II

110TH CONGRESS
1ST SESSION

S. 334

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

IN THE SENATE OF THE UNITED STATES

JANUARY 18, 2007

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

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A BILL

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

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

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

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

6 (b) TABLE OF CONTENTS.—

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1 **SEC. 2. FINDINGS.**

2 Congress makes the following findings:

1 (1) Americans want affordable, guaranteed pri-
2 vate health coverage that makes them healthier and
3 can never be taken away.
4 (2) American health care provides primarily
5 "sick care" and does not do enough to prevent
6 chronic illnesses like heart disease, stroke, and dia-
7 betes. This results in significantly higher health
8 costs for all Americans.
9 (3) Staying as healthy as possible often requires
10 an individual to change behavior and assume more
11 personal responsibility for his or her health.
12 (4) Personal responsibility for one's health
13 should include purchasing one's own private health
14 care coverage.
15 (5) To accompany this new focus on staying
16 healthy and personal responsibility, our government
17 must guarantee that all Americans receive private
18 affordable health coverage that can never be taken
19 away.
20 (6) Financing this guarantee should be a
21 shared responsibility between individuals, the Gov-
22 ernment, and employers.
23 (7) The $2,200,000,000,000 spent annually on
24 American health care must be spent more effectively
25 in order to meet this guarantee.

1 (8) This guarantee must include easier access
2 to understandable information about the quality,
3 cost, and effectiveness of health care providers, prod-
4 ucts, and services.
5 (9) The fact that businesses in the United
6 States compete globally against businesses whose
7 governments pay for health care, coupled with the
8 aging of the American population and the explosive
9 growth of preventable health problems, makes the
10 status quo in American health care unacceptable.

11 **SEC. 3. DEFINITIONS.**

12 In this Act:
13 (1) ADULT INDIVIDUAL.—The term ''adult indi-
14 vidual'' means an individual who—
15 (A) is—
16 (i) age 19 or older;
17 (ii) a resident of a State;
18 (iii)(I) a United States citizen; or
19 (II) an alien with permanent resi-
20 dence;
21 (iv) not a dependent child; and
22 (v) not an alien unlawfully present in
23 the United States; and

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

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

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

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

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

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

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

1 fined in paragraph (7)) which is licensed to engage
2 in the business of insurance in a State and which is
3 subject to State law which regulates insurance (with-
4 in the meaning of section 514(b)(2) of the Employee
5 Retirement Income Security Act of 1974). Such
6 term does not include a group health plan.
7 (8) HEALTH MAINTENANCE ORGANIZATION.—
8 The term ''health maintenance organization''
9 means—
10 (A) a federally qualified health mainte-
11 nance organization (as defined in section
12 1301(a)),
13 (B) an organization recognized under State
14 law as a health maintenance organization, or
15 (C) a similar organization regulated under
16 State law for solvency in the same manner and
17 to the same extent as such a health mainte-
18 nance organization.
19 (9) PERSONAL RESPONSIBILITY CONTRIBU-
20 TION.—The term ''personal responsibility contribu-
21 tion'' means a payment made by a covered individual
22 to a health care provider or a health insurance
23 issuer with respect to the provision of health care
24 services under a HAPI plan, not including any
25 health insurance premium payment.

1 (10) QUALIFIED COLLECTIVE BARGAINING
2 AGREEMENT.—
3 (A) IN GENERAL.—The term ''qualified
4 collective bargaining agreement'' means an
5 agreement between a qualified collective bar-
6 gaining employer and an employee organization
7 that represents the employees of such employer
8 that is in effect until the date that is the earlier
9 of—
10 (i) January 1 of the first year which
11 is more than 7 years after the date of en-
12 actment of this Act, or
13 (ii) the date the collective bargaining
14 agreement expires.
15 (B) QUALIFIED COLLECTIVE BARGAINING
16 EMPLOYER.—The term ''qualified collective bar-
17 gaining employer'' means an employer who pro-
18 vides health insurance to employees under the
19 terms of a collective bargaining agreement
20 which is entered into before the date of the en-
21 actment of this Act.
22 (11) SECRETARY.—The term ''Secretary''
23 means the Secretary of Health and Human Services.
24 (12) STATE.—The term ''State'' means each of
25 the several States of the United States, the District

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

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

9 TITLE I—HEALTHY AMERICANS 10 PRIVATE INSURANCE PLANS

11 Subtitle A—Guaranteed Private 12 Coverage

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

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

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

24 (a) INDIVIDUAL RESPONSIBILITY.—

1 (1) ADULT INDIVIDUALS.—Each adult indi-
2 vidual shall have the responsibility to enroll in a
3 HAPI plan offered through the HHA of the adult
4 individual's State of residence, unless the adult indi-
5 vidual—
6 (A) provides evidence of receipt of coverage
7 under, or enrollment in a health plan offered
8 through—
9 (i) the Medicare program under title
10 XVIII of the Social Security Act;
11 (ii) a health insurance plan offered by
12 the Department of Defense;
13 (iii) an employee benefit plan through
14 a former employer;
15 (iv) a qualified collective bargaining
16 agreement;
17 (v) the Department of Veterans Af-
18 fairs; or
19 (vi) the Indian Health Service; or
20 (B) is opposed to health plan coverage for
21 religious reasons, including an individual who
22 declines health plan coverage due to a reliance
23 on healing using spiritual means through prayer
24 alone.

1 (2) DEPENDENT CHILDREN.—Each adult indi-
2 vidual shall have the responsibility to enroll each de-
3 pendent child of the adult individual in a HAPI plan
4 offered through the HHA of the adult individual's
5 State of residence, unless the adult individual—
6 (A) provides evidence that the dependent
7 child is enrolled in a health plan offered
8 through a program described in paragraph
9 (1)(A); or
10 (B) is described in paragraph (1)(B).
11 (3) VERIFICATION OF RELIGIOUS EXCEPTION.—
12 Each State shall develop guidelines for determining
13 and verifying the individuals who qualify for the ex-
14 ception under paragraph (1)(B).
15 (b) PENALTY FOR FAILURE TO PURCHASE COV-
16 ERAGE.—
17 (1) PENALTY.—
18 (A) IN GENERAL.—In the case of an indi-
19 vidual described in subparagraph (B), such in-
20 dividual shall be subject to a late enrollment
21 penalty in an amount determined under sub-
22 paragraph (C).
23 (B) INDIVIDUALS SUBJECT TO PENALTY.—
24 An individual described in this subparagraph is
25 an adult individual for whom there is a contin-

1 uous period of 63 days or longer, beginning on
2 the applicable date (as defined in subparagraph
3 (E)) and ending on the date of enrollment in a
4 HAPI plan, during all of which the individual—
5 (i) was not covered under a HAPI
6 plan or a health plan offered through a
7 program described in paragraph (1)(A) of
8 section 102(a); and
9 (ii) was not described in paragraph
10 (1)(B) of such section.
11 (C) AMOUNT OF PENALTY.—
12 (i) IN GENERAL.—The amount deter-
13 mined under this subparagraph for an in-
14 dividual is an amount equal to the sum
15 of—
16 (I) the number of uncovered
17 months multiplied by the weighted av-
18 erage of the monthly premium for
19 HAPI plans of the same class of cov-
20 erage as the individual's in the appli-
21 cable coverage area (determined with-
22 out regard to any subsidy under sec-
23 tion 121); and
24 (II) 15 percent of the amount de-
25 termined under subclause (I).

1 (ii) UNCOVERED MONTH DEFINED.—
2 For purposes of this subsection, the term
3 "uncovered month" means, with respect to
4 an individual, any month beginning on or
5 after the applicable date (as defined in
6 subparagraph (E)) unless the individual
7 can demonstrate that the individual—
8 (I) was covered under a HAPI
9 plan or a health plan offered through
10 a program described in paragraph
11 (1)(A) of section 102(a) for any por-
12 tion of such month; or
13 (II) was described in paragraph
14 (1)(B) of such section for any portion
15 of such month.
16 A month shall not be treated as an uncov-
17 ered month if the individual has already
18 paid a late enrollment penalty under this
19 subsection for such month or if the indi-
20 vidual was incarcerated for the entire
21 month.
22 (D) PAYMENT.—Payment of any late en-
23 rollment penalty by an individual under this
24 subsection shall be made to the HHA of the in-

1 dividual's State of residence under procedures
2 established by the State.
3 (E) APPLICABLE DATE.—In this para-
4 graph, the term "applicable date" means the
5 earlier of—
6 (i) the day after the end of the State's
7 first open enrollment period for HAPI
8 plans (during which all adult individuals
9 are eligible to enroll); and
10 (ii) the day after the end of the first
11 enrollment period for a fallback HAPI plan
12 in the State.
13 (2) WAIVER.—An HHA of a State may reduce
14 or waive the amount of any late enrollment penalty
15 applicable to an individual under this subsection if
16 payment of such penalty would constitute a hardship
17 (determined under procedures established by the
18 State).
19 (3) ENFORCEMENT.—Each State shall deter-
20 mine appropriate mechanisms, which may not in-
21 clude revocation or ineligibility for coverage under a
22 HAPI plan, to enforce the responsibility of each
23 adult individual to purchase HAPI plan coverage for
24 such individual and any dependent children of such
25 individual under subsection (a).

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

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

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

9 (a) OPTIONS.—A State HHA—
10 (1) shall require that at least 2 HAPI plans
11 that comply with the requirements of subsection (b),
12 be offered through the HHA to each individual in
13 the State;
14 (2) may require the offering of 1 or more HAPI
15 plans that include coverage for benefits, items, or
16 services required by the State in addition to the
17 standardized benefits, items, or services required
18 under subsection (b) for HAPI plans if—
19 (A) such additional benefits, items, and
20 services build upon the standardized benefits
21 package;
22 (B) a list of such additional benefits,
23 items, or services, and the prices applicable to
24 such additional benefits, items, and services, is
25 displayed in a manner that is separate from the

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

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

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

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

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

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

1 cluding coverage of an initial primary care as-
2 sessment and annual physical examinations;
3 (B) provide benefits for wellness programs
4 and incentives to promote the use of such pro-
5 grams;
6 (C) provide coverage for catastrophic med-
7 ical events that result in out-of-pocket costs for
8 an individual or family if lifetime limits are ex-
9 hausted;
10 (D) designate a health care provider, such
11 as a primary care physician, nurse practitioner,
12 or other qualified health provider, to monitor
13 the health and health care of a covered individ-
14 uals (such provider shall be known as the
15 "health home" of the covered individual);
16 (E) ensure that, as part of the first visit
17 with a primary care physician or the health
18 home of a covered individual, such provider and
19 individual determine a care plan to maximize
20 the health of the individual through wellness
21 and prevention activities;
22 (F) provide benefits for comprehensive dis-
23 ease prevention, early detection, disease man-
24 agement, and chronic condition management

1 that meets minimum standards developed by
2 the Secretary;
3 (G) provide for the application of personal
4 responsibility contribution requirements with re-
5 spect to covered benefits in a manner that may
6 be similar to the cost sharing requirements ap-
7 plied as of January 1, 2007, under the Blue
8 Cross/Blue Shield Standard Plan provided
9 under the Federal Employees Health Benefit
10 Program under chapter 89 of title 5, United
11 States Code, except that no contributions shall
12 be required for—
13 (i) preventive items or services; and
14 (ii) early detection, disease manage-
15 ment, or chronic pain treatment items or
16 services; and
17 (H) comply with the requirements of sec-
18 tion 112.
19 (2) DETERMINATION OF BENEFITS BY SEC-
20 RETARY.—Not later than 1 year after the date of
21 enactment of this Act, the Secretary shall promul-
22 gate guidelines concerning the benefits, items, and
23 services that are covered under paragraph (1).
24 (3) COVERAGE FOR FAMILY PLANNING.—

1 (A) IN GENERAL.—Except as provided in
2 subparagraph (B), a health insurance issuer
3 shall make available supplemental coverage for
4 abortion services that may be purchased in con-
5 junction with enrollment in a HAPI plan or an
6 actuarially equivalent healthy American plan.
7 (B) RELIGIOUS AND MORAL EXCEPTION.—
8 Nothing in this paragraph shall be construed to
9 require a health insurance issuer affiliated with
10 a religious institution to provide the coverage
11 described in subparagraph (A).
12 (4) RULE OF CONSTRUCTION.—Nothing in this
13 subsection shall be construed to prohibit a HAPI
14 plan from providing coverage for benefits, items, and
15 services in addition to the coverage required under
16 this subsection. No premium subsidies shall be avail-
17 able under subtitle C for any portion of the pre-
18 miums for a HAPI plan that are attributable to
19 such additional benefits, items, or services.
20 (c) ACTUARIALLY EQUIVALENT HEALTHY AMERICAN
21 PLANS.—Each actuarially equivalent healthy American
22 plan offered through an HHA shall—
23 (1) cover all treatments, items, services, and
24 providers at least to the same extent as those cov-
25 ered under a HAPI plan that—

1 (A) shall include coverage for—
2 (i) preventive items and services (in-
3 cluding well baby care and well child care
4 and appropriate immunizations) and dis-
5 ease management services;
6 (ii) inpatient and outpatient hospital
7 services;
8 (iii) physicians' surgical and medical
9 services; and
10 (iv) laboratory and x-ray services; and
11 (B) may include additional supplemental
12 benefits to the extent approved by the State
13 and provided for in advance in the plan con-
14 tract; and
15 (2) ensure that no personal responsibility con-
16 tribution requirements are applied for prevention
17 and chronic disease management benefits, items, or
18 services.
19 (d) PREMIUMS AND RATING REQUIREMENTS.—
20 (1) CLASSES OF COVERAGE.—With respect to a
21 HAPI plan, a health insurance issuer shall provide
22 for the following classes of coverage:
23 (A) Coverage of an individual.

1 (B) Coverage of a married couple or do-
2 mestic partnership (as determined by a State)
3 without dependent children.
4 (C) Coverage of an adult individual with 1
5 or more dependent children.
6 (D) Coverage of a married couple or do-
7 mestic partnership (as determined by a State)
8 with 1 or more dependent children.
9 (2) DETERMINATIONS OF PREMIUMS.—With re-
10 spect to each class of coverage described in para-
11 graph (1), a health insurance issuer shall determine
12 the premium amount for a HAPI plan using ad-
13 justed community rating principals, as described in
14 paragraphs (3) and (4) established by the State.
15 States may permit premium variations based only on
16 geography, tobacco use, and family size. A State
17 may determine to have no variation.
18 (3) REWARDS.—A State shall permit a health
19 insurance issuer to provide premium discounts and
20 other incentives to enrollees based on the participa-
21 tion of such enrollees in wellness, chronic disease
22 management, and other programs designed to im-
23 prove the health of the enrollees.
24 (4) LIMITATION.—A health insurance issuer
25 shall not consider age, gender, industry, health sta-

1 tus, or claims experience in determining premiums
2 under this subsection.
3 (e) APPLICATION OF STATE MANDATE LAWS.—State
4 benefit mandate laws that would otherwise be applicable
5 to HAPI plans shall be preempted.

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

7 (a) IN GENERAL.—Each HAPI plan offered through
8 a HHA shall—
9 (1) provide for increased portability through
10 limitations on the application of preexisting condi-
11 tion exclusions, in a manner similar to that provided
12 for under section 2701 of the Public Health Service
13 Act (42 U.S.C. 300gg), as such section existed on
14 the day before the date of enactment of this Act, ex-
15 cept that the State shall develop procedures to en-
16 sure that preexisting exclusion limitations do not
17 apply to new enrollees who had no applicable cred-
18 itable coverage immediately prior to the first enroll-
19 ment period;
20 (2) provide for the guaranteed availability of
21 coverage to prospective enrollees in a manner similar
22 to that provided for under section 2711 of the Pub-
23 lic Health Service Act (42 U.S.C. 300gg–11), as
24 such section existed on the day before the date of
25 enactment of this Act;

1 (3) provide for the guaranteed renewability of
2 coverage in a manner similar to that provided for
3 under section 2712 of the Public Health Service Act
4 (42 U.S.C. 300gg–12), as such section existed on
5 the day before the date of enactment of this Act, ex-
6 cept that the prohibition on market reentry provided
7 for under such section shall be deemed to be 2 years;
8 (4) prohibit discrimination against individual
9 enrollees and prospective enrollees based on health
10 status in a manner similar to that provided for
11 under section 2702 of the Public Health Service Act
12 (42 U.S.C. 300gg–1), as such section existed on the
13 day before the date of enactment of this Act;
14 (5) provide coverage protections for enrollees
15 who are mothers and newborns in a manner similar
16 to that provided for under section 2704 of the Pub-
17 lic Health Service Act (42 U.S.C. 300gg–3), as such
18 section existed on the day before the date of enact-
19 ment of this Act;
20 (6) provide for full parity in the application of
21 certain limits to mental health benefits in a manner
22 similar to that provided for under section 2705 of
23 the Public Health Service Act (42 U.S.C. 300gg–4),
24 as such section existed on the day before the date
25 of enactment of this Act;

1 (7) provide coverage for reconstructive surgery
2 following a mastectomy in a manner similar to that
3 provided for under section 2706 of the Public
4 Health Service Act (42 U.S.C. 300gg–5), as such
5 section existed on the day before the date of enact-
6 ment of this Act; and
7 (8) prohibit discrimination on the basis of ge-
8 netic information, as provided for under subsection
9 (b).
10 (b) GENETIC NONDISCRIMINATION.—
11 (1) PROHIBITION ON GENETIC INFORMATION AS
12 A CONDITION OF ELIGIBILITY.—A HAPI plan shall
13 not establish rules for the eligibility (including con-
14 tinued eligibility) of any individual to enroll in cov-
15 erage under the plan based on genetic information
16 (including information about a request for or receipt
17 of genetic services by an individual or family mem-
18 ber of such individual).
19 (2) PROHIBITION ON GENETIC INFORMATION IN
20 SETTING PREMIUM RATES.—A HAPI plan shall not
21 adjust premium or personal responsibility contribu-
22 tion amounts for an individual on the basis of ge-
23 netic information concerning the individual or a fam-
24 ily member of the individual (including information

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

(3) GENETIC TESTING.—

(A) LIMITATION ON REQUESTING OR REQUIRING GENETIC TESTING.—A HAPI plan shall not request or require an individual or a family member of such individual to undergo a genetic test.

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

(i) limit the authority of a health care professional who is providing health care services with respect to an individual to request that such individual or a family member of such individual undergo a genetic test;

(ii) limit the authority of a health care professional who is employed by or affiliated with a HAPI plan and who is providing health care services to an individual as part of a bona fide wellness program to notify such individual of the availability of a genetic test or to provide information to such individual regarding such genetic test; or

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

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

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

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

16 (b) COMPOSITION.—

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

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

22 (B) at least 1 such member shall be an
23 ethicist;

1 (C) at least 1 such member shall be a rep-
2 resentative of health care providers, including
3 nurses and other nonphysician providers;
4 (D) at least 1 such member shall be a rep-
5 resentative of health insurance issuers;
6 (E) at least 1 such member shall be a
7 health care consumer;
8 (F) at least 1 such member shall be a rep-
9 resentative of the United States Preventive
10 Services Task Force; and
11 (G) at least 1 such member shall be an ac-
12 tuary.
13 (2) GEOGRAPHIC BALANCE.—The Comptroller
14 General shall ensure the geographic diversity of the
15 members appointed under paragraph (1).
16 (c) TERMS, VACANCIES.—Members of the Advisory
17 Committee shall be appointed for a term of 3 years and
18 may be reappointed for 1 additional term. In appointing
19 members, the Comptroller General shall stagger the terms
20 of the initial members so that the terms of one-third of
21 the members expire each year. Vacancies in the member-
22 ship of the Advisory Committee shall not affect the Com-
23 mittee's ability to carry out its functions. The Comptroller
24 General shall appoint an individual to fill the remaining

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

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

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

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

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

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

Subtitle C—Eligibility for Premium and Personal Responsibility Contribution Subsidies

SEC. 121. ELIGIBILITY FOR PREMIUM SUBSIDIES.

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

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

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

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

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

13 (A) the excess of—

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

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

19 (B) the excess of—

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

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

1 (3) APPLICABLE PERCENTAGE.—For purposes
2 of this subsection, the applicable percentage is 400
3 percent.
4 (c) BASIC PREMIUM SUBSIDY AMOUNT.—For pur-
5 poses of this section, the term ''basic premium subsidy
6 amount'' means, with respect to any individual, the lesser
7 of—
8 (1) the annual premium for the HAPI plan
9 under which the individual is a covered individual; or
10 (2) the weighted average of the premium for
11 HAPI plans of the same class of coverage (as de-
12 scribed in section 111(d)(1)) as the individual's in
13 the applicable coverage area.
14 (d) CHANGE IN STATUS NOTIFICATION.—
15 (1) IN GENERAL.—If an individual's modified
16 adjusted income changes such that the individual be-
17 comes eligible or ineligible for a subsidy under this
18 section, the individual shall report that change to
19 the HHA of the individual's State of residence not
20 more than 60 days after the change takes effect. If
21 an individual reports the change within 60 days
22 under the preceding sentence, the individual's HAPI
23 plan coverage shall be deemed credible coverage for
24 the purposes of maintaining coverage for preexisting
25 conditions.

1 (2) ADJUSTMENT.—The HHA shall adjust the
2 premium subsidy of such individual to take effect on
3 the first month after the date of the notification
4 under paragraph (1) for which the next premium
5 payment would be due from the individual.
6 (e) CATASTROPHIC EVENT.—A State may develop
7 mechanisms to ensure that covered individuals do not have
8 a break in coverage due to a catastrophic financial event.

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

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

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

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

4 (a) DETERMINATION OF MODIFIED ADJUSTED
5 GROSS INCOME.—
6 (1) IN GENERAL.—In this subtitle, the term
7 ''modified adjusted gross income'' means adjusted
8 gross income (as defined in section 62 of the Inter-
9 nal Revenue Code of 1986)—
10 (A) determined without regard to sections
11 86, 135, 137, 199, 221, 222, 911, 931, and
12 933 of such Code; and
13 (B) increased by—
14 (i) the amount of interest received or
15 accrued during the taxable year which is
16 exempt from tax under such Code; and
17 (ii) the amount of any social security
18 benefits (as defined in section 86(d) of
19 such Code) received or accrued during the
20 taxable year.
21 (2) TAXABLE YEAR TO BE USED TO DETER-
22 MINE MODIFIED ADJUSTED GROSS INCOME.—In ap-
23 plying this subtitle to determine an individual's an-
24 nual premiums, the covered individual's modified ad-
25 justed gross income shall be such income determined

1 using the individual's most recent income tax return
2 or other information furnished to the Secretary by
3 such individual, as the Secretary may require.
4 (b) POVERTY LINE.—In this subtitle, the term "pov-
5 erty line" has the meaning given such term in section
6 673(2) of the Community Health Services Block Grant
7 Act (42 U.S.C. 9902(2)), including any revision required
8 by such section.
9 (c) OTHER PROCEDURES TO DETERMINE SUB-
10 SIDIES.—The Secretary shall promulgate regulations to be
11 used by HHAs to calculate the premium subsidies under
12 section 121 and personal responsibility subsidies under
13 section 122 for individuals whose modified adjusted gross
14 income described in subsection (a)(2) is significantly lower
15 than the modified adjusted gross income of the year in-
16 volved.
17 (d) SPECIAL RULE FOR UNLAWFULLY PRESENT
18 ALIENS.—A health insurance issuer shall remit to the
19 Federal Government any funding, including any subsidy
20 payments, received by such issuer from the Federal Gov-
21 ernment on behalf of any adult alien who is unlawfully
22 present in the United States.
23 (e) SPECIAL RULE FOR ALIENS.—The Secretary of
24 Homeland Security may not extend or renew an alien's

eligibility for status in the United States or adjust the status of an alien in the United States if the alien owes—

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

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

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

Subtitle D—Wellness Programs

SEC. 131. REQUIREMENTS FOR WELLNESS PROGRAMS.

(a) DEFINITION.—In this Act, the term ''wellness program'' means a program that consists of a combination of activities that are designed to increase awareness, assess risks, educate, and promote voluntary behavior change to improve the health of an individual, modify his or her consumer health behavior, enhance his or her personal well-being and productivity, and prevent illness and injury.

(b) DISCOUNTS.—

1 (1) ELIGIBILITY.—With respect to a HAPI
2 plan that is offered in a State that permits premium
3 discounts for enrollees who participate in a wellness
4 program, to be eligible to receive such a discount,
5 the administrator of the wellness program, on behalf
6 of the enrollee, shall certify in writing to the plan
7 that—
8 (A)(i) the enrollee is participating in an
9 approved wellness program; or
10 (ii) the dependent child of the enrollee is
11 participating in an approved wellness program;
12 and
13 (B) the wellness program meets the re-
14 quirements of this subsection.
15 (2) REQUIREMENTS.—A wellness program
16 meets the requirements of this paragraph if such
17 program—
18 (A) is reasonably designed (as determined
19 by the HAPI plan) to promote good health and
20 prevent disease for program participants;
21 (B) has been approved by the HAPI plan
22 for purposes of applying participation discounts;
23 (C) is offered to all enrollees in a HAPI
24 plan regardless of health status;

1 (D) permits any enrollee for whom it is un-
2 reasonably difficult to meet the initial program
3 standard for participation due to a medical con-
4 dition (or for whom it is medically inadvisable
5 to attempt) an opportunity to meet a reason-
6 able alternative participation standard—
7 (i)(I) that is developed prior to enroll-
8 ment of the enrollee; or
9 (II) that is developed in consultation
10 with the enrollee after enrollment of the
11 enrollee, after a determination has been
12 made that the enrollee cannot safely meet
13 the program participation standard; and
14 (ii) the availability of which is dis-
15 closed in the original documents relating to
16 participation in the program;
17 (E) applies procedures for determining
18 whether an enrollee is participating in a mean-
19 ingful manner in the program, including proce-
20 dures to determine if such participation is re-
21 sulting in lifestyle changes that are indicative of
22 an improved health outcome or outcomes; and
23 (F) meets any other requirements imposed
24 by the HAPI plan.

1 (3) RELATION TO HEALTH STATUS.—Participa-
2 tion in a wellness program may not be used by a
3 HAPI plan to make rate or discount determinations
4 with respect to the health status of an enrollee.
5 (4) AVAILABILITY OF DISCOUNTS.—
6 (A) OFFERING OF ENROLLMENT.—A
7 HAPI plan shall provide enrollees with the op-
8 portunity to participate in a wellness program
9 (for purposes of qualifying for premium dis-
10 counts) at least once each year.
11 (B) DETERMINATIONS.—Determinations
12 with respect to the successful participation by
13 an enrollee in a wellness program for purposes
14 of qualifying for discounts shall be made by the
15 HAPI plan based on a retrospective review of
16 the scope of activities of the enrollee under the
17 program. The HAPI plan may require a min-
18 imum level of successful participation in such a
19 program prior to applying any premium dis-
20 count.
21 (C) PARTICIPATION IN MULTIPLE PRO-
22 GRAMS.—An enrollee may participate in mul-
23 tiple wellness programs to reach the maximum
24 premium discount permitted by the HAPI plan
25 under applicable State law.

1 (5) PERSONAL RESPONSIBILITY CONTRIBUTION
2 DISCOUNT.—A HAPI plan may elect to provide dis-
3 counts in the amount of the personal responsibility
4 contribution that is required of an enrollee if the en-
5 rollee participates in an approved wellness program.
6 (c) EMPLOYER INCENTIVE FOR WELLNESS PRO-
7 GRAMS.—For provisions relating to employers deducting
8 the costs of offering wellness programs or worksite health
9 centers see section 162(l) of the Internal Revenue Code
10 of 1986.

11 TITLE II—HEALTHY START FOR 12 CHILDREN

13 Subtitle A—Benefits and Eligibility

14 SEC. 201. GENERAL GOAL AND AUTHORIZATION OF APPRO- 15 PRIATIONS FOR HAPI PLAN COVERAGE FOR 16 CHILDREN.

17 (a) GENERAL GOAL.—It is the general goal of this
18 Act to provide essential, good quality, affordable, and pre-
19 vention-oriented health care coverage for all children in
20 the United States.
21 (b) AUTHORIZATION OF APPROPRIATIONS.—There is
22 authorized to be appropriated, such sums as may be nec-
23 essary for each fiscal year to enable the Secretary to pro-
24 vide assistance to States to enable such States to ensure
25 that each child who is a member of a family with a modi-

fied adjusted gross income that is below 300 percent of the poverty line as applicable to a family of the size involved, who is not otherwise eligible for coverage as a dependent under a HAPI plan maintained by his or her parents, is covered under a HAPI plan provided through the State HHA.

(c) POLICIES AND PROCEDURES.—The Secretary shall develop policies and procedures to be applied by the States to identify children described in subsection (a) and to provide such children with coverage under a HAPI plan. States shall determine, in consultation with health insurance issuers, a separate class of coverage to assure affordable child coverage.

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

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

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

1 covered under a HAPI plan provided through the State
2 HHA continues to receive medical assistance under State
3 Medicaid plans in a manner that—
4 (1) is provided in coordination with, and as a
5 supplement to, the coverage provided the child under
6 the HAPI plan in which the child is enrolled;
7 (2) does not supplant the child's coverage under
8 a HAPI plan; and
9 (3) ensures that the child receives any items or
10 services that are not available under the HAPI plan
11 in which they are enrolled but that the child would
12 have received under the Medicaid program of the
13 State in which the child resides if the Healthy Amer-
14 icans Act had not been enacted, including items and
15 services described in section 1905(a)(4)(B) (relating
16 to early and periodic screening, diagnostic, and
17 treatment services defined in section 1905(r) and
18 provided in accordance with the requirements of sec-
19 tion 1902(a)(43)).
20 (b) DEFINITION.—In this section, the term ''child'',
21 in addition to the meaning given that term under section
22 201(d), includes any individual who would be considered
23 a child under the Medicaid program of the State in which
24 the individual resides.

Subtitle B—Service Providers

SEC. 211. INCLUSION OF PROVIDERS UNDER HAPI PLANS.

(a) IN GENERAL.—To ensure that children have access to health care in their communities, and that such care is provided to such children for no cost or on a reimbursable basis, a HAPI plan shall ensure that health care items and services may be obtained by such children from, at a minimum, the providers described in subsection (b) if available in the area involved.

(b) PROVIDERS DESCRIBED.—The providers described in this subsection include the following:

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

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

(3) A federally qualified health center.

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

(5) An Indian health service facility.

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

(a) DEFINITION.—In this section, the term ''school-based health center'' means a health center that—

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

1 (2) is operated in collaboration with the school
2 in which such center is located;
3 (3) is administered by a community-based orga-
4 nization including a hospital, public health depart-
5 ment, community health center, or nonprofit health
6 care agency;
7 (4) at a minimum, provides to school-aged chil-
8 dren—
9 (A) primary health care services, including
10 comprehensive health assessments, and diag-
11 nosis and treatment of minor, acute, and chron-
12 ic medical conditions and Healthy Start bene-
13 fits;
14 (B) mental health services, including crisis
15 intervention, counseling, and emergency psy-
16 chiatric care at the school or by referral;
17 (C) the availability of services at the school
18 when the school is open and 24-hour coverage
19 through an on-call system with other providers
20 to ensure access when the school or health cen-
21 ter is closed;
22 (D) services through the use of a qualified
23 and appropriately credentialed individual, in-
24 cluding a nurse practitioner or physician assist-

1 ant, a mental health professional, a physician,
2 and a health assistant; and
3 (E) by not later than January 1, 2010, an
4 electronic medical record relating to the indi-
5 vidual; and
6 (5) may provide optional preventive dental serv-
7 ices, consistent with State licensure law, through the
8 use of dental hygienists or dental assistants that
9 provide preventive services such as basic oral exams,
10 cleanings, and sealants.
11 (b) ACCESS TO SCHOOL-BASED HEALTH CEN-
12 TERS.—
13 (1) IN GENERAL.—A school-based health center
14 may provide services to students in more than 1
15 school if the school district or other supervising
16 State entity determined that capacity and geo-
17 graphic location make such provision of services ap-
18 propriate.
19 (2) ENROLLMENT.—Upon the enrollment of a
20 student in a school with a school-based health cen-
21 ter, the center will provide the student with the op-
22 portunity to enroll, after parental consent, to receive
23 health care from the center.
24 (3) REIMBURSEMENT FOR SERVICES.—

1 (A) IN GENERAL.—A school-based health
2 center may seek reimbursement from a third
3 party payer if available, including a HAPI plan,
4 if a child receives health care items or services
5 through the center.
6 (B) USE OF FUNDS.—Amounts received
7 from a third party payer under subparagraph
8 (A) shall be allocated to the school-based health
9 center that provided the care for which the re-
10 imbursement was provided for use by that cen-
11 ter for providing additional health care items
12 and services.
13 (c) DEVELOPMENTAL GRANTS.—
14 (1) IN GENERAL.—The Secretary shall award
15 grants to local school districts and communities for
16 the establishment and operation of school-based
17 health centers.
18 (2) ELIGIBILITY.—To be eligible for a grant
19 under paragraph (1), a local school district or local
20 community shall submit to the Secretary an applica-
21 tion at such time, in such manner, and containing
22 such information as the Secretary may require.
23 (3) SELECTION CRITERIA.—In awarding grants
24 under this subsection, the Secretary shall give pri-
25 ority to—

1 (A) an applicant that will use amounts
2 under the grant to establish a school-based
3 health center in a medically underserved area,
4 or an area for which there are extended dis-
5 tances between the school involved and appro-
6 priate providers of care for school-aged children
7 in the geographic area involved;
8 (B) an applicant that will use amounts
9 under the grant to establish a school-based
10 health center in a school that serves students
11 with the highest incidence of unmet medical
12 and psycho-social needs; and
13 (C) an applicant that can demonstrate that
14 State, local, or community partners, or any
15 combination of such entities, have provided at
16 least 50 percent of the funding for the school-
17 based health center involved to ensure the ongo-
18 ing operation of the center.
19 (4) USE OF FUNDS.—A grantee shall use
20 amounts received under a grant under this sub-
21 section to establish and operate a school-based
22 health center. Not less than 50 percent of the
23 amounts received under the grant shall be used for
24 the ongoing operations of the center.

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

(e) AUTHORIZATION OF APPROPRIATIONS.—There is authorized to be appropriated, such sums as may be necessary for each fiscal year to carry out this section.

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.

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

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

1 ized care or home and community-based services;
2 and
3 (2) ensures that, after December 31 of the last
4 calendar year ending before the first calendar year
5 in which coverage under a HAPI plan begins, each
6 such individual continues to receive medical assist-
7 ance under State Medicaid programs in a manner
8 that—
9 (A) is provided in coordination with, and
10 as a supplement to, the coverage provided the
11 individual under the HAPI plans in which the
12 individual is enrolled;
13 (B) does not supplant the individual's cov-
14 erage under a HAPI plan; and
15 (C) ensures that the individual receives
16 any items or services that are not available
17 under the HAPI plan in which the individual is
18 enrolled but that the individual would have re-
19 ceived under the Medicaid program of the State
20 in which the individual resides if the Healthy
21 Americans Act had not been enacted.
22 (b) DEFINITIONS.—In this section—
23 (1) the term "institutionalized care" means the
24 health care provided under the Medicaid plan of the
25 State of residence of an elderly or disabled individual

1 who is a patient in a hospital, nursing facility, inter-
2 mediate care facility for the mentally retarded, or an
3 institution for mental diseases (as such terms are
4 defined for purposes of such plan); and
5 (2) the term ''home and community-based serv-
6 ices'' means any services which may be offered
7 under the Medicaid plan of the State of residence of
8 an elderly or disabled individual under a home and
9 community-based waiver authorized for a State
10 under section 1115 of the Social Security Act (42
11 U.S.C. 1315) or under subsection (c), (d), or (i) of
12 section 1915 of such Act (42 U.S.C. 1396n).

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

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

18 (a) IN GENERAL.—Title XIX of the Social Security
19 Act is amended by adding at the end the following new
20 section:
21 ''STATE CHOICES FOR LONG-TERM CARE PROGRAM
22 ''SEC. 1940. (a) IN GENERAL.—Notwithstanding any
23 other provision of this title, the Secretary shall permit a
24 State to establish and operate under the State plan under
25 this title (including such a plan operating under a state-

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

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

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

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

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

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

1 "(C) addressing issues related to ensuring
2 the safety and quality of the long-term care
3 services provided to the individual.
4 "(3) INFORMED CHOICE.—The program shall
5 have procedures to ensure that each individual that
6 is likely to satisfy the eligibility criteria established
7 for the program under paragraph (6) who is dis-
8 charged from a hospital or who resides in a nursing
9 facility, intermediate care facility for the mentally
10 retarded, or institution for mental diseases and who
11 requires long-term care services is informed of the
12 options available to the individual under the pro-
13 gram for obtaining such services.
14 "(4) SELF-DIRECTED OPTION.—The program
15 shall provide an individual enrolled in the program
16 with the option to elect to plan and purchase the
17 long-term care services that are contained in the in-
18 dividual's benefit package under the direction and
19 control of the individual (or the individual's author-
20 ized representative), subject to an individualized
21 budget developed for, and with the involvement of,
22 the individual (or the individual's authorized rep-
23 resentative).
24 "(5) EQUAL ACCESS TO INSTITUTIONAL CARE
25 AND HOME AND COMMUNITY-BASED SERVICES.—The

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

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

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

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

1 services provided under a home and community-based waiver approved for the State; and

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

6 "(B) be based on a strategy for prioritizing and allocating expenditures so that those individuals with the highest level of need for long-term care services are assured of receiving such services through an institutional facility or through a home and community-based provider, based on the individual's needs and preferences.

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

16 "(1) AGREEMENT TO LIMIT FEDERAL EXPENDITURES.—

18 "(A) IN GENERAL.—The State agrees to an aggregate limit for a 5-year period for Federal payments under section 1903(a) for expenditures for medical assistance for long-term care services under the State plan and administrative expenditures related to the provision of such assistance.

1 "(B) CALCULATION OF AGGREGATE
2 LIMIT.—The 5-year aggregate limit applicable
3 to a State under subparagraph (A) shall be de-
4 termined by the State and the Secretary based
5 on the following:
6 "(i) HISTORICAL AND PROJECTED
7 CASELOADS.—The historical and projected
8 State caseloads (determined for a 5-year
9 period, respectively) of individuals receiving
10 nursing facility services, services in an in-
11 termediate care facility for the mentally re-
12 tarded, services in an institution for men-
13 tal diseases, or services provided under a
14 home and community-based waiver ap-
15 proved for the State under the State plan,
16 based on data from the Secretary, the Bu-
17 reau of the Census, the Commissioner of
18 Social Security, and such other sources as
19 the Secretary may approve.
20 "(ii) HISTORICAL AND PROJECTED
21 EXPENDITURES.—The historical and pro-
22 jected expenditures (determined for a 5-
23 year period, respectively) for the services
24 identified in clause (i). Projected expendi-
25 tures shall be determined without regard to

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

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

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

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

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

22 "(e) INDEPENDENT EVALUATION AND REPORT.—

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

1 demic institution to conduct an ongoing independent
2 evaluation of the program that assesses—
3 ''(A) the quality of the long-term care serv-
4 ices provided under the program;
5 ''(B) the cost-effectiveness of such services;
6 ''(C) consumer satisfaction; and
7 ''(D) the consistency and accuracy with
8 which the prioritization of need criteria required
9 under subsection (b)(6)(B) is applied.
10 ''(2) BIENNIAL REPORTS.—The organization or
11 institution conducting the evaluation required under
12 this subsection shall submit biennial reports to the
13 Secretary regarding the results of the evaluation.
14 ''(f) DEFINITION OF LONG-TERM CARE SERVICES.—
15 For purposes of this section, the term 'long-term care
16 services' has the meaning given such term by a State es-
17 tablishing and operating a program under this section,
18 subject to approval by the Secretary.''.
19 (b) EFFECTIVE DATE.—The amendment made by
20 subsection (a) takes effect on the date of enactment of
21 this Act.
22 **SEC. 312. SIMPLER AND MORE AFFORDABLE LONG-TERM**
23 **CARE INSURANCE COVERAGE.**
24 (a) QUALIFIED LONG-TERM CARE INSURANCE CON-
25 TRACT MUST SATISFY QUALIFIED LONG-TERM CARE

1 PLAN REQUIREMENTS.—Section 7702B(b)(1)(A) (defin-
2 ing qualified long-term care insurance contract) is amend-
3 ed by inserting ''through a qualified long-term care plan''
4 after ''qualified long-term care services''.
5 (b) QUALIFIED LONG-TERM CARE PLAN.—Section
6 7702B is amended by adding at the end the following new
7 subsection:
8 ''(h) QUALIFIED LONG-TERM CARE PLAN.—For pur-
9 poses of this section—
10 ''(1) IN GENERAL.—The term 'qualified long-
11 term care plan' means an insurance plan that meets
12 the standards and requirements set forth in para-
13 graph (2) (including the 2009 NAIC Model Regula-
14 tion or 2009 Federal Regulation (as the case may
15 be)) on or after the date specified in paragraph (5).
16 ''(2) DEVELOPMENT OF STANDARDS AND RE-
17 QUIREMENTS FOR QUALIFIED LONG-TERM CARE
18 PLANS.—
19 ''(A) IN GENERAL.—If, within 9 months
20 after the date of the enactment of this sub-
21 section, the National Association of Insurance
22 Commissioners (in this subsection referred to as
23 the 'Association') adopts a model regulation (in
24 this section referred to as the '2009 NAIC
25 Model Regulation') to incorporate—

1 "(i) limitations on the groups or pack-
2 ages of benefits that may be offered under
3 a long-term care insurance policy con-
4 sistent with paragraphs (3) and (4),
5 "(ii) uniform language and definitions
6 to be used with respect to such benefits,
7 "(iii) uniform format to be used in the
8 policy with respect to such benefits, and
9 "(iv) other standards required by the
10 Secretary of Health and Human Services
11 paragraph (1) shall be applied in each State, ef-
12 fective for policies issued to policyholders on
13 and after the date specified in paragraph (5).
14 "(B) SECRETARIAL RESPONSIBILITY.—If
15 the Association does not adopt the 2009 NAIC
16 Model Regulation within the 9-month period
17 specified in subparagraph (A), the Secretary
18 shall promulgate, not later than 9 months after
19 the end of such period, a regulation (in this sec-
20 tion referred to as the '2009 Federal Regula-
21 tion') and paragraph (1) shall be applied in
22 each State, effective for policies issued to pol-
23 icyholders on and after the date specified in
24 paragraph (5).

1 "(C) CONSULTATION.—In promulgating
2 standards and requirements under this para-
3 graph, the Association or Secretary shall con-
4 sult with a working group composed of rep-
5 resentatives of issuers of long-term care insur-
6 ance policies, consumer groups, long-term care
7 insurance beneficiaries, and other qualified indi-
8 viduals. Such representatives shall be selected
9 in a manner so as to insure balanced represen-
10 tation among the interested groups.
11 "(3) LIMITATIONS OF GROUPS OR PACKAGES OF
12 BENEFITS.—The benefits under the 2009 NAIC
13 Model Regulation or 2009 Federal Regulation shall
14 provide—
15 "(A) for such groups or packages of bene-
16 fits as may be appropriate taking into account
17 the considerations specified in paragraph (4)
18 and the requirements of the succeeding sub-
19 paragraphs,
20 "(B) for identification of a core group of
21 basic benefits common to all policies, and
22 "(C) that the total number of different
23 benefit packages (counting the core group of
24 basic benefits described in subparagraph (B)
25 and each other combination of benefits that

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

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

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

10 "(B) balance the objectives of—

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

13 "(ii) avoiding adverse selection,

14 "(iii) providing consumer choice,

15 "(iv) providing market stability, and

16 "(v) promoting competition.

17 "(5) EFFECTIVE DATE.—

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

1 "(B) REQUIRED STATE LEGISLATION.—In
2 the case of a State which the Secretary identi-
3 fies, in consultation with the Association, as—
4 "(i) requiring State legislation (other
5 than legislation appropriating funds) in
6 order for long-term care insurance policies
7 to meet the 2009 NAIC Model Regulation
8 or 2009 Federal Regulation, but
9 "(ii) having a legislature which is not
10 scheduled to meet in 2009 in a legislative
11 session in which such legislation may be
12 considered,
13 the date specified in this paragraph is the first
14 day of the first calendar quarter beginning after
15 the close of the first legislative session of the
16 State legislature that begins on or after Janu-
17 ary 1, 2010. For purposes of the preceding sen-
18 tence, in the case of a State that has a 2-year
19 legislative session, each year of such session
20 shall be deemed to be a separate regular session
21 of the State legislature.".
22 (c) ADDITIONAL CONSUMER PROTECTIONS.—
23 (1) IN GENERAL.—Section 7702B(g)(1) (relat-
24 ing to consumer protection provisions) is amended—

1 (A) by striking subparagraph (A) and in-
2 serting the following new paragraph:
3 "(1) the requirements of the 1993 NAIC model
4 regulation and model Act described in paragraph (2)
5 and the 2000 NAIC model regulation and model Act
6 described in paragraph (5),",
7 (B) by striking "and" at the end of sub-
8 paragraph (B),
9 (C) by striking the period at the end of
10 subparagraph (C) and inserting ", and", and
11 (D) by adding at the end the following new
12 subparagraph:
13 "(D) the requirements relating to manda-
14 tory offer and information under paragraph
15 (6).".
16 (2) NAIC MODEL REGULATION AND ACT.—Sec-
17 tion 7702B(g) is amended—
18 (A) by inserting "1993 NAIC" after "RE-
19 QUIREMENTS OF" in the heading for paragraph
20 (2),
21 (B) by redesignating paragraph (5) as
22 paragraph (7), and
23 (C) by inserting after paragraph (4) the
24 following new paragraph:

1 "(5) REQUIREMENTS OF 2000 NAIC MODEL REG-
2 ULATION AND ACT.—
3 "(A) IN GENERAL.—The requirements of
4 this paragraph are met with respect to any con-
5 tract if such contract meets—
6 "(i) MODEL REGULATION.—The fol-
7 lowing requirements of the model regula-
8 tion:
9 "(I) Section 6A (other than para-
10 graph (5) thereof) and the require-
11 ments of section 6B of the model Act
12 relating to such section 6A.
13 "(II) Section 6B (other than
14 paragraph (7) thereof).
15 "(III) Sections 6C, 6D, 6E, and
16 7.
17 "(IV) Section 8 (other than sec-
18 tions 8F, 8G, 8H, and 8I thereof).
19 "(V) Sections 9, 11, 12, 14, 15,
20 and 22.
21 "(VI) Section 23, including inac-
22 curate completion of medical histories
23 (other than paragraphs (1), (6), and
24 (9) of section 23C).
25 "(VII) Sections 24 and 25.

1 "(VIII) The provisions of section
2 26 relating to contingent nonforfeiture
3 benefits, if the policyholder declines
4 the offer of a nonforfeiture provision
5 described in paragraph (4).
6 "(IX) Sections 29 and 30.
7 "(ii) MODEL ACT.—The following re-
8 quirements of the model Act:
9 "(I) Sections 6C and 6D.
10 "(II) The provisions of section 8
11 relating to contingent nonforfeiture
12 benefits.
13 "(III) Sections 6F, 6G, 6H, 6J,
14 6K, and 7.
15 "(B) DEFINITIONS.—For purposes of this
16 paragraph—
17 "(i) MODEL PROVISIONS.—The terms
18 'model regulation' and 'model Act' mean
19 the long-term care insurance model regula-
20 tion, and the long-term care insurance
21 model Act, respectively, promulgated by
22 the National Association of Insurance
23 Commissioners (as adopted as of October
24 2000).

1 "(ii) COORDINATION.—Any provision
2 of the model regulation or model Act listed
3 under clause (i) or (ii) of subparagraph
4 (A) shall be treated as including any other
5 provision of such regulation or Act nec-
6 essary to implement the provision.
7 "(iii) DETERMINATION.—For pur-
8 poses of this section and section 4980C,
9 the determination of whether any require-
10 ment of a model regulation or the model
11 Act has been met shall be made by the
12 Secretary.".
13 (d) MANDATORY OFFER AND INFORMATION.—Sec-
14 tion 7702B(g), as amended by subsection (c), is amended
15 by inserting after paragraph (5) the following new para-
16 graph:
17 "(6) MANDATORY OFFER AND INFORMATION.—
18 The requirements of this paragraph are met if—
19 "(A) MANDATORY OFFER.—Any person
20 who sells a long-term care insurance policy to
21 an individual shall make available for sale to
22 the individual a long-term care insurance policy
23 with only the core group of basic benefits (de-
24 scribed in subsection (h)(3)(B)).

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

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

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

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

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.

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

(1) in subsection (a)(2), by striking ''and (i)'' and inserting ''(i), and (j)''; and

(2) by adding at the end the following new subsection:

''(j)(1) With respect to the monthly premium amount for months after December 2008, the Secretary may adjust (under procedures established by the Secretary) the amount of such premium for an individual based on whether or not the individual participates in certain healthy behaviors, such as weight management, exercise, nutrition counseling, refraining from tobacco use, designating a health home, and other behaviors determined appropriate by the Secretary.

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

8 Subtitle B—Promoting Primary 9 Care for Medicare Beneficiaries

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

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

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

17 "(a) PAYMENT.—

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

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

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

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

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

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

20 ''(3) PRIMARY CARE PROVIDER.—

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

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

9 Subtitle C—Chronic Care Disease 10 Management

11 SEC. 421. CHRONIC CARE DISEASE MANAGEMENT.

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

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

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

1 the population of such beneficiaries (as determined
2 by the Secretary).
3 "(2) DEVELOPMENT.—In developing and imple-
4 menting the program under paragraph (1), the Sec-
5 retary shall—
6 "(A) take into consideration—
7 "(i) the results of chronic care im-
8 provement programs conducted under sec-
9 tion 1807, including the independent eval-
10 uations of such programs conducted under
11 section 1807(b)(5) and any outcomes re-
12 ports submitted under section
13 1807(e)(4)(A); and
14 "(ii) the results of the payments to
15 primary care providers under section
16 1807A; and
17 "(B) consult individuals with expertise in
18 chronic care disease management.
19 "(b) IDENTIFICATION AND ENROLLMENT.—The Sec-
20 retary shall establish procedures for identifying and enroll-
21 ing Medicare beneficiaries who may benefit from participa-
22 tion in the program.
23 "(c) CHRONIC CARE DISEASE MANAGEMENT PAY-
24 MENT FOR NON-PRIMARY CARE PHYSICIANS.—

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

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

17 "(d) DEFINITIONS.—In this section:

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

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

1 "(A) is not a primary care physician (as
2 defined in section 1807A (b)(3)(B)); and
3 "(B) provides chronic care disease manage-
4 ment services to a Medicare beneficiary under
5 the program.".

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

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

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

13 (c) USE OF CERTAIN INFORMATION.—In developing
14 the information described in subsection (b), the Secretary
15 shall utilize—
16 (1) information on the performance of providers
17 in chronic disease demonstration projects and pay
18 for performance efforts; and
19 (2) additional information determined appro-
20 priate by the Secretary.

21 Subtitle D—Part D Improvements

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

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

1 ing subsection (i) (relating to noninterference) and by in-
2 serting the following:
3 "(i) AUTHORITY TO NEGOTIATE PRICES WITH MAN-
4 UFACTURERS.—
5 "(1) IN GENERAL.—Subject to paragraph (4),
6 in order to ensure that beneficiaries enrolled under
7 prescription drug plans and MA–PD plans pay the
8 lowest possible price, the Secretary shall have au-
9 thority similar to that of other Federal entities that
10 purchase prescription drugs in bulk to negotiate con-
11 tracts with manufacturers of covered part D drugs,
12 consistent with the requirements and in furtherance
13 of the goals of providing quality care and containing
14 costs under this part.
15 "(2) MANDATORY RESPONSIBILITIES.—The
16 Secretary shall be required to—
17 "(A) negotiate contracts with manufactur-
18 ers of covered part D drugs for each fallback
19 prescription drug plan under subsection (g);
20 and
21 "(B) participate in negotiation of contracts
22 of any covered part D drug upon request of an
23 approved prescription drug plan or MA–PD
24 plan.

1 "(3) RULE OF CONSTRUCTION.—Nothing in
2 paragraph (2) shall be construed to limit the author-
3 ity of the Secretary under paragraph (1) to the man-
4 datory responsibilities under paragraph (2).
5 "(4) NO PARTICULAR FORMULARY OR PRICE
6 STRUCTURE.—In order to promote competition
7 under this part and in carrying out this part, the
8 Secretary may not require a particular formulary or
9 institute a price structure for the reimbursement of
10 covered part D drugs.
11 "(5) USE OF SAVINGS TO REDUCE COVERAGE
12 GAP.—The Secretary shall establish a process for
13 using the savings to the Medicare Prescription Drug
14 Account through the use of the authority provided
15 under this subsection (including the mandatory re-
16 sponsibilities under paragraph (2)) to reduce the
17 coverage gap under section 1860D–2.".
18 (b) CONFORMING AMENDMENT.—Section 1860D–
19 2(b) of the Social Security Act (42 U.S.C. 1395w–102(b))
20 is amended in the matter preceding paragraph (1) by
21 striking "For purposes" and inserting "Subject to section
22 1860D–11(i)(5), for purposes".
23 (c) EFFECTIVE DATE.—The amendments made by
24 this section shall take effect on the date of enactment of
25 this Act.

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

5 (a) PROCESS.—Notwithstanding any other provision
6 of law, by not later than 30 days after the date of enact-
7 ment of this Act, the Secretary of Health and Human
8 Services (in this section referred to as the ''Secretary'')
9 shall establish a process under which an applicable indi-
10 vidual may terminate enrollment in the prescription drug
11 plan or the MA–PD plan in which they are enrolled and
12 enroll in any prescription drug plan or MA–PD plan—
13 (1) that provides some coverage of covered part
14 D drugs (as defined in subsection (e) of section
15 1860D–2 of the Social Security Act (42 U.S.C.
16 1395w–102)) after the individual has reached the
17 initial coverage limit under the plan but has not
18 reached the annual out-of-pocket threshold under
19 subsection (b)(4)(B) of such section; and
20 (2) subject to subsection (b), that serves the
21 area in which the individual resides.
22 (b) SPECIAL RULE PERMITTING APPLICABLE INDI-
23 VIDUALS TO ENROLL IN A PRESCRIPTION DRUG PLAN
24 OUTSIDE OF THE REGION IN WHICH THE INDIVIDUAL
25 RESIDES.—In the case of an applicable individual who re-
26 sides in a PDP region under section 1860D–11(a)(2) of

1 the Social Security Act (42 U.S.C. 1395w–111(a)(2)) in
2 which there is no prescription drug plan available that pro-
3 vides some coverage of brand name covered part D drugs
4 (as so defined) after the individual has reached the initial
5 coverage limit under the plan but before the individual has
6 reached such annual out-of-pocket threshold, the Sec-
7 retary shall ensure that the process established under sub-
8 section (a) permits the individual to enroll in a prescrip-
9 tion drug plan that provides such coverage but is in an-
10 other PDP region. The Secretary shall determine the PDP
11 region in which the individual may enroll in such a pre-
12 scription drug plan.
13 (c) NOTIFICATION OF APPLICABLE INDIVIDUALS.—
14 Under the process established under subsection (a), the
15 Secretary shall notify, or require sponsors of prescription
16 drug plans and organizations offering MA–PD plans to
17 notify, applicable individuals of the option to change plans
18 under such process. Such notice shall be provided to an
19 applicable individual within 30 days of meeting the defini-
20 tion of such an individual.
21 (d) PROCESS IN EFFECT THROUGH 2012.—The
22 process established under subsection (a) shall remain in
23 effect through December 31, 2012.
24 (e) DEFINITIONS.—In this section:

1 (1) APPLICABLE INDIVIDUAL.—The term ''ap-
2 plicable individual'' means a part D eligible indi-
3 vidual (as defined in section 1860D–1(a)(3)(A) of
4 the Social Security Act (42 U.S.C. 1395w–
5 101(a)(3)(A)) who, with respect to a year—
6 (A) is enrolled in a prescription drug plan
7 or an MA–PD plan that does not provide any
8 coverage of covered part D drugs (as so de-
9 fined) after the individual has reached the ini-
10 tial coverage limit under the plan but has not
11 reached such annual out-of-pocket threshold;
12 and
13 (B) has reached such initial coverage limit
14 or is within $750 of reaching such limit.
15 (2) PRESCRIPTION DRUG PLAN; MA–PD PLAN.—
16 The terms ''prescription drug plan'' and ''MA–PD
17 plan'' have the meanings given those terms in sec-
18 tion 1860D–41(a)(14) of the Social Security Act (42
19 U.S.C. 1395w–151(a)(14)) and section 1860D–
20 1(a)(3)(C) of such Act (42 U.S.C. 1395w–
21 101(a)(3)(C)), respectively.

Subtitle E—Improving Quality in Hospitals for All Patients

SEC. 441. IMPROVING QUALITY IN HOSPITALS FOR ALL PATIENTS.

(a) IMPROVING HEALTHCARE QUALITY FOR ALL PATIENTS.—

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

(A) in subparagraph (U), by striking "and" at the end;

(B) in subparagraph (V), by striking the period at the end and inserting ", and"; and

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

"(W) in the case of hospitals, to demonstrate to accrediting bodies measurable improvement in quality control with respect to all patients and to have in place quality control programs that are directed at care for all patients and that include—

"(i) rapid response teams that can assist patients with unstable vital signs;

"(ii) heart attack treatments with proven reliability;

1 ''(iii) procedures that reduce medication
2 errors;
3 ''(iv) aggressive infection prevention, with
4 special focus on surgeries and infections with
5 the highest death rates;
6 ''(v) procedures that reduce the threat of
7 pneumonia, with special focus on the incidence
8 of ventilator-related illness; and
9 ''(vi) such other elements as the Secretary
10 determines appropriate.''.
11 (2) EFFECTIVE DATE.—The amendments made
12 by paragraph (1) shall apply to hospitals as of the
13 date that is 2 years after the date of enactment of
14 this Act.
15 (b) PANEL OF INDEPENDENT EXPERTS.—Beginning
16 not later than the date that is 2 years after the date of
17 enactment of this Act, in order to ensure that hospitals
18 practice state-of-the-art quality control, the Secretary
19 shall convene a panel of independent experts to update the
20 measures of quality control and the types of quality con-
21 trol programs, including the elements of such programs,
22 required under section 1866(a)(1)(W) of the Social Secu-
23 rity Act, as added by subsection (a), not less frequently
24 than on an annual basis.

Subtitle F—End-of-Life Care Improvements

SEC. 451. PATIENT EMPOWERMENT AND FOLLOWING A PATIENT'S HEALTH CARE WISHES.

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

(1) in subparagraph (V), by striking ''and'' at the end;

(2) in subparagraph (W), by striking the period at the end and inserting '', and''; and

(3) by inserting after subparagraph (W) the following new subparagraph:

''(X) to provide each patient with a document designed to promote patient autonomy by documenting the patient's treatment preferences (and coordinating these preferences with physician orders) that at a minimum—

''(i) transfers with the patient from one setting to another;

''(ii) provides a summary of treatment preferences in multiple scenarios by the patient or the patient's guardian and a physician or other practitioner's order for care;

1 ''(iii) is easy to read in an emergency situ-
2 ation;
3 ''(iv) reduces repetitive activities in com-
4 plying with the Patient Self Determination Act;
5 ''(v) ensures that the use of the document
6 is voluntary by the patient or the patient's
7 guardian;
8 ''(vi) is easily accessible in a patient's med-
9 ical chart; and
10 ''(vii) does not supplant State health care
11 proxy, living wills, or other end-of-life care
12 forms.''.
13 (b) EFFECTIVE DATE.—The amendments made by
14 subsection (a) shall apply to entities as of the date that
15 is 2 years after the date of enactment of this Act.
16 **SEC. 452. PERMITTING HOSPICE BENEFICIARIES TO RE-**
17 **CEIVE CURATIVE CARE.**
18 (a) IN GENERAL.—Section 1812 of the Social Secu-
19 rity Act (42 U.S.C. 1395d) is amended—
20 (1) in subsection (a)(4), by striking ''in lieu of
21 certain other benefits,''; and
22 (2) in subsection (d)—
23 (A) in paragraph (1), by striking ''instead
24 of certain other benefits under this title''; and

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

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

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

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

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

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

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

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

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

3 **SEC. 454. CLEARINGHOUSE.**

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

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

21 **Subtitle G—Additional Provisions**

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

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

1 "(4) ADDITIONAL COST INFORMATION.—A con-
2 tract under this section shall require a Medicare Ad-
3 vantage Organization to aggregate claims informa-
4 tion into episodes of care and to provide such infor-
5 mation to the Secretary so that costs for specific
6 hospitals and physicians may be measured and com-
7 pared. The Secretary shall make such information
8 public on an annual basis.".
9 (b) EFFECTIVE DATE.—The amendment made by
10 subsection (a) shall apply to contracts entered into on or
11 after the date of enactment of this Act.

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

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

21 TITLE V—STATE HEALTH HELP
22 AGENCIES

23 **SEC. 501. ESTABLISHMENT.**

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

1 after the date of enactment of this Act, establish or des-
2 ignate a State agency, to be known as the State ''Health
3 Help Agency'' (referred to in this Act as a ''HHA'') to—
4 (1) carry out the administration of HAPI plans
5 to individuals in such State; and
6 (2) carry out the functions described in section
7 502.

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

9 (a) PROMOTION OF PREVENTION AND WELLNESS.—
10 Each HHA shall promote prevention and wellness for all
11 State residents, including through the implementation of
12 programs that—
13 (1) educate residents about responsibility for in-
14 dividual health and the health of children;
15 (2) upon request, distribute information to cov-
16 ered individuals regarding the availability of wellness
17 programs;
18 (3) make available to the public, with respect to
19 each health insurance issuer and each HAPI plan,
20 the number of covered individuals who have des-
21 ignated a health home described in section 111(b);
22 and
23 (4) promote the use and understanding of
24 health information technology.

1 (b) ENROLLMENT OVERSIGHT.—Each HHA shall
2 oversee enrollment in HAPI plans by—
3 (1) providing standardized, unbiased informa-
4 tion on HAPI plans and supplemental health insur-
5 ance options;
6 (2) not less than once per year, administering
7 open enrollment periods for individuals;
8 (3) allowing a covered individual to make en-
9 rollment changes during a 30-day period following
10 marriage, divorce, birth, adoption or placement for
11 adoption, and other circumstances;
12 (4) establish procedures for health insurance
13 issuers to report to the HHA of each State in which
14 the issuer offers a HAPI plan, the health insurance
15 status of State residents in order for the HHA to
16 report annual on the number of uninsured and other
17 relevant data;
18 (5) establish procedures for default enrollment
19 of uninsured individuals into low-cost HAPI plans
20 for individuals or families who do not enroll, are not
21 covered under a health plan offered through a pro-
22 gram described in paragraphs (1)(A) of section
23 102(a), and are not described in paragraph (1)(B)
24 of such section;

1 (6) establish procedures for hospitals and other
2 providers to report to the HHA if an individual
3 seeks care and is uninsured or does not know his or
4 her health insurance status;
5 (7) ensure that the enrollment of all individuals
6 into HAPI plans, including those individuals assisted
7 by an employer, insurance agent, or other person, is
8 administered by the HHA;
9 (8) develop standardized language for HAPI
10 plan terms and conditions and require participating
11 health insurance issuers to use such language in
12 plan information documents;
13 (9) provide prospective enrollees with a com-
14 parative document that describes all the HAPI plans
15 in which the individual may enroll; and
16 (10) to assist consumers in choosing a HAPI
17 plan, publish information that includes loss ratios,
18 outcome data regarding wellness programs, disease
19 detection and chronic care management programs
20 categorized by health insurance issuer, and other
21 data as the HHA determines appropriate.
22 (c) DETERMINATION AND ADMINISTRATION OF
23 HAPI PLAN SUBSIDIES.—Each HHA shall oversee the
24 determination and administration of HAPI plan subsidies
25 by—

1 (1) informing State residents about how subsidy
2 eligibility determinations are made;
3 (2) obtaining necessary information about in-
4 come from individuals and Federal and State agen-
5 cies;
6 (3) making eligibility determinations on an indi-
7 vidual basis and informing individuals of such deter-
8 minations;
9 (4) establishing a process by which an indi-
10 vidual may appeal an eligibility determination;
11 (5) collecting from health insurance issuers an
12 administrative fee for joining the HHA system and
13 offering a HAPI plan in a State;
14 (6) collecting premium payments made by, or
15 on behalf of, covered individuals, and remitting such
16 payments to the HAPI plans; and
17 (7) collecting Federal premium subsidies for
18 covered individuals and remitting such subsidies to
19 HAPI plans.
20 (d) PREMIUM RATING RULES.—Each HHA shall en-
21 sure that the premium payments for each HAPI plan are
22 determined in accordance with the rating rules described
23 in section 111(d).
24 (e) EMPOWERMENT OF INDIVIDUALS TO MAKE
25 HEALTH CARE DECISIONS.—Each HHA shall, upon en-

1 rollment of an individual in a HAPI plan, provide such
2 individual with information regarding—
3 (1) the right of individuals to refuse treatment
4 and to make end-of-life care decisions;
5 (2) State laws relating to end-of-life care, in-
6 cluding applicable State law with respect to health
7 care proxies, advanced directives, living wills, and
8 other documentation by which individuals may make
9 their care decisions known;
10 (3) contact information for any State end-of-life
11 care advocates; and
12 (4) applicable State forms on health proxies,
13 advanced directives, living wills, and other such doc-
14 umentation.
15 (f) DETERMINATION OF PLAN COVERAGE AREAS.—
16 Each HHA shall establish, and may revise, HAPI plan
17 coverage areas for the State in which the HHA is located.
18 The service area of a HAPI plan shall consist of an entire
19 coverage area established under the preceding sentence.
20 (g) COOPERATION AMONG STATES.—States that
21 share 1 or more metropolitan statistical area may enter
22 into agreements to share administrative responsibilities
23 described under this section.
24 (h) TRANSITION FROM MEDICAID AND SCHIP; CO-
25 ORDINATION OF SUPPLEMENTAL MEDICAL ASSISTANCE

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

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

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

19 (b) SUBMISSION OF STATE HHA PLAN.—Each HHA
20 plan submitted by a State shall provide for—
21 (1) the establishment of an HHA within such
22 State by the date that is 2 years after the date of
23 enactment of this Act;

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

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

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

11 TITLE VI—SHARED 12 RESPONSIBILITIES

13 Subtitle A—Individual 14 Responsibilities

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

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

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

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

dividual eligibility for premium and personal responsibility contribution subsidies.

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

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

(1) submit any required monthly premium payments;

(2) submit any personal responsibility contributions as required; and

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

Subtitle B—Employer Responsibilities

SEC. 611. HEALTH CARE RESPONSIBILITY PAYMENTS.

(a) PAYMENT REQUIREMENTS.—

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

"CHAPTER 24A—HEALTH CARE RESPONSIBILITY PAYMENTS

"SUBCHAPTER A—EMPLOYER SHARED RESPONSIBILITY PAYMENTS

"SUBCHAPTER B—INDIVIDUAL SHARED RESPONSIBILITY PAYMENTS

"SUBCHAPTER C—GENERAL PROVISIONS

"Subchapter A—Employer Shared Responsibility Payments

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

"SEC. 3411. PAYMENT REQUIREMENT.

"(a) EMPLOYER SHARED RESPONSIBILITY PAYMENTS.—Every employer shall pay an employer shared responsibility payment for each calendar year in an amount equal to the product of—

"(1) the number of full-time equivalent employees employed by the employer during the preceding calendar year, multiplied by

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

"(b) APPLICABLE PERCENTAGE.—For purposes of subsection (a)(2)—

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

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

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

1 or local government, or any other type of entity for
2 which the Secretary determines that calculating rev-
3 enue per employee is not appropriate, the applicable
4 percentage shall be—
5 "(A) in the case of a large employer, 17
6 percent, and
7 "(B) in the case of a small employer, 2
8 percent.
9 "(3) ADDITIONAL RATE FOR CERTAIN SMALL
10 EMPLOYERS.—
11 "(A) IN GENERAL.—In the case of a small
12 employer, the applicable percentage determined
13 under paragraph (1) shall be increased by 0.1
14 percent for each full-time equivalent employee
15 employed by the employer during the preceding
16 calendar year in excess of 50.
17 "(B) MAXIMUM ADDITIONAL RATE.—The
18 increase in the applicable percentage deter-
19 mined under this paragraph shall not exceed 15
20 percent.
21 "(4) REVENUE PER EMPLOYEE NATIONAL PER-
22 CENTILE RANK.—At the beginning of each calendar
23 year, the Secretary, in consultation with the Sec-
24 retary of Labor, shall publish a table, based on sam-
25 pling of employers, to be used in determining the na-

1 tional percentile for revenue per employee amounts
2 for the preceding calendar year.
3 ‘‘(c) TRANSITION RATES.—
4 ‘‘(1) TRANSITION RATE FOR EMPLOYERS PRE-
5 VIOUSLY PROVIDING HEALTH INSURANCE.—
6 ‘‘(A) IN GENERAL.—In the case of the first
7 and second calendar years to which this section
8 applies, in the case of any employer who pro-
9 vided health insurance coverage for employees
10 on the day before the date of enactment of the
11 Healthy Americans Act, the employer shared
12 responsibility payment shall be, in lieu of the
13 amount determined under subsection (a), an
14 amount equal to—
15 ‘‘(i) 100 percent of the designated em-
16 ployee health insurance premium amount
17 of such employer, minus
18 ‘‘(ii) the employee salary investment
19 amount.
20 ‘‘(B) EMPLOYEE SALARY INVESTMENT
21 AMOUNT.—For purposes of this paragraph—
22 ‘‘(i) IN GENERAL.—The term ‘em-
23 ployee salary investment amount’ means
24 the lesser of—

1 "(I) the excess of the amount of
2 average yearly wages paid to all em-
3 ployees for such year over the amount
4 of average yearly wages paid to such
5 employee for the year before the first
6 year this section applies, or
7 "(II) the designated employee
8 health insurance premium amount of
9 such employer.
10 "(ii) NONDISCRIMINATION RULES.—
11 No amount paid by an employer shall be
12 treated as an employee salary investment
13 amount unless such amount is distributed
14 to all employees on a basis that is propor-
15 tional to the amount of wages paid to such
16 employee before such distribution.
17 "(iii) NOTICE REQUIREMENT.—No
18 amount paid by an employer shall be treat-
19 ed as an employee salary investment
20 amount unless the employer gives each em-
21 ployee notice of the amount of the des-
22 ignated employee health insurance pre-
23 mium amount paid by the employer with
24 respect to the employee.

"(C) EMPLOYER SHARED RESPONSIBILITY CREDIT.—The Secretary may provide a credit to private employers who provided health insurance benefits greater than the 80th percentile of the national average in the 2 years prior to enactment of this Act, can demonstrate the benefits provided encouraged prevention and wellness activities as defined in this Act, and continue to provide wellness programs

"(D) SPECIAL RULE FOR SELF-INSURED EMPLOYERS.—In the case of any employer who provided health care coverage for employees through self-insurance, 'average HAPI plan premium amount for the first year this section applies' shall be substituted for 'designated employee health insurance premium amount of such employer' in subparagraphs (A)(i) and (B)(i)(II).

"(E) REGULATIONS.—The Secretary may establish such rules and regulations as necessary to carry out the purposes of this paragraph.

"(2) TRANSITION RATE FOR OTHER EMPLOYERS.—In the case of any employer who did not provide health insurance to employees on the day before

the date of enactment of the Healthy Americans Act—

"(A) the employer shared responsibility payment for the first year this section applies shall be an amount equal ⅓ of the amount otherwise required under this section (determined without regard to this subsection), and

"(B) the employer shared responsibility payment for the second year this section applies shall be an amount equal ⅔ of the amount otherwise required under this section (determined without regard to this subsection).

"SEC. 3412. INSTRUMENTALITIES OF THE UNITED STATES.

"Notwithstanding any other provision of law (whether enacted before or after the enactment of this section) which grants to any instrumentality of the United States an exemption from taxation, such instrumentality shall not be exempt from the payment required by section 3411 unless such provision of law grants a specific exemption, by reference to section 3111 from the payment required by such section.

"Subchapter B—Individual Shared Responsibility Payments

"Sec. 3421. Amount of payment.
"Sec. 3422. Deduction of tax from wages.

1 **"SEC. 3421. AMOUNT OF PAYMENT.**

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

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

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

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

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

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

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

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

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

3 **"Subchapter C—General Provisions**

"Sec. 3431. Definitions and special rules.
"Sec. 3432. Labor contracts.

4 **"SEC. 3431. DEFINITIONS AND SPECIAL RULES.**

5 "(a) DEFINITIONS.—For purposes of this chapter—
6 "(1) AVERAGE HAPI PLAN PREMIUM
7 AMOUNT.—The term 'average HAPI plan premium
8 amount' means the national average yearly premium
9 for HAPI plans with standard coverage (as deter-
10 mined under section 103(b) of the Healthy Ameri-
11 cans Act), determined without regard to differing
12 classes of coverage.
13 "(2) DESIGNATED EMPLOYEE HEALTH INSUR-
14 ANCE PREMIUM AMOUNT.—The term 'designated
15 employee health insurance premium amount' means
16 the greater of—
17 "(A) the yearly premium paid by an em-
18 ployer for health insurance coverage for employ-
19 ees for the most recent calendar year ending be-
20 fore the date of enactment of the Healthy
21 Americans Act, or
22 "(B) the yearly premium paid by an em-
23 ployer for health insurance coverage for employ-

1 ees for the year before the first year this section
2 applies.
3 "(3) EMPLOYER.—
4 "(A) IN GENERAL.—The term 'employer'
5 has the meaning given such term under section
6 3401(d).
7 "(B) AGGREGATION RULES.—For purposes
8 of this chapter, all persons treated as a single
9 employer under subsection (a) or (b) of section
10 52 shall be treated as 1 person.
11 "(4) EMPLOYMENT.—The term 'employment'
12 has the meaning given such term under section
13 3121(b).
14 "(5) FULL-TIME EQUIVALENT EMPLOYEE.—
15 The term 'full-time equivalent employee' means the
16 equivalent number of full-time employees of an em-
17 ployer determined for any year under the following
18 formula:
19 "(A) The sum of the number of full-time
20 employees employed by the employer for more
21 than 3 months during such year, plus
22 "(B) The quotient of—
23 "(i) the sum of the average weekly
24 hours worked during such year for each

1 employee of the employer (including com-
2 mon law employees) who—
3 ''(I) was employed by such em-
4 ployer during such year for more than
5 3 months, and
6 ''(II) is not a full-time employee,
7 divided by
8 ''(ii) 40.
9 ''(6) FULL-TIME EMPLOYEE.—The term 'full-
10 time employee' means an employee (including a com-
11 mon law employee) who during an average workweek
12 performs, or can reasonably be expected to perform,
13 at least 40 hours of work. The Secretary may pre-
14 scribe alternative rules for determining full-time
15 equivalent employees in occupations or industries not
16 using a standard workweek.
17 ''(7) HAPI PLAN.—The term 'HAPI plan' has
18 the meaning given such term under section 3 of the
19 Healthy Americans Act.
20 ''(8) HAPI PLAN PREMIUM AMOUNT.—The
21 term 'HAPI plan premium amount' means, with re-
22 spect to any individual, the monthly premium for the
23 HAPI plan under which such individual is enrolled,
24 determined after taking into account any subsidy

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

"(9) LARGE EMPLOYER.—The term 'large employer' means, with respect to any year, an employer who employs an average of over 200 full-time equivalent employees during such year.

"(10) REVENUE PER EMPLOYEE.—The term 'revenue per employee' means, with respect to any employer for any year, the gross receipts of the employer for such year divided by the number of full-time equivalent employees employed by such employer for such year.

"(11) SMALL EMPLOYER.—The term 'small employer' means, with respect to any year, an employer who employs an average of 200 or fewer full-time equivalent employees during such year.

"(12) WAGES.—The term 'wages' has the meaning given such term under section 3401(a).

"(b) SPECIAL RULES.—

"(1) SPECIAL RULE FOR SELF-EMPLOYED INDIVIDUALS.—For purposes of this chapter, a self-employed individual (as defined by section 401(c)(1)(B)) shall be treated as both a full-time equivalent employee and as an employer.

1 "(2) TREATMENT OF PAYMENTS.—For pur-
2 poses of this title, the payments required by sections
3 3411 and 3421 shall be treated as a tax imposed by
4 such sections, respectively.
5 "(3) OTHER SPECIAL RULES.—For purposes of
6 this chapter, rules similar to rules under the fol-
7 lowing provisions shall apply:
8 "(A) Section 3122 (relating to Federal
9 service).
10 "(B) Section 3123 (relating to deductions
11 as constructive payments).
12 "(C) Section 3125 (relating to returns in
13 the case of governmental employees in States,
14 Guam, American Samoa, and the District of
15 Columbia).
16 "(D) Section 3126 (relating to return and
17 payment by government employer).
18 "(E) Section 3127 (relating to exemption
19 for employers and their employees where both
20 are members of religious faiths opposed to par-
21 ticipation in social security act programs).
22 **"SEC. 3432. LABOR CONTRACTS.**
23 "(a) IN GENERAL.—This chapter shall not apply with
24 respect to any qualified collective bargaining employee of

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

3 “(1) January 1 of the first year which is more
4 than 7 years after the date of the enactment of this
5 chapter, or

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

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

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

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

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

“CHAPTER 24A—HEALTH CARE RESPONSIBILITY PAYMENTS”.

1 (b) COLLECTION OF INDIVIDUAL SHARED RESPONSI-
2 BILITY PAYMENTS THROUGH ESTIMATED TAXES.—Sec-
3 tion 6654 of the Internal Revenue Code of 1986 (relating
4 to failure by individual to pay estimated tax) is amended—
5 (1) in subsection (a), by striking ‘‘and the tax
6 under chapter 2’’ and inserting ‘‘, the tax under
7 chapter 2, and the individual shared responsibility
8 payment required under subchapter B of chapter
9 24A’’, and
10 (2) in subsection (f)—
11 (A) by striking ‘‘minus’’ at the end of
12 paragraph (2) and inserting ‘‘plus’’,
13 (B) by redesignating paragraph (3) as
14 paragraph (5), and
15 (C) by inserting after paragraph (2) the
16 following new paragraphs:
17 ‘‘(3) the individual shared responsibility pay-
18 ment required under subchapter B of chapter 24A,
19 minus
20 ‘‘(4) the amount withheld as an individual
21 shared responsibility payment under section 3422,
22 minus’’.
23 (c) EFFECTIVE DATE.—The amendments made by
24 this section shall apply to calendar years beginning at
25 least 2 years after the date of the enactment of this Act.

1 **SEC. 612. DISTRIBUTION OF INDIVIDUAL RESPONSIBILITY**
2 **PAYMENTS TO HHAS.**

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

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

13 Subtitle C—Insurer
14 Responsibilities

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

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

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

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

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

1 quirements of the health insurance issuers and other
2 relevant requirements;
3 (3) demonstrate how the provider reimburse-
4 ment methodology used by such an issuer has been
5 adjusted to reward providers for achieving quality
6 and cost efficiency in prevention, early detection of
7 disease, and chronic care management;
8 (4) ensure enrollees have the opportunity to
9 designate a health home as described in section
10 111(b) and make public how many enrollees per pol-
11 icy have designated a health home;
12 (5) upon enrollment, make available to each
13 covered individual an initial physical and a care
14 plan;
15 (6) create and implement an electronic medical
16 record for each covered individual, unless the indi-
17 vidual submits a notification to the issuer that the
18 individual declines to have such a record;
19 (7) contribute to the financing of the HHAs by
20 incorporating into the administration component of
21 premiums an additional amount to reimburse HHAs
22 for administrative costs;
23 (8) comply with loss ratios as established by the
24 Secretary under subsection (e);

1 (9) use standardized common claims forms and
2 uniform billing practices as provided for under sub-
3 section (c);
4 (10) require that hospitals, as a condition of re-
5 ceiving payment, send bills that are in an amount
6 more than $5,000 to the covered individual (without
7 regard to whether the covered individual is respon-
8 sible for full or partial payment of the bill) and pro-
9 vide the individual the contact information of a per-
10 son who can discuss the bill with the individual;
11 (11) provide incentives such as premium dis-
12 counts—
13 (A) for parents, if a covered child partici-
14 pates in wellness activities and the health of
15 such child improves; and
16 (B) for adults covered by a plan to partici-
17 pate in prevention, wellness and chronic disease
18 management programs;
19 (12) report to the HHA of the State in which
20 the issuer offers HAPI plans, outcome data regard-
21 ing wellness program, disease detection and chronic
22 care management, and loss ratio information, so
23 that the HHAs may make such data available to the
24 public in a consumer-friendly format;

1 (13) work with the Agency for Healthcare Re-
2 search and Quality, medical experts, and patient
3 groups to make information on high quality afford-
4 able health providers available to all Americans with-
5 in 2 years of the date of enactment of this Act
6 through a website searchable by zip code;
7 (14) provide to the HHA of each State in which
8 the issuer offers a HAPI plan, detailed information
9 on the HAPI plans offered by such issuer, using
10 standardized language as required by the HHA, so
11 that the HHA may compile a document that com-
12 pares the HAPI plans for use by prospective enroll-
13 ees; and
14 (15) paying to the HHA of each State in which
15 the issuer seeks to offer a HAPI plan the amount
16 of the administrative fee assessed by the HHA
17 under section 502(c)(5) to enter the HHA system of
18 that State.
19 (c) UNIFORM BILLING PRACTICES.—
20 (1) IN GENERAL.—A health insurance issuer of-
21 fering a HAPI plan in a State shall not receive sub-
22 sidy payments from the applicable State HHA un-
23 less such issuer agrees to use standardized common
24 claim forms prescribed by the applicable State HHA.

1 (2) EXCEPTION.—Paragraph (1) shall not
2 apply to any State worker's compensation system.
3 (d) CHRONIC CARE PROGRAMS OFFERED BY
4 ISSUERS.—
5 (1) IN GENERAL.—A health insurance issuer of-
6 fering a HAPI plan in a State shall provide a chron-
7 ic care program to provide early identification and
8 management of chronic diseases.
9 (2) DETERMINATION OF CHRONIC CARE PRO-
10 GRAM.—Each State HHA shall determine what con-
11 stitutes a chronic care program under this sub-
12 section and whether to collect and report financial
13 information related to chronic care programs.
14 (3) UNIFORM CLINICAL PERFORMANCE STAND-
15 ARDS.—Each chronic care program offered by a
16 health insurance issuer shall use a uniform set of
17 clinical performance standards prescribed by the
18 HHA of the State in which the issuer offers a HAPI
19 plan (in consultation with the State Medicare quality
20 improvement organizations and patient and physi-
21 cian organizations) which should include encourage-
22 ment that the issuers not require personal responsi-
23 bility contributions for clinically-needed services to
24 treat or manage a covered individual's chronic dis-
25 ease, particularly if the individual is taking an active

1 management role in working with their provider to
2 manage any such disease.
3 (4) REPORTING BY ISSUERS.—Five years after
4 the date of enactment of this Act and on an annual
5 basis thereafter, each health insurance issuer shall
6 report to the applicable State Insurance Commis-
7 sioner, State Secretary of Health or other state enti-
8 ty selected by the State HHA, the chronic care man-
9 agement performance of the issuer as measured by
10 the uniform clinical performance standards described
11 in paragraph (3). The issuer shall make such per-
12 formance public in a manner accessible to the public.
13 (e) PRIVATE INSURANCE COMPANY LOSS RATIO.—
14 (1) IN GENERAL.—The Secretary, in consulta-
15 tion with consumer and patient organizations, the
16 National Association of Insurance Commissioners,
17 and health insurance issuers (including health main-
18 tenance organizations) shall establish a loss ratio for
19 issuers of HAPI plans.
20 (2) DETERMINATION OF LOSS RATIO.—In de-
21 termining the loss ratio, administrative costs shall be
22 defined as expenses consisting of all actual, allow-
23 able, allocable, and reasonable expenses incurred in
24 the adjudication of subscriber benefit claims or in-

1 curred in the health insurance issuer's overall oper-
2 ation of the business.
3 (3) ADMINISTRATIVE EXPENSES.—
4 (A) IN GENERAL.—Unless otherwise deter-
5 mined by an agreement between a State HHA
6 and a health insurance issuer, the administra-
7 tive expenses of an issuer shall—
8 (i) include all taxes (excluding pre-
9 mium taxes) reinsurance premiums, med-
10 ical and dental consultants used in the ad-
11 judication process, concurrent or managed
12 care review when not billed by a health
13 care provider and other forms of utilization
14 review, the cost of maintaining eligibility
15 files, legal expenses incurred in the litiga-
16 tion of benefit payments, and bank charges
17 for letters of credit; and
18 (ii) not include the cost of personnel,
19 equipment, and facilities directly used in
20 the delivery of health care services (benefit
21 costs), payments to HHAs for establish-
22 ment and administration of HHAs, and
23 the cost of overseeing chronic disease man-
24 agement programs and wellness programs.

Subtitle D—State Responsibilities

SEC. 631. STATE RESPONSIBILITIES.

(a) GENERAL REQUIREMENTS.—As a condition of receiving payment under section 503, each State shall—

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

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

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

(B) comply with the requirements of this Act;

(3) ensure that health insurance issuers offering a HAPI plan in such State comply with the requirements described in section 621;

(4) ensure that HAPI plans offer premium discounts and incentives for participation in wellness programs;

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

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

1 (A) solvency and financial standards for
2 health insurance issuers;
3 (B) fair marketing practices for health in-
4 surance issuers;
5 (C) grievances and appeals for covered in-
6 dividuals; and
7 (D) patient protection;
8 (7) eliminate fictitious group prohibitions; and
9 (8) comply with subsections (b) and (c).
10 (b) ENSURING MAXIMUM ENROLLMENT.—Each
11 State shall—
12 (1) collect and exchange data with Federal and
13 other public agencies as necessary to maintain a
14 database containing information on the health insur-
15 ance enrollment status of all State residents;
16 (2) implement methods to check enrollment sta-
17 tus and enroll individuals in HAPI plans, such as
18 through the Department of Motor Vehicles of the
19 State, the enrollment of children in elementary and
20 secondary schools, the voter registration authority of
21 the State, and other checkpoints determined appro-
22 priate by the State;
23 (3) implement mechanisms, which may not in-
24 clude revocation or ineligibility for coverage under a
25 HAPI plan, to enforce the responsibility of each

1 adult individual to purchase HAPI plan coverage for
2 such individual and any dependent children of such
3 individual; and
4 (4) implement a mechanism to automatically
5 enroll individuals in a HAPI plan who present in
6 emergency departments without health insurance.
7 (c) MAINTENANCE OF EFFORT.—Each State shall
8 submit an annual report to the Secretary that dem-
9 onstrates that, for each State fiscal year that begins on
10 or after January 1 of the first calendar year in which
11 HAPI coverage begins under this Act, State expenditures
12 for health services (as defined by the Secretary) are not
13 less than the amount equal to—
14 (1) in the case of the first State fiscal year for
15 which such a report is submitted, 100 percent of the
16 total amount of the State share of expenditures for
17 such services under all public health programs oper-
18 ated in the State that are funded in whole or in part
19 with State expenditures (including the Medicaid pro-
20 gram) for the most recent State fiscal year ending
21 before January 1 of the first calendar year in which
22 HAPI coverage begins under this Act ; and
23 (2) in the case of any subsequent State fiscal
24 year for which such a report is submitted, the
25 amount applicable under this subsection for the pre-

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

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

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

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

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

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

24 (c) DETERMINATIONS BY SECRETARY.—

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

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

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

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

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

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

Subtitle E—Federal Fallback Guarantee Responsibility

SEC. 641. FEDERAL GUARANTEE OF ACCESS TO COVERAGE.

(a) FEDERAL GUARANTEE.—

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

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

(b) CONTRACTS.—

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

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

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

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

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

14 Subtitle F—Federal Financing
15 Responsibilities

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

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

SEC. 652. RECAPTURE OF MEDICARE AND 90 PERCENT OF MEDICAID FEDERAL DSH FUNDS TO STRENGTHEN MEDICARE AND ENSURE CONTINUED SUPPORT FOR PUBLIC HEALTH PROGRAMS.

(a) RECAPTURE OF MEDICARE DSH FUNDS.—

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

(2) SAVINGS TO PART A TRUST FUND.—The savings to the Federal Hospital Insurance Trust Fund by reason of the amendment made by paragraph (1) shall be used to strengthen the financial solvency of such Trust Fund.

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

(1) HEALTHY AMERICANS PUBLIC HEALTH TRUST FUND.—Subchapter A of chapter 98 of the Internal Revenue Code of 1986 (relating to trust fund code) is amended by adding at the end the following new section:

"SEC. 9511. HEALTHY AMERICANS PUBLIC HEALTH TRUST FUND.

"(a) CREATION OF TRUST FUND.—There is established in the Treasury of the United States a trust fund to be known as the 'Healthy Americans Public Health Trust Fund', consisting of any amount appropriated or credited to the Trust Fund as provided in this section or section 9602(b).

"(b) TRANSFER TO TRUST FUND OF 90 PERCENT OF MEDICAID DSH FUNDS.—There are hereby appropriated to the Healthy Americans Public Health Trust Fund the following amounts:

"(1) In the case of the second, third, and fourth quarters of the first fiscal year in which coverage under a HAPI plan begins under the Healthy Americans Act, an amount equal to 90 percent of the amount that would otherwise have been appropriated for the purpose of making payments to States under section 1903(a) of the Social Security Act for the Federal share of disproportionate share hospital payments made under section 1923 of such Act for such quarters of that fiscal year but for subsections (c)(2) and (d)(2)(D) of section 1941 of the such Act, as determined by the Secretary of Health and Human Services.

"(2) In the case of each succeeding fiscal year, an amount equal to 90 percent of the amount that would otherwise have been appropriated for the purpose of making payments to States under section 1903(a) of the Social Security Act for the Federal share of disproportionate share hospital payments made under section 1923 of such Act for that fiscal year but for subsections (c)(1) and (d)(2)(D) of section 1941 of such Act, as determined by the Secretary of Health and Human Services, taking into account the percentage change, if any, in the consumer price index for all urban consumers (U.S. city average) for the preceding fiscal year.

"(c) EXPENDITURES FROM TRUST FUND.—With respect to each fiscal year for which transfers are made under subsection (b), amounts in the Healthy Americans Public Health Trust Fund shall be available for that fiscal year for the following purposes:

"(1) PROVIDING PREMIUM AND PERSONAL RESPONSIBILITY CONTRIBUTION SUBSIDIES.—For making appropriations authorized under section 651 of the Healthy Americans Act for providing premium and personal responsibility contribution subsidies in accordance with section 122 of such Act.

1 "(2) MAKING BONUS PAYMENTS TO STATES
2 FOR IMPLEMENTING MEDICAL MALPRACTICE RE-
3 FORM.—For making appropriations for bonus pay-
4 ments to States in accordance with section 802 of
5 such Act for implementing a State medical mal-
6 practice reform law that complies with subsection
7 (b) of such section.
8 "(3) REDUCING THE FEDERAL BUDGET DEF-
9 ICIT.—The Secretary shall transfer any amounts in
10 the Trust Fund that are not expended as of Sep-
11 tember 30 of a fiscal year for a purpose described
12 in paragraph (1), (2), or (3) to the general revenues
13 account of the Treasury.".
14 (2) CLERICAL AMENDMENT.—The table of sec-
15 tions for such subchapter is amended by adding at
16 the end the following new item:

"Sec. 9511. Healthy Americans Public Health Trust Fund.".

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 I—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.

(a) INCOME TAX EXCLUSION.—

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

''(a) GENERAL RULE.—Gross income of an individual does not include—

''(1) if such individual is an employee, shared responsibility payments made by an employer under section 3411,

1 "(2) if such individual is a former employee be-
2 fore the first calendar year beginning 2 years after
3 the date of the enactment of the Healthy Americans
4 Act, employer-provided coverage under an accident
5 or health plan,
6 "(3) if such individual is a qualified collective
7 bargaining employee under an accident or health
8 plan in effect on January 1 of the first calendar year
9 beginning 2 years after the date of the enactment of
10 the Healthy Americans Act, employer-provided cov-
11 erage under such plan during any transition period
12 described in section 3432, and
13 "(4) employer-provided coverage for qualified
14 long-term care services (as defined in section
15 7702B(c)).".
16 (2) CONFORMING AMENDMENTS.—Section 106
17 of such Code is amended—
18 (A) by adding at the end of subsection (b)
19 the following new paragraph:
20 "(8) TERMINATION.—This subsection shall not
21 apply to contributions made in any calendar year be-
22 ginning at least 2 years after the date of the enact-
23 ment of the Healthy Americans Act.",
24 (B) by inserting "and before the first cal-
25 endar year beginning 2 years after the date of

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

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

9 (b) PAYROLL TAXES.—

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

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

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

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

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

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

21 ''(9) qualified health care fringe.''.

22 (b) QUALIFIED HEALTH CARE FRINGE.—

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

1 subsection (o) as subsection (p) and by inserting
2 after subsection (n) the following new subsection:
3 ''(o) QUALIFIED HEALTH CARE FRINGE.—For pur-
4 poses of this section, the term 'qualified health care fringe'
5 means—
6 ''(1) any wellness program described in section
7 131 of the Healthy Americans Act, and
8 ''(2) any on-site first aid coverage for employ-
9 ees.''.
10 (2) NONDISCRIMINATORY TREATMENT.—Sec-
11 tion 132(j)(1) of such Code (relating to exclusions
12 under subsection (a)(1) and (2) apply to highly com-
13 pensated employees only if no discrimination) is
14 amended—
15 (A) by striking ''Paragraphs (1) and (2) of
16 subsection (a)'' and inserting ''Paragraphs (1),
17 (2), and (9) of subsection (a)'', and
18 (B) by striking ''SUBSECTION (a)(1) AND
19 (2)'' in the heading and inserting ''SUB-
20 SECTIONS (a)(1), (2), AND (9)''.
21 (c) EFFECTIVE DATE.—The amendments made by
22 this section shall apply to calendar years beginning at
23 least 2 years after the date of the enactment of the
24 Healthy Americans Act.

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

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

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

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

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

18 ''(3) any accident or health plan in effect on
19 January 1 of the first calendar year beginning 2
20 years after the date of the enactment of the Healthy
21 Americans Act with respect to coverage for qualified
22 collective bargaining employees during a transition
23 period described in section 3432,

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

1 "(5) any accident or health plan which constitutes on-site first aid coverage for employees, and

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

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

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

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

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

17 "(21) INDIVIDUAL SHARED RESPONSIBILITY PAYMENTS.—

19 "(A) IN GENERAL.—In the case of a taxpayer with gross income for the taxable year exceeding 100 percent of the poverty line (adjusted for the size of the family involved) for the calendar year in which such taxable year begins and who is enrolled in a HAPI plan under the Healthy Americans Act, the deduc-

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

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

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

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

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

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

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

1 "(B) APPLICABLE FRACTION.—For pur-
2 poses of subparagraph (A)(ii), the applicable
3 fraction is the fraction (not to exceed 1)—
4 "(i) the numerator of which is the
5 gross income of the taxpayer for the tax-
6 able year expressed as a percentage of the
7 poverty line (adjusted for the size of the
8 family involved) minus such poverty line
9 for the calendar year in which such taxable
10 year begins, and
11 "(ii) the denominator of which is 400
12 percent of the poverty line (adjusted for
13 the size of the family involved) minus such
14 poverty line.
15 "(C) PHASEOUT OF DEDUCTION
16 AMOUNT.—
17 "(i) IN GENERAL.—The amount oth-
18 erwise determined under subparagraph (A)
19 for any taxable year shall be reduced by
20 the amount determined under clause (ii).
21 "(ii) AMOUNT OF REDUCTION.—The
22 amount determined under this clause shall
23 be the amount which bears the same ratio
24 to the amount determined under subpara-
25 graph (A) as—

1 "(I) the excess of the taxpayer's
2 modified adjusted gross income for
3 such taxable year, over $62,500
4 ($125,000 in the case of a joint re-
5 turn), bears to
6 "(II) $62,500 ($125,000 in the
7 case of a joint return).
8 Any amount determined under this clause
9 which is not a multiple of $1,000 shall be
10 rounded to the next lowest $1,000.
11 "(D) INFLATION ADJUSTMENT.—In the
12 case of any taxable year beginning in a calendar
13 year after 2009, each dollar amount contained
14 in subparagraph (A)(ii) and subparagraph
15 (C)(ii)(I) shall be increased by an amount equal
16 to such dollar amount, multiplied by the cost-
17 of-living adjustment determined under section
18 1(f)(3) for the calendar year in which the tax-
19 able year begins, determined by substituting
20 'calendar year 2008' for 'calendar year 1992' in
21 subparagraph (B) thereof. Any increase deter-
22 mined under the preceding sentence shall be
23 rounded to the nearest multiple of $50 ($1,000
24 in the case of the dollar amount contained in
25 subparagraph (C)(ii)(I)).

1 "(E) DETERMINATION OF MODIFIED AD-
2 JUSTED GROSS INCOME.—
3 "(i) IN GENERAL.—For purposes of
4 this paragraph, the term 'modified ad-
5 justed gross income' means adjusted gross
6 income—
7 "(ii) determined without regard to
8 this section and sections 86, 135, 137,
9 199, 221, 222, 911, 931, and 933, and
10 "(iii) increased by—
11 "(I) the amount of interest re-
12 ceived or accrued during the taxable
13 year which is exempt from tax under
14 this title, and
15 "(II) the amount of any social se-
16 curity benefits (as defined in section
17 86(d)) received or accrued during the
18 taxable year.
19 "(F) POVERTY LINE.—For purposes of
20 this paragraph, the term 'poverty line' has the
21 meaning given such term in section 673(2) of
22 the Community Health Services Block Grant
23 Act (42 U.S.C. 9902(2)), including any revision
24 required by such section.".

1 (b) CONFORMING AMENDMENT.—Section
2 213(d)(1)(D) of the Internal Revenue Code of 1986 is
3 amended by inserting ''amounts paid under section 3421
4 and'' after ''including''.
5 (c) EFFECTIVE DATE.—The amendments made by
6 this section shall apply to payments made in calendar
7 years beginning at least 2 years after the date of the en-
8 actment of this Act.

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

12 (a) TERMINATION OF CREDIT FOR HEALTH INSUR-
13 ANCE COSTS OF ELIGIBLE INDIVIDUALS.—Section 35 of
14 the Internal Revenue Code of 1986 (relating to health in-
15 surance costs of eligible individuals) is amended by adding
16 at the end the following new subsection:
17 ''(h) TERMINATION.—This section shall not apply to
18 payments made in any calendar year beginning at least
19 2 years after the date of the enactment of the Healthy
20 Americans Act.''.
21 (b) TERMINATION OF HEALTH CARE EXPENSE RE-
22 IMBURSEMENT UNDER CAFETERIA PLANS.—
23 (1) IN GENERAL.—Section 125 of the Internal
24 Revenue Code of 1986 (relating to cafeteria plans)
25 is amended by redesignating subsection (h) as sub-

1 section (i) and by inserting after subsection (g) the
2 following new subsection:
3 "(h) TERMINATION.—This section shall not apply to
4 health benefits coverage in any calendar year beginning
5 at least 2 years after the date of the enactment of the
6 Healthy Americans Act.".
7 (2) LONG-TERM CARE ALLOWED UNDER CAFE-
8 TERIA PLANS.—
9 (A) IN GENERAL.—Section 125(f) of such
10 Code (defining qualified benefits) is amended by
11 striking the last sentence.
12 (B) EFFECTIVE DATE.—The amendment
13 made by this paragraph shall apply to contracts
14 issued with respect to any calendar year begin-
15 ning at least 2 years after the date of the en-
16 actment of this Act.
17 (c) TERMINATION OF ARCHER MSA CONTRIBU-
18 TIONS.—Section 220 of the Internal Revenue Code of
19 1986 (relating to Archer MSAs) is amended—
20 (1) by inserting "and made before the first cal-
21 endar year beginning 2 years after the date of the
22 enactment of the Healthy Americans Act" after "in
23 cash" in subsection (d)(1)(A)(i), and
24 (2) by adding at the end the following new sub-
25 section:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

6 "(e) SPECIAL APPLICATION OF SUBPART.—

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

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

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

"Sec. 7875. Termination of certain provisions.".

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

SEC. 671. GROUP AND INDIVIDUAL HEALTH PLAN REQUIREMENTS NOT APPLICABLE TO HAPI PLANS.

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

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

“(e) HAPI PLANS.—For purposes of this section, the terms ‘group health plan’ and ‘large group health plan’ shall not include any HAPI plan under the Healthy Americans Act.”.

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

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

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

5 **"§ 8915. Termination**

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

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

"8915. Termination.".

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

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

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

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

1 child health assistance under child health plans under title
2 XXI are—
3 "(1) informed of—
4 "(A) the guarantee of private coverage for
5 essential services for all Americans established
6 by the Healthy Americans Act; and
7 "(B) each individual's personal responsi-
8 bility—
9 "(i) for health care prevention;
10 "(ii) to enroll (or to be enrolled on
11 their behalf) in a HAPI plan through the
12 applicable State HHA during an open en-
13 rollment period; and
14 "(iii) to submit necessary documenta-
15 tion to their State HHA so that the HHA
16 may determine the individual's eligibility
17 for premium and personal responsibility
18 contribution subsidies;
19 "(2) provided with appropriate assistance in
20 transitioning from receiving medical assistance
21 under State Medicaid plans or child health assist-
22 ance under child health plans for their primary
23 health coverage to obtaining such coverage through
24 enrollment in HAPI plans in a manner that ensures
25 continuation of coverage for such individuals;

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

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

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

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

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

1 "(c) CONTINUED SUPPORT FOR DSH EXPENDI-
2 TURES.—
3 "(1) IN GENERAL.—Notwithstanding any other
4 provision of this title, with respect to each fiscal year
5 that begins after the first calendar year in which
6 coverage under a HAPI plan begins in accordance
7 with the Healthy Americans Act, the DSH allotment
8 for each State otherwise applicable under section
9 1923(f) for that fiscal year shall be reduced by 90
10 percent and no payment shall be made under section
11 1903(a) to a State with respect to any payment ad-
12 justment made under section 1923 for hospitals in
13 the State for quarters in the fiscal year in excess of
14 the reduced DSH allotment for the State applicable
15 for such year.
16 "(2) SPECIAL RULE FOR LAST 3 QUARTERS OF
17 FIRST FISCAL YEAR IN WHICH COVERAGE UNDER A
18 HAPI PLAN BEGINS.—With respect to the first fiscal
19 year in which coverage under a HAPI plan begins
20 in accordance with the Healthy Americans Act, the
21 Secretary shall reduce the DSH allotment for each
22 State that is otherwise applicable under section
23 1923(f) for that fiscal year so that each such DSH
24 allotment reflects a 90 percent reduction in the allot-

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

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

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

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

1 "(A) medical assistance for the mainte-
2 nance of medicare cost-sharing in accordance
3 with subsection (b);
4 "(B) medical assistance for individuals who
5 are eligible for supplemental medical assistance
6 under this title after such date in accordance
7 with section 202 or 301 of the Healthy Ameri-
8 cans Act;
9 "(C) payments for expenditures for estab-
10 lishing and operating a State Choices for Long-
11 Term Care Program under section 1940 (sub-
12 ject to the aggregate 5-year limit established
13 under subsection (c)(1) of such section); and
14 "(D) payment adjustments under section
15 1923 for hospitals in the State that do not ex-
16 ceed the reduced DSH allotment for the State
17 determined under subsection (c)".
18 (b) APPLICATION TO SCHIP.—
19 (1) APPLICATION OF TRANSITION REQUIRE-
20 MENTS.—Section 2107(e)(1) of the Social Security
21 Act (42 U.S.C. 1397gg(e)(1)) is amended by adding
22 at the end the following:
23 "(E) Section 1941(a) (relating to transi-
24 tion to coverage under HAPI plans and, in the
25 case of paragraph (3) of such section, the re-

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

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

9 ''TERMINATION

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

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

Subtitle A—Effective Health Services and Products

SEC. 701. ONE TIME DISALLOWANCE OF DEDUCTION FOR ADVERTISING AND PROMOTIONAL EXPENSES FOR CERTAIN PRESCRIPTION PHARMACEUTICALS.

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

"SEC. 280I. ONE TIME DISALLOWANCE OF DEDUCTION FOR CERTAIN PRESCRIPTION PHARMACEUTICALS ADVERTISING AND PROMOTIONAL EXPENSES.

"(a) IN GENERAL.—No deduction shall be allowed under this chapter for expenses relating to advertising or promoting the sale and use of prescription pharmaceuticals other than drugs for rare diseases or conditions (within the meaning of section 45C) for any taxable year which includes any portion of—

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

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

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

21 (b) CONFORMING AMENDMENT.—The table of sec-
22 tions for such part IX is amended by adding after the
23 item relating to section 280H the following new item:

"Sec. 280I. One time disallowance of deduction for certain prescription pharmaceuticals advertising and promotional expenses.".

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

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

6 (a) IN GENERAL.—
7 (1) NEW DRUGS.—Section 505 of the Federal
8 Food, Drug, and Cosmetic Act (21 U.S.C. 355) is
9 amended by adding at the end the following:
10 ''(o)(1) The sponsor of a new drug application under
11 subsection (b) may include as part of such application a
12 full report of an investigation which has been made to
13 show, with respect to the new drug that is the subject of
14 the application—
15 ''(A) the population for whom the drug is ap-
16 propriate; and
17 ''(B) the effectiveness of the drug when com-
18 pared to the effectiveness of drugs on the market as
19 of the date that the application is submitted.
20 ''(2) If a sponsor of a new drug application under
21 subsection (b) includes in such application the report de-
22 scribed under paragraph (1) then, notwithstanding any
23 other provision of law, the Secretary shall apply section
24 505A(b) to the drug that is the subject of such application
25 in the same manner as the Secretary applies such section

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

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

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

13 ‘‘(B) such disclosure—

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

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

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

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

1 (2) NEW DEVICES.—Section 515(c) of the Fed-
2 eral Food, Drug, and Cosmetic Act (21 U.S.C.
3 360e) is amended by adding at the end the fol-
4 lowing:
5 ''(5)(A) A person that files a report seeking pre-
6 market approval under this subsection may include as part
7 of such report a full description of an investigation which
8 has been made to show, with respect to the device that
9 is the subject of the report—
10 ''(i) the population for whom the device is ap-
11 propriate; and
12 ''(ii) the effectiveness of the device when com-
13 pared to the effectiveness of devices on the market
14 as of the date that the report is submitted.
15 ''(B) If a person that files a report seeking premarket
16 approval under this subsection includes in such report the
17 description referred to under subparagraph (A), then the
18 Secretary shall certify to the Director of the United States
19 Patent and Trademark Office that such person included
20 such description in such report so that the Director may
21 extend the patent with respect to such device under section
22 702(b) of the Healthy Americans Act.
23 ''(C) If a person that files a report seeking premarket
24 approval under this subsection does not include in such
25 report the description referred to under subparagraph (A)

1 then, notwithstanding any other provision of law, the Sec-
2 retary shall require that—
3 "(i) all promotional material with respect to
4 such device include the following disclosure: 'This
5 device has not been proven to be more effective than
6 other devices on the market for any condition or ill-
7 ness mentioned in this advertisement.'; and
8 "(ii) such disclosure—
9 "(I) appears at the beginning and end of
10 any audio and visual promotional material;
11 "(II) constitutes not less than 20 percent
12 of the time of any audio and visual promotional
13 material; and
14 "(III)(aa) in any promotional material, in-
15 cludes a clear and conspicuous printed state-
16 ment that is larger than other print used in
17 such promotional material; and
18 "(bb) in any audio and visual promotional
19 material, includes such statement in audio as
20 well as visual format.".
21 (b) EXTENSION OF DEVICE PATENTS.—If the Direc-
22 tor of the United States Patent and Trademark Office re-
23 ceives a certification from the Secretary pursuant to sec-
24 tion 515(c)(5) of the Federal Food, Drug, and Cosmetic
25 Act (as added under subsection (a)), the Director shall

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

4 (c) EFFECTIVE DATE.—This section shall apply to
5 new drug applications filed under section 505(b) of the
6 Federal Food, Drug, and Cosmetic Act (21 U.S.C. 355(b)
7 and to applications for premarket approval of devices
8 under section 515 of such Act (21 U.S.C. 350e) 180 days
9 after the date of enactment of this Act.

10 **SEC. 703. MEDICAL SCHOOLS AND FINDING WHAT WORKS**
11 **IN HEALTH CARE.**

12 Part B of title IX of the Public Health Service Act
13 (42 U.S.C. 299b et seq.) is amended by adding at the end
14 the following:

15 **"SEC. 918. MEDICAL SCHOOLS AND FINDING WHAT WORKS**
16 **IN HEALTH CARE.**

17 "(a) ESTABLISHMENT OF WEBSITE.—Not later than
18 1 year after the date of enactment of the Healthy Ameri-
19 cans Act, the Agency shall establish an Internet website—

20 "(1) on which researchers at medical schools
21 and other institutions may post the results of their
22 research concerning evidence-informed best practices
23 for improving the quality and efficiency of care; and

24 "(2) that—

1 ''(A) includes a description on how to implement such best practices; and
3 ''(B) clearly identifies the funding source for the research.
5 ''(b) PILOT PROGRAM.—
6 ''(1) ESTABLISHMENT.—Using the information about evidence-informed best practices from the website under subsection (a) and other sources, the Agency, through the National Research Training Program and in consultation with medical schools, shall develop a pilot program to establish methods by which medical school curricula and training may be updated regularly to reflect best practices to improve quality and efficiency in medical practice.
15 ''(2) APPLICATION TO PARTICIPATE.—To participate in the pilot program, an entity shall—
17 ''(A) be an accredited medical school; and
18 ''(B) submit an application at such time, in such manner, and containing such information as the Secretary may require.
21 ''(3) PARTICIPANTS.—The Secretary shall ensure that not less than 28 medical schools shall be included in the pilot program.
24 ''(4) DURATION; PUBLICATION OF RESULTS.—The Agency shall—

1 "(A) operate the pilot program for 3 years;
2 and
3 "(B) not later than 180 days after the
4 date of the completion of the pilot program,
5 publish and make public the results of the pilot
6 program; and
7 "(C) include, as part of the published re-
8 sults under subparagraph (B), recommenda-
9 tions on how to assure that all medical school
10 curricula is updated on a regular basis to re-
11 flect best practices to improve quality and effi-
12 ciency in medical practice.".

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

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

22 (b) QUALITY OF CARE STANDARD.—To develop the
23 information displayed on the website with respect to the
24 quality of care of a health care provider, the Secretary
25 shall—

1 (1) on the date of establishment of the website,
2 use information on the performance of providers in
3 quality initiatives under the Medicare program, in-
4 cluding demonstration projects, reporting initiatives,
5 and pay for performance efforts; and

6 (2) not later than 3 years after the date of es-
7 tablishment of the website, in addition to the infor-
8 mation used under paragraph (1), use quality of
9 care standards developed in consultation with, and
10 similar to standards used by, Medicare quality im-
11 provement organizations of each State.

12 (c) AFFORDABILITY STANDARD.—Not later than 2
13 years after the date of enactment of this Act, the Sec-
14 retary shall, in consultation with health insurance issuers
15 that offer a HAPI plan, develop guidelines by which each
16 health care provider reports to the Secretary with respect
17 to the affordability of services by such provider. The Sec-
18 retary shall ensure that such guidelines—

19 (1) on the date of establishment of such guide-
20 lines, provide for the reporting of affordability of
21 primary care services; and

22 (2) by a date that is no later than 3 years after
23 the date of enactment of this Act, provide for the re-
24 porting of other services.

Subtitle B—Other Provisions to Improve Health Care Services and Quality

SEC. 711. INDIVIDUAL MEDICAL RECORDS.

The Secretary shall establish procedures to ensure that an individual's medical record is considered the property of such individual.

SEC. 712. BONUS PAYMENT FOR MEDICAL MALPRACTICE REFORM.

(a) IN GENERAL.—Effective 3 years after the date of enactment of this Act, a State shall be eligible for bonus payments under this Act if the State has enacted and is implementing a State medical malpractice reform law that complies with subsection (b).

(b) REQUIREMENTS FOR STATE REFORM LAW.—A State medical malpractice reform law complies with this subsection if such law—

(1) requires that an individual who files a medical malpractice action in State court have the facts of such individual's case reviewed prior to such filing by a panel that consists of—

(A) not less than 1 qualified medical expert, chosen in consultation with the State Medicare quality improvement organizations or

1 physician speciality society, whose expertise is
2 appropriate for case;
3 (B) not less than 1 legal expert; and
4 (C) not less than 1 community representa-
5 tive to verify that there is reasonable cause to
6 believe that a malpractice claim exists;
7 (2) permits an individual to engage in voluntary
8 non-binding mediation with respect to the mal-
9 practice claim involved prior to filing an action in
10 State court;
11 (3) imposes sanctions against plaintiffs and at-
12 torneys who file frivolous medical malpractice claims
13 in State courts;
14 (4) prohibits attorneys who file 3 frivolous med-
15 ical malpractice actions in State courts from filing
16 any another medical malpractice action in such
17 courts for a period of 10 years; and
18 (5) provides for the application of a presump-
19 tion of reasonableness with respect to a medical mal-
20 practice action if the defendant establishes that the
21 defendant provided the items or services involved in
22 accordance with accepted clinical practice guidelines
23 established by the specialty of which the defendant
24 is board certified or listed in the National Guideline

1 Clearinghouse, unless such presumption is rebutted
2 by a preponderance of the evidence.
3 (c) USE OF BONUS PAYMENTS.—A State shall use
4 bonus payments received under this section to carry out
5 activities related to disease and illness prevention and for
6 the provision of enhanced health care services for children.
7 (d) PROCEDURES.—The Secretary, in consultation
8 with the Attorney General, shall by regulation establish
9 guidelines for the implementation of this section.

10 TITLE VIII—CONTAINING MED- 11 ICAL COSTS AND GETTING 12 MORE VALUE FOR THE 13 HEALTH CARE DOLLAR

14 **SEC. 801. COST-CONTAINMENT RESULTS OF THE HEALTHY**
15 **AMERICANS ACT.**

16 Congress finds that the Healthy Americans Act will
17 result in the following:
18 (1) Private insurance companies will be forced
19 to hold down costs and will slow the rate of growth
20 because they are required to offer standardized
21 Healthy American Private Insurance plans.
22 (2) Administrative savings will be derived from
23 decoupling employers from the health care infra-
24 structure and reducing employers' and insurers' ad-
25 ministrative costs.

1 (3) Private insurance companies will implement
2 uniform billing and common claims forms.
3 (4) Congress will reclaim Medicare and Med-
4 icaid disproportionate share hospital (DSH) pay-
5 ments because previously uninsured persons will go
6 to providers on an outpatient basis instead of an
7 emergency department.
8 (5) State and local governments will save
9 money on programs they operated for the uninsured
10 before enactment of this Act.
11 (6) The Federal Government will save money
12 on Federal tax subsidies that reward inefficient care
13 and are regressive.
14 (7) The Federal Government and the private
15 sector will save money if the Food and Drug Admin-
16 istration determines whether products provide new
17 value.
18 (8) Reducing medical errors will save the gov-
19 ernment and the private sector money.
20 (9) Requiring hospitals to send large bills to pa-
21 tients for their review will reduce errors in medical
22 billing and force major providers to be more cost
23 conscious.

1 (10) Requiring insurers to reimburse for quality
2 and cost effective services will hold down private sec-
3 tor costs.
4 (11) Reduction of Medicare's restriction on bar-
5 gaining power for prescription drugs will reduce
6 costs for sole source drugs and other medications.
7 (12) Establishment of electronic medical
8 records by insurers will create savings.
9 (13) Publication of cost and quality data will
10 enable people to look up by zip code affordable high-
11 quality providers.

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