactment of the Healthy
3 Americans Act.”.

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

“8915. Termination.”.

7 **SEC. 673. MEDICAID AND SCHIP.**

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

11 “TRANSITION TO COVERAGE UNDER HAPI PLANS; RE-
12 QUIREMENT TO PROVIDE SUPPLEMENTAL COV-
13 ERAGE; TERMINATION OF UNNECESSARY PROVISIONS

14 “SEC. 1944. (a) TRANSITION AND SUPPLEMENTAL
15 COVERAGE REQUIREMENTS.—The Secretary shall provide
16 technical assistance to States and health insurance issuers
17 of HAPI plans to ensure that individuals receiving medical
18 assistance under State Medicaid plans under this title or
19 child health assistance under child health plans under title
20 XXI are—

21 “(1) informed of—

22 “(A) the guarantee of private coverage for
23 essential services for all Americans established
24 by the Healthy Americans Act; and

1 “(B) each individual’s personal responsi-
2 bility—

3 “(i) for health care prevention;

4 “(ii) to enroll (or to be enrolled on
5 their behalf) in a HAPI plan through the
6 applicable State HHA during an open en-
7 rollment period; and

8 “(iii) to submit necessary documenta-
9 tion to their State HHA so that the HHA
10 may determine the individual’s eligibility
11 for premium and personal responsibility
12 contribution subsidies;

13 “(2) provided with appropriate assistance in
14 transitioning from receiving medical assistance
15 under State Medicaid plans or child health assist-
16 ance under child health plans for their primary
17 health coverage to obtaining such coverage through
18 enrollment in HAPI plans in a manner that ensures
19 continuation of coverage for such individuals; and

20 “(3) notwithstanding any other provision of this
21 title, after December 31 of the last calendar year
22 ending before the first calendar year in which cov-
23 erage under a HAPI plan begins in accordance with
24 the Healthy Americans Act, provided with medical
25 assistance that consists of supplemental coverage

1 that meets the requirements of sections 202 and 301
2 of such Act.

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

8 “(1) a State shall continue to provide medical
9 assistance for Medicare cost-sharing to individuals
10 described in section 1902(a)(10)(E) as if the
11 Healthy Americans Act had not been enacted; and

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

15 “(c) CONTINUED SUPPORT FOR DSH EXPENDI-
16 TURES.—

17 “(1) IN GENERAL.—Notwithstanding any other
18 provision of this title, with respect to each fiscal year
19 that begins after the first calendar year in which
20 coverage under a HAPI plan begins in accordance
21 with the Healthy Americans Act, the DSH allotment
22 for each State otherwise applicable under section
23 1923(f) for that fiscal year shall be reduced by 90
24 percent and no payment shall be made under section
25 1903(a) to a State with respect to any payment ad-

1 justment made under section 1923 for hospitals in
2 the State for quarters in the fiscal year in excess of
3 the reduced DSH allotment for the State applicable
4 for such year.

5 “(2) SPECIAL RULE FOR LAST 3 QUARTERS OF
6 FIRST FISCAL YEAR IN WHICH COVERAGE UNDER A
7 HAPI PLAN BEGINS.—With respect to the first fiscal
8 year in which coverage under a HAPI plan begins
9 in accordance with the Healthy Americans Act, the
10 Secretary shall reduce the DSH allotment for each
11 State that is otherwise applicable under section
12 1923(f) for that fiscal year so that each such DSH
13 allotment reflects a 90 percent reduction in the allot-
14 ment for the second, third, and fourth quarters of
15 that fiscal year.

16 “(d) TERMINATION OF ALL FEDERAL PAYMENTS
17 UNDER THIS TITLE OTHER THAN FOR MEDICARE COST-
18 SHARING OR SUPPLEMENTAL MEDICAL ASSISTANCE.—
19 Notwithstanding any other provision of this title:

20 “(1) no individual other than an individual to
21 which section 202 or 301 of the Healthy Americans
22 Act applies is entitled to medical assistance under a
23 State plan approved under this title for any item or
24 service furnished after December 31 of the last cal-
25 endar year ending before the first calendar year in

1 which coverage under a HAPI plan begins in accord-
2 ance with such Act;

3 “(2) no payment shall be made to a State
4 under section 1903(a) for any item or service fur-
5 nished after that date or for any other sums ex-
6 pended by a State for which a payment would have
7 been made under such section, other than for the
8 Federal medical assistance percentage of the total
9 amount expended by a State for each fiscal year
10 quarter beginning after that date for providing—

11 “(A) medical assistance for the mainte-
12 nance of Medicare cost-sharing in accordance
13 with subsection (b);

14 “(B) medical assistance for individuals who
15 are eligible for supplemental medical assistance
16 under this title after such date in accordance
17 with section 202 or 301 of the Healthy Ameri-
18 cans Act; and

19 “(C) payment adjustments under section
20 1923 for hospitals in the State that do not ex-
21 ceed the reduced DSH allotment for the State
22 determined under subsection (c).”.

23 (b) APPLICATION TO SCHIP.—

24 (1) APPLICATION OF TRANSITION REQUIRE-
25 MENTS.—Section 2107(e)(1) of the Social Security

1 Act (42 U.S.C. 1397gg(e)(1)) is amended by adding
2 at the end the following:

3 “(M) Section 1944(a) (relating to transi-
4 tion to coverage under HAPI plans and, in the
5 case of paragraph (3) of such section, the re-
6 quirement to provide supplemental medical as-
7 sistance for targeted low-income children who
8 are provided child health assistance as optional
9 targeted low-income children under title
10 XIX).”.

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

14 “TERMINATION
15 “SEC. 2114. Notwithstanding any other provision of
16 this title, no payment shall be made to a State under sec-
17 tion 2105(a) with respect to child health assistance for
18 any item or service furnished after December 31 of the
19 last calendar year ending before the first calendar year
20 in which coverage under a HAPI plan begins in accord-
21 ance with the Healthy Americans Act.”.

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

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

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

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

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

23 “(1) the 3-year period which begins on the date
24 of a new drug application approval with respect to
25 such a pharmaceutical, unless the manufacturer of

1 such pharmaceutical is subject to a comparison ef-
2 fectiveness study, including over-the-counter medica-
3 tion (if appropriate), or

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

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

17 (b) CONFORMING AMENDMENT.—The table of sec-
18 tions for such part IX is amended by adding after the
19 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.”.

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

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

2 (a) IN GENERAL.—

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

6 “(w)(1) The sponsor of a new drug application under
7 subsection (b) may include as part of such application a
8 full report of an investigation which has been made to
9 show, with respect to the new drug that is the subject of
10 the application—

11 “(A) the population for whom the drug is ap-
12 propriate; and

13 “(B) the effectiveness of the drug when com-
14 pared to the effectiveness of drugs on the market as
15 of the date that the application is submitted.

16 “(2) If a sponsor of a new drug application under
17 subsection (b) includes in such application the report de-
18 scribed under paragraph (1) then, notwithstanding any
19 other provision of law, the Secretary shall apply section
20 505A(b) to the drug that is the subject of such application
21 in the same manner as the Secretary applies such section
22 to a new drug in the pediatric population that is the sub-
23 ject of a study described in such section.

24 “(3) If a sponsor of a new drug application under
25 subsection (b) does not include in such application the re-
26 port described under paragraph (1) then, notwithstanding

1 any other provision of law, the Secretary shall require
2 that—

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

8 “(B) 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 of
12 the time of any audio and visual promotional
13 material; and

14 “(iii)(I) 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 “(II) in any audio and visual promotional
19 material, includes such statement in audio as
20 well as visual format.”.

21 (2) NEW DEVICES.—Section 515(c) of the Fed-
22 eral Food, Drug, and Cosmetic Act (21 U.S.C.
23 360e) is amended by adding at the end the fol-
24 lowing:

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

6 “(i) the population for whom the device is ap-
7 propriate; and

8 “(ii) the effectiveness of the device when com-
9 pared to the effectiveness of devices on the market
10 as of the date that the report is submitted.

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

19 “(C) If a person that files a report seeking premarket
20 approval under this subsection does not include in such
21 report the description referred to under subparagraph (A)
22 then, notwithstanding any other provision of law, the Sec-
23 retary shall require that—

24 “(i) all promotional material with respect to
25 such device include the following disclosure: ‘This

1 device has not been proven to be more effective than
2 other devices on the market for any condition or ill-
3 ness mentioned in this advertisement.’; and

4 “(ii) such disclosure—

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

7 “(II) constitutes not less than 20 percent
8 of the time of any audio and visual promotional
9 material; and

10 “(III)(aa) in any promotional material, in-
11 cludes a clear and conspicuous printed state-
12 ment that is larger than other print used in
13 such promotional material; and

14 “(bb) in any audio and visual promotional
15 material, includes such statement in audio as
16 well as visual format.”.

17 (b) EXTENSION OF DEVICE PATENTS.—If the Direc-
18 tor of the United States Patent and Trademark Office re-
19 ceives a certification from the Secretary pursuant to sec-
20 tion 515(c)(5) of the Federal Food, Drug, and Cosmetic
21 Act (as added under subsection (a)), the Director shall
22 extend, for a period of 2 years, the patent in effect with
23 respect to such device under title 35 of the United States
24 Code.

1 (c) EFFECTIVE DATE.—This section shall apply to
2 new drug applications filed under section 505(b) of the
3 Federal Food, Drug, and Cosmetic Act (21 U.S.C. 355(b))
4 and to applications for premarket approval of devices
5 under section 515 of such Act (21 U.S.C. 350e) 180 days
6 after the date of enactment of this Act.

7 **SEC. 703. MEDICAL SCHOOLS AND FINDING WHAT WORKS**
8 **IN HEALTH CARE.**

9 Part B of title IX of the Public Health Service Act
10 (42 U.S.C. 299b et seq.) is amended by adding at the end
11 the following:

12 **“SEC. 918. MEDICAL SCHOOLS AND FINDING WHAT WORKS**
13 **IN HEALTH CARE.**

14 “(a) ESTABLISHMENT OF WEB SITE.—Not later
15 than 1 year after the date of enactment of the Healthy
16 Americans Act, the Agency shall establish an Internet
17 Web site—

18 “(1) on which researchers at medical schools
19 and other institutions may post the results of their
20 research concerning evidence-informed best practices
21 for improving the quality and efficiency of care; and

22 “(2) that—

23 “(A) includes a description on how to im-
24 plement such best practices; and

1 “(B) clearly identifies the funding source
2 for the research.

3 “(b) PILOT PROGRAM.—

4 “(1) ESTABLISHMENT.—Using the information
5 about evidence-informed best practices from the Web
6 site under subsection (a) and other sources, the
7 Agency, through the National Research Training
8 Program and in consultation with medical schools,
9 shall develop a pilot program to establish methods
10 by which medical school curricula and training may
11 be updated regularly to reflect best practices to im-
12 prove quality and efficiency in medical practice.

13 “(2) APPLICATION TO PARTICIPATE.—To par-
14 ticipate in the pilot program, an entity shall—

15 “(A) be an accredited medical school; and

16 “(B) submit an application at such time,
17 in such manner, and containing such informa-
18 tion as the Secretary may require.

19 “(3) PARTICIPANTS.—The Secretary shall en-
20 sure that not less than 28 medical schools shall be
21 included in the pilot program.

22 “(4) DURATION; PUBLICATION OF RESULTS.—
23 The Agency shall—

24 “(A) operate the pilot program for 3 years;

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

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

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

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

20 (b) **QUALITY OF CARE STANDARD.**—To develop the
21 information displayed on the Web site with respect to the
22 quality of care of a health care provider, the Secretary
23 shall—

24 (1) on the date of establishment of the Web
25 site, use information on the performance of pro-

1 viders in quality initiatives under the Medicare pro-
2 gram, including demonstration projects, reporting
3 initiatives, and pay for performance efforts; and

4 (2) not later than 3 years after the date of es-
5 tablishment of the Web site, in addition to the infor-
6 mation used under paragraph (1), use quality of
7 care standards developed in consultation with, and
8 similar to standards used by, Medicare quality im-
9 provement organizations of each State.

10 (c) AFFORDABILITY STANDARD.—Not later than 2
11 years after the date of enactment of this Act, the Sec-
12 retary shall, in consultation with health insurance issuers
13 that offer a HAPI plan, develop guidelines by which each
14 health care provider reports to the Secretary with respect
15 to the affordability of services by such provider. The Sec-
16 retary shall ensure that such guidelines—

17 (1) on the date of establishment of such guide-
18 lines, provide for the reporting of affordability of
19 primary care services; and

20 (2) by a date that is no later than 3 years after
21 the date of enactment of this Act, provide for the re-
22 porting of other services.

1 **TITLE VIII—ENHANCED HEALTH**
2 **CARE VALUE**

3 **SEC. 801. RESEARCH ON COMPARATIVE EFFECTIVENESS**
4 **OF HEALTH CARE ITEMS AND SERVICES.**

5 (a) EXPANSION OF SCOPE OF RESEARCH.—Sub-
6 section (a) of section 1013 of the Medicare Prescription
7 Drug, Improvement, and Modernization Act of 2003 (Pub-
8 lic Law 108–173) is amended—

9 (1) in paragraph (1)—

10 (A) in subparagraph (A)—

11 (i) by striking “programs established
12 under titles XVIII, XIX, and XXI of the
13 Social Security Act” and inserting “Fed-
14 eral health care programs (as defined in
15 subparagraph (C))”;

16 (ii) by striking “shall conduct and
17 support research” and inserting “shall con-
18 duct and support research, which may in-
19 clude clinical research,”;

20 (iii) in clause (i), by striking “and” at
21 the end;

22 (iv) in clause (ii), by striking the pe-
23 riod at the end and inserting “; and”; and

24 (v) by adding at the end the following:

1 “(iii) gaps in current research which
2 may necessitate research beyond system-
3 atic reviews of existing evidence.”;

4 (B) by adding at the end the following new
5 subparagraph:

6 “(C) FEDERAL HEALTH CARE PROGRAMS
7 DEFINED.—For purposes of this section, the
8 term ‘Federal health care program’ means each
9 of the following:

10 “(i) Any program established under
11 title XVIII, XIX, or XXI of the Social Se-
12 curity Act.

13 “(ii) The Federal employees health
14 benefits program under chapter 89 of title
15 5, United States Code.

16 “(iii) A health program operated
17 under title 38, United States Code, by the
18 Department of Veterans Affairs.

19 “(iv) The TRICARE program under
20 chapter 55 of title 10, United States Code.

21 “(v) A medical care program of the
22 Indian Health Service or of a tribal organi-
23 zation.

24 “(vi) A HAPI plan under the Healthy
25 Americans Act.”;

1 (2) in paragraph (2)—

2 (A) in subparagraph (C)(i), by striking
3 “the programs established” and inserting “Fed-
4 eral health care programs, including the pro-
5 grams established”;

6 (B) in subparagraph (C)(ii), by striking
7 “and” at the end;

8 (C) in subparagraph (C)(iii), by striking
9 the period at the end and inserting “; and”;

10 (D) by inserting after subparagraph (C)
11 the following:

12 “(iv) shall provide for edu-
13 cation to physicians, other health
14 care providers, and the public
15 (including patients and con-
16 sumers) about the information on
17 comparative effectiveness that is
18 available as a result of research
19 funded under this section.”; and

20 (E) by adding at the end the following:

21 “(D) COMPARATIVE EFFECTIVENESS ADVI-
22 SORY BOARD.—

23 “(i) IN GENERAL.—Effective as of the
24 date of the enactment of this subpara-
25 graph, the stakeholder group consulted for

1 purposes of subparagraph (C)(1) shall be
2 known as the Comparative Effectiveness
3 Advisory Board. Any reference in a law,
4 map, regulation, document, paper, or other
5 record of the United States to such stake-
6 holder group shall be deemed to be a ref-
7 erence to the Comparative Effectiveness
8 Advisory Board.

9 “(ii) COMPOSITION OF BOARD.—The
10 members of the Comparative Effectiveness
11 Advisory Board shall consist of—

12 “(I) the Director of the Agency
13 for Healthcare Research and Quality;
14 and

15 “(II) up to 14 additional mem-
16 bers who shall represent broad con-
17 stituencies of stakeholders including
18 clinicians, patients, researchers, third-
19 party payers, consumers of Federal
20 and State beneficiary programs, and
21 health care industry professionals.

22 “(iii) APPOINTMENT; TERMS.—The
23 Comptroller General of the United States
24 shall appoint the members of the Compara-
25 tive Effectiveness Advisory Board. Each

1 member shall be appointed for a term of 2
2 years. The members appointed for the first
3 term following the date of the enactment
4 of this subparagraph shall be appointed
5 not later than 90 days after such date of
6 enactment. Any member serving on the
7 Advisory Board as of such date of enact-
8 ment may continuing serving through the
9 end of the member's term.

10 “(iv) CONFLICTS OF INTEREST.—In
11 appointing the members of the Compara-
12 tive Effectiveness Advisory Board (and the
13 members of any panel that reports to the
14 Board), the Comptroller General of the
15 United States shall take into consideration
16 any financial conflicts of interest.

17 “(E) ADDITIONAL AUTHORITIES.—In addi-
18 tion to any authorities vested in the Compara-
19 tive Effectiveness Advisory Board as of the day
20 before the date of the enactment of this sub-
21 paragraph, the Comparative Effectiveness Advi-
22 sory Board shall have the following authorities:

23 “(i) To provide input on research pri-
24 orities.

1 “(ii) To recommend how to organize
2 research funded under this section taking
3 into consideration the full range of appro-
4 priate methodologies, including randomized
5 control trials, practical clinical trials, ob-
6 servation studies, and synthesis of existing
7 research.

8 “(iii) To make recommendations on
9 how findings resulting from research fund-
10 ed under this section should be described,
11 presented, and disseminated.

12 “(iv) To make recommendations to
13 the Congress and the Secretary, not later
14 than 2 years after the date of the enact-
15 ment of this subparagraph, regarding the
16 establishment of one or more federally
17 funded research and development centers.

18 “(v) To identify, consistent with sub-
19 paragraph (C)(i), highest priorities (such
20 as treatments that are highly utilized or
21 are for high-cost, chronic illnesses) for re-
22 search, demonstrations, and evaluations to
23 support and improve Federal health care
24 programs.

1 “(vi) To ensure that such priorities
2 are in accordance with the principles de-
3 scribed in subparagraph (F).

4 “(vii) To establish a clinical peer re-
5 view advisory panel (comprised of meth-
6 odologists, health service researchers, and
7 medical experts) for each such priority to
8 advise the Secretary on validating the
9 science and methods used to conduct com-
10 parative effectiveness studies.

11 “(F) PRINCIPLES.—Research conducted or
12 supported under this section shall be in accord-
13 ance with the following principles:

14 “(i) INDEPENDENCE.—The setting of
15 the agenda and use of the research shall be
16 insulated from inappropriate political or
17 stakeholder influence.

18 “(ii) SCIENTIFIC CREDIBILITY.—The
19 methods for conducting the research shall
20 be scientifically based.

21 “(iii) TRANSPARENCY.—All aspects of
22 the prioritization of research, the conduct
23 of the research, and any recommendations
24 based on the research shall be carried out
25 in a transparent manner.

1 “(iv) INCLUSION OF INPUT FROM
2 STAKEHOLDERS.—Patients, providers,
3 health care consumer representatives,
4 health industry representatives, and law-
5 makers shall be consulted regarding prior-
6 ities and dissemination of the research.”;

7 (3) in paragraph (3)(C), by adding at the end
8 the following:

9 “(iii) UPDATES.—The Secretary shall
10 make available and disseminate updated
11 evaluations, syntheses, and findings under
12 this subparagraph not less than every 6
13 months.”; and

14 (4) in paragraph (4)(A), by striking “the pro-
15 grams established under titles XVIII, XIX, and XXI
16 of the Social Security Act” and inserting “the Fed-
17 eral health care programs”.

18 (b) REPORTS TO CONGRESS.—Such section is further
19 amended—

20 (1) by redesignating subsection (e) as sub-
21 section (f); and

22 (2) by inserting after subsection (d) the fol-
23 lowing:

24 “(e) REPORTS.—Not later than 1 year after the date
25 of the enactment of this subsection, and annually there-

1 after, the Secretary, in consultation with the Comparative
2 Effectiveness Advisory Board, shall submit to Congress a
3 report on the activities conducted under this section. The
4 report submitted under this subsection in 2013 shall in-
5 clude a description of the total activities conducted under
6 this section since the date of the enactment of this sub-
7 section, including—

8 “(1) an evaluation of the return on the invest-
9 ment in the program conducted under this section,
10 including the overall cost of the program, the sci-
11 entific knowledge created through the program, and
12 the ways in which such knowledge has been used;

13 “(2) an evaluation of any backlog of unfunded
14 research projects; and

15 “(3) an assessment of—

16 “(A) how the program is working;

17 “(B) the governance structure of the pro-
18 gram;

19 “(C) the ability of the program to include
20 public comment and patient perspectives in pri-
21 ority setting; and

22 “(D) the ability of the program to dissemi-
23 nate findings and conclusions.”.

1 **SEC. 802. HEALTH CARE COMPARATIVE EFFECTIVENESS**
2 **RESEARCH TRUST FUND; FINANCING FOR**
3 **TRUST FUND.**

4 (a) ESTABLISHMENT OF TRUST FUND.—

5 (1) IN GENERAL.—Subchapter A of chapter 98
6 of the Internal Revenue Code of 1986 (relating to
7 Trust Fund code), as amended by this Act, is
8 amended by adding at the end the following new sec-
9 tion:

10 **“SEC. 9512. HEALTH CARE COMPARATIVE EFFECTIVENESS**
11 **RESEARCH TRUST 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 ‘Health Care Comparative Effective-
15 ness Research Trust Fund’ (hereinafter in this section re-
16 ferred to as the ‘Trust Fund’), consisting of such amounts
17 as may be appropriated or credited to such Trust Fund
18 as provided in this section and section 9602(b).

19 “(b) TRANSFERS TO FUND.—There are hereby ap-
20 propriated to the Trust Fund the following:

21 “(1) Amounts equivalent to the net revenues re-
22 ceived in the Treasury from the fees imposed under
23 subchapter B of chapter 34 (relating to fees on
24 health insurance and self-insured plans).

25 “(2) Subject to subsection (c)(2), for each fiscal
26 year beginning with fiscal year 2010, amounts deter-

1 mined by the Secretary of Health and Human Serv-
2 ices to be equivalent to fair share amount deter-
3 mined under subsection (c) multiplied by the average
4 number of individuals entitled to benefits under part
5 A, or enrolled under part B, of title XVIII of the So-
6 cial Security Act during such fiscal year.

7 The amounts appropriated under paragraph (2) shall be
8 transferred from the Federal Hospital Insurance Trust
9 Fund (established under section 1817 of the Social Secu-
10 rity Act) and from the Federal Supplementary Medical In-
11 surance Trust Fund (established under section 1841 of
12 such Act), and from the Medicare Prescription Drug Ac-
13 count within such Trust Fund, in proportion (as estimated
14 by the Secretary) to the total expenditures during such
15 fiscal year that are made under title XVIII of such Act
16 from the respective Trust Fund or account.

17 “(c) FAIR SHARE AMOUNT.—

18 “(1) IN GENERAL.—The Secretary of Health
19 and Human Services shall compute for each fiscal
20 year (beginning with fiscal year 2010) a fair share
21 amount under this subsection that is an amount
22 that, when applied under this section and subchapter
23 B of chapter 34 of the Internal Revenue Code of
24 1986, will result in revenues to the Trust Fund (tak-

1 ing into account any outstanding balance in the
2 Trust Fund) for the fiscal year as follows:

3 “(A) for fiscal year 2010, \$100,000,000;

4 “(B) for fiscal year 2011, \$200,000,000;

5 and

6 “(C) for each of fiscal years 2012 through
7 2014, \$900,000,000.

8 “(2) LIMITATION ON MEDICARE FUNDING.—In
9 no case shall the amount transferred under sub-
10 section (b)(2) for any fiscal year exceed
11 \$200,000,000.

12 “(d) EXPENDITURES FROM FUND.—Amounts in the
13 Trust Fund are available to the Secretary of Health and
14 Human Services for carrying out section 1013 of the
15 Medicare Prescription Drug, Improvement, and Mod-
16 ernization Act of 2003.

17 “(e) NET REVENUES.—For purposes of this section,
18 the term ‘net revenues’ means the amount estimated by
19 the Secretary based on the excess of—

20 “(1) the fees received in the Treasury under
21 subchapter B of chapter 34, over

22 “(2) the decrease in the tax imposed by chapter
23 1 resulting from the fees imposed by such sub-
24 chapter.”.

1 (2) CLERICAL AMENDMENT.—The table of sec-
 2 tions for such subchapter A is amended by adding
 3 at the end thereof the following new item:

“Sec. 9512. Health Care Comparative Effectiveness Research Trust Fund.”.

4 (b) FINANCING FOR FUND FROM FEES ON INSURED
 5 AND SELF-INSURED HEALTH PLANS.—

6 (1) GENERAL RULE.—Chapter 34 of the Inter-
 7 nal Revenue Code of 1986 is amended by adding at
 8 the end the following new subchapter:

9 **“Subchapter B—Insured Health Plans**

“Sec. 4375. Health insurance.

“Sec. 4376. Definitions and special rules.

10 **“SEC. 4375. HEALTH INSURANCE.**

11 “(a) IMPOSITION OF FEE.—There is hereby imposed
 12 on each specified health insurance policy for each policy
 13 year a fee equal to the fair share amount determined
 14 under section 9512(c)(1) multiplied by the average num-
 15 ber of lives covered under the policy.

16 “(b) LIABILITY FOR FEE.—The fee imposed by sub-
 17 section (a) shall be paid by the issuer of the policy.

18 “(c) SPECIFIED HEALTH INSURANCE POLICY.—For
 19 purposes of this section—

20 “(1) IN GENERAL.—Except as otherwise pro-
 21 vided in this section, the term ‘specified health in-
 22 surance policy’ means any accident or health insur-

1 ance policy issued with respect to individuals resid-
2 ing in the United States.

3 “(2) EXEMPTION OF CERTAIN POLICIES.—The
4 term ‘specified health insurance policy’ does not in-
5 clude any insurance policy if substantially all of the
6 coverage provided under such policy relates to—

7 “(A) liabilities incurred under workers’
8 compensation laws,

9 “(B) tort liabilities,

10 “(C) liabilities relating to ownership or use
11 of property,

12 “(D) credit insurance,

13 “(E) Medicare supplemental coverage, or

14 “(F) such other similar liabilities as the
15 Secretary may specify by regulations.

16 “(3) TREATMENT OF PREPAID HEALTH COV-
17 ERAGE ARRANGEMENTS.—

18 “(A) IN GENERAL.—In the case of any ar-
19 rangement described in subparagraph (B)—

20 “(i) such arrangement shall be treated
21 as a specified health insurance policy, and

22 “(ii) the person referred to in such
23 subparagraph shall be treated as the
24 issuer.

1 “(B) DESCRIPTION OF ARRANGEMENTS.—

2 An arrangement is described in this subpara-
3 graph if under such arrangement fixed pay-
4 ments or premiums are received as consider-
5 ation for any person’s agreement to provide or
6 arrange for the provision of accident or health
7 coverage to residents of the United States, re-
8 gardless of how such coverage is provided or ar-
9 ranged to be provided.

10 **“SEC. 4376. DEFINITIONS AND SPECIAL RULES.**

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

13 “(1) ACCIDENT AND HEALTH COVERAGE.—The
14 term ‘accident and health coverage’ means any cov-
15 erage which, if provided by an insurance policy,
16 would cause such policy to be a specified health in-
17 surance policy (as defined in section 4375(c)).

18 “(2) INSURANCE POLICY.—The term ‘insurance
19 policy’ means any policy or other instrument where-
20 by a contract of insurance is issued, renewed, or ex-
21 tended.

22 “(3) UNITED STATES.—The term ‘United
23 States’ includes any possession of the United States.

24 “(b) TREATMENT OF GOVERNMENTAL ENTITIES.—

1 “(1) IN GENERAL.—For purposes of this sub-
2 chapter—

3 “(A) the term ‘person’ includes any gov-
4 ernmental entity, and

5 “(B) notwithstanding any other law or rule
6 of law, governmental entities shall not be ex-
7 empt from the fees imposed by this subchapter
8 except as provided in paragraph (2).

9 “(2) TREATMENT OF EXEMPT GOVERNMENTAL
10 PROGRAMS.—In the case of an exempt governmental
11 program, no fee shall be imposed under section 4375
12 or section 4376 on any covered life under such pro-
13 gram.

14 “(3) EXEMPT GOVERNMENTAL PROGRAM DE-
15 FINED.—For purposes of this subchapter, the term
16 ‘exempt governmental program’ means—

17 “(A) any insurance program established
18 under title XVIII of the Social Security Act,

19 “(B) the medical assistance program es-
20 tablished by title XIX or XXI of the Social Se-
21 curity Act,

22 “(C) any program established by Federal
23 law for providing medical care (other than
24 through insurance policies) to individuals (or

1 the spouses and dependents thereof) by reason
2 of such individuals being—

3 “(i) members of the Armed Forces of
4 the United States, or

5 “(ii) veterans, and

6 “(D) any program established by Federal
7 law for providing medical care (other than
8 through insurance policies) to members of In-
9 dian tribes (as defined in section 4(d) of the In-
10 dian Health Care Improvement Act).

11 “(c) TREATMENT AS TAX.—For purposes of subtitle
12 F, the fees imposed by this subchapter shall be treated
13 as if they were taxes.

14 “(d) NO COVER OVER TO POSSESSIONS.—Notwith-
15 standing any other provision of law, no amount collected
16 under this subchapter shall be covered over to any posses-
17 sion of the United States.”

18 (2) CLERICAL AMENDMENT.—Chapter 34 of
19 such Code is amended by striking the chapter head-
20 ing and inserting the following:

21 **“CHAPTER 34—TAXES ON CERTAIN**
22 **INSURANCE POLICIES**

“SUBCHAPTER A—POLICIES ISSUED BY FOREIGN INSURERS

“SUBCHAPTER B—INSURED HEALTH PLANS

1 **“Subchapter A—Policies Issued By Foreign**
2 **Insurers”.**

3 (3) EFFECTIVE DATE.—The amendments made
4 by this section shall apply with respect to policies
5 and plans for portions or policy or plan years begin-
6 ning on or after October 1, 2008.

7 **SEC. 803. IMPROVED COORDINATION OF HEALTH SERVICES**
8 **RESEARCH.**

9 (a) ADDITIONAL DUTIES FOR FCCCER.—

10 (1) PUBLIC MEETINGS.—Not later than 120
11 days after the date of the enactment of this Act, the
12 Federal Coordinating Council for Comparative Ef-
13 fectiveness Research established under section 804
14 of division A of the American Recovery and Rein-
15 vestment Act of 2009 (Public Law 111–5), in this
16 section referred to as the “Council”, shall hold pub-
17 lic meetings with producers and users of health serv-
18 ices research to examine—

19 (A) the major infrastructure challenges
20 facing the field of health services research;

21 (B) the field’s research priorities over the
22 next 5 years;

23 (C) the current portfolio of health services
24 research being funded;

1 (D) ways to stimulate innovation in the
2 field of health services research; and

3 (E) ways in which the field of health serv-
4 ices research might help to transform the health
5 care system by 2021.

6 (2) ADDITIONAL MEETINGS.—The Council may
7 hold additional public meetings on subjects other
8 than those listed in the paragraph (1) so long as the
9 meetings are determined to be necessary by the
10 Council in carrying out its duties. Additional meet-
11 ings are not required to be completed within the
12 time period specified in paragraph (1).

13 (3) DEVELOP A STRATEGIC PLAN.—Not later
14 than 2 years after the meetings described in para-
15 graph (1) and (2) are completed, the Council shall
16 prepare and make public through the Internet and
17 other channels a strategic plan for the field of health
18 services research, which plan shall include the fol-
19 lowing:

20 (A) A health services research agenda to
21 address the Nation’s evolving health care prior-
22 ities.

23 (B) A plan for addressing the infrastruc-
24 ture needs of the field of health services re-
25 search, including professional development for

1 the next generation of researchers and improved
2 methods and data.

3 (C) A plan for fostering innovation in the
4 field of health services research.

5 (D) A uniform definition of health services
6 research and standard research categories to be
7 used across the funders of health services re-
8 search in developing research budgets and re-
9 porting research expenditures.

10 (b) ANNUAL REPORT.—Not later than 1 year after
11 the publication of the Council’s strategic plan under sub-
12 section (a)(3), and annually thereafter, the Council shall
13 report to the Congress on, and make public a detailed de-
14 scription of, the following:

15 (1) The Council’s progress in implementing the
16 strategic plan.

17 (2) Organizational expenditures in health serv-
18 ices research by the Federal agencies participating
19 in the Council; according to the uniform definition
20 and standard research categories developed by the
21 Council.

1 **TITLE IX—CONTAINING MED-**
2 **ICAL COSTS AND GETTING**
3 **MORE VALUE FOR THE**
4 **HEALTH CARE DOLLAR**

5 **SEC. 901. COST-CONTAINMENT RESULTS OF THE HEALTHY**
6 **AMERICANS ACT.**

7 Congress finds that the Healthy Americans Act will
8 result in the following:

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

13 (2) Administrative savings will be derived from
14 decoupling employers from the health care infra-
15 structure and reducing employers' and insurers' ad-
16 ministrative costs.

17 (3) Private insurance companies will implement
18 uniform billing and common claims forms.

19 (4) Congress will reclaim Medicare and Med-
20 icaid disproportionate share hospital (DSH) pay-
21 ments because previously uninsured persons will go
22 to providers on an outpatient basis instead of an
23 emergency department.

1 (5) State and local governments will save
2 money on programs they operated for the uninsured
3 before enactment of this Act.

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

7 (7) The Federal Government and the private
8 sector will save money if the Food and Drug Admin-
9 istration determines whether products provide new
10 value.

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

13 (9) Requiring hospitals to send large bills to pa-
14 tients for their review will reduce errors in medical
15 billing and force major providers to be more cost
16 conscious.

17 (10) Requiring insurers to reimburse for quality
18 and cost effective services will hold down private sec-
19 tor costs.

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

23 (12) Establishment of electronic medical
24 records by insurers will create savings.

1 (13) Publication of cost and quality data will
2 enable people to look up by zip code affordable high-
3 quality providers.

○