109TH CONGRESS 1ST SESSION

S. 1503

To reduce healthcare costs, expand access to affordable healthcare coverage, and improve healthcare and strengthen the healthcare safety net, and for other purposes.

IN THE SENATE OF THE UNITED STATES

July 26, 2005

Mr. Frist (for himself, Mr. McConnell, Mr. Gregg, Mr. Enzi, Ms. Murkowski, and Mr. Demint) introduced the following bill; which was read twice and referred to the Committee on Finance

A BILL

- To reduce healthcare costs, expand access to affordable healthcare coverage, and improve healthcare and strengthen the healthcare safety net, and for other purposes.
 - 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 America Act of 2005".
- 6 (b) Table of Contents.—The table of contents of
- 7 this Act is as follows:
 - Sec. 1. Short title; table of contents.

Sec. 2. Findings.

TITLE I—MAKING HEALTH CARE MORE AFFORDABLE

Subtitle A—Medical Liability Reform

- Sec. 101. Short title.
- Sec. 102. Findings and purpose.
- Sec. 103. Encouraging speedy resolution of claims.
- Sec. 104. Compensating patient injury.
- Sec. 105. Maximizing patient recovery.
- Sec. 106. Additional health benefits.
- Sec. 107. Punitive damages.
- Sec. 108. Authorization of payment of future damages to claimants in health care lawsuits.
- Sec. 109. Definitions.
- Sec. 110. Effect on other laws.
- Sec. 111. State flexibility and protection of States' rights.
- Sec. 112. Applicability; effective date.

Subtitle B—Health Information Technology

CHAPTER 1—GENERAL PROVISIONS

- Sec. 121. Improving health care, quality, safety, and efficiency.
- Sec. 122. HIPAA report.
- Sec. 123. Study of reimbursement incentives.
- Sec. 124. Reauthorization of incentive grants regarding telemedicine.
- Sec. 125. Sense of the Senate on physician payment.
- Sec. 126. Establishment of quality measurement systems for medicare valuebased purchasing programs.
- Sec. 127. Exception to Federal anti-kickback and physician self referral laws for the provision of permitted support.

CHAPTER 2—VALUE BASED PURCHASING

Sec. 131. Value based purchasing programs.

Subtitle C—Patient Safety and Quality Improvement

- Sec. 141. Short title.
- Sec. 142. Findings and purposes.
- Sec. 143. Amendments to Public Health Service Act.
- Sec. 144. Studies and reports.

Subtitle D—Fraud and Abuse

Sec. 151. National expansion of the medicare-medicaid data match pilot program.

Subtitle E—Miscellaneous Provisions

- Sec. 161. Sense of the Senate on establishing a mandated benefits commission.
- Sec. 162. Enforcement of reimbursement provisions by fiduciaries.

TITLE II—EXPANDING ACCESS TO AFFORDABLE HEALTH COVERAGE THROUGH TAX INCENTIVES AND OTHER INITIATIVES

Subtitle A—Refundable Health Insurance Credit

- Sec. 201. Refundable health insurance costs credit.
- Sec. 202. Advance payment of credit to issuers of qualified health insurance.

Subtitle B—High Deductible Health Plans and Health Savings Accounts

- Sec. 211. Deduction of premiums for high deductible health plans.
- Sec. 212. Refundable credit for contributions to health savings accounts of small business employees.

Subtitle C—Improvement of the Health Coverage Tax Credit

- Sec. 221. Change in State-based coverage rules related to preexisting conditions.
- Sec. 222. Eligibility of spouse of certain individuals entitled to medicare.
- Sec. 223. Eligible PBGC pension recipient.
- Sec. 224. Application of option to offer State-based coverage to Puerto Rico, Northern Mariana Islands, American Samoa, Guam, and the United States Virgin Islands.
- Sec. 225. Clarification of disclosure rules.
- Sec. 226. Clarification that State-based COBRA continuation coverage is subject to same rules as Federal COBRA.
- Sec. 227. Application of rules for other specified coverage to eligible alternative taa recipients consistent with rules for other eligible individuals.

Subtitle D—Long-Term Care Insurance

Sec. 231. Sense of the Senate concerning long-term care.

Subtitle E—Other Provisions

- Sec. 241. Disposition of unused health benefits in cafeteria plans and flexible spending arrangements.
- Sec. 242. Microentrepreneurs.
- Sec. 243. Study on access to affordable health insurance for full-time college and university students.
- Sec. 244. Extension of funding for operation of State high risk health insurance pools.
- Sec. 245. Sense of the senate on affordable health coverage for small employers.

Subtitle F—Covering Kids

- Sec. 251. Short title.
- Sec. 252. Grants to promote innovative outreach and enrollment under medicaid and SCHIP.
- Sec. 253. State option to provide for simplified determinations of a child's financial eligibility for medical assistance under medicaid or child health assistance under SCHIP.

TITLE III—IMPROVING CARE AND STRENGTHENING THE SAFETY NET

Subtitle A—High Needs Areas

- Sec. 301. Purpose.
- Sec. 302. High need community health centers.
- Sec. 303. Grant application process.

Subtitle B—Qualified Integrated Health Care systems

Sec. 321. Grants to qualified integrated health care systems.

Subtitle C—Miscellaneous Provisions

- Sec. 331. Community health center collaborative access expansion.
- Sec. 332. Improvements to section 340B program.
- Sec. 333. Forbearance for student loans for physicians providing services in free clinics.
- Sec. 334. Amendments to the Public Health Service Act relating to liability.
- Sec. 335. Sense of the Senate concerning health disparities.

1 SEC. 2. FINDINGS.

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- 2 Congress makes the following findings:
- (1) Health care costs are growing rapidly, put ting health insurance and needed care out of reach
 for too many Americans.
 - (2) Rapidly growing health care costs pose a threat to the United States economy, as they make American businesses less competitive and make it more difficult to create new jobs.
 - (3) Growing health care costs are compromising the stability of health care safety net and entitlement programs.
 - (4) There are a series of steps Congress can and should take to slow the growth of health care costs, expand access to health coverage, and improve access to quality health care for millions of Americans.

TITLE I—MAKING HEALTH CARE

2 **MORE AFFORDABLE**

3 Subtitle A—Medical Liability

4 Reform

5 SEC. 101. SHORT TITLE.

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- This subtitle may be cited as the "Patients First Act of 2005".
- 8 SEC. 102. FINDINGS AND PURPOSE.
- 9 (a) FINDINGS.—
 - (1) Effect on health care access and costs.—Congress finds that our current civil justice system is adversely affecting patient access to health care services, better patient care, and cost-efficient health care, in that the current health care liability system is a costly and ineffective mechanism for resolving claims of health care liability and compensating injured patients, and is a deterrent to the sharing of information among health care professionals which impedes efforts to improve patient safety and quality of care.
 - (2) EFFECT ON INTERSTATE COMMERCE.— Congress finds that the health care and insurance industries are industries affecting interstate commerce and the health care liability litigation systems existing throughout the United States are activities

- that affect interstate commerce by contributing to the high costs of health care and premiums for health care liability insurance purchased by health care system providers.
 - (3) EFFECT ON FEDERAL SPENDING.—Congress finds that the health care liability litigation systems existing throughout the United States have a significant effect on the amount, distribution, and use of Federal funds because of—
 - (A) the large number of individuals who receive health care benefits under programs operated or financed by the Federal Government;
 - (B) the large number of individuals who benefit because of the exclusion from Federal taxes of the amounts spent to provide them with health insurance benefits; and
 - (C) the large number of health care providers who provide items or services for which the Federal Government makes payments.
- 20 (b) Purpose.—It is the purpose of this subtitle to 21 implement reasonable, comprehensive, and effective health 22 care liability reforms designed to—
- 23 (1) improve the availability of health care serv-24 ices in cases in which health care liability actions

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- have been shown to be a factor in the decreased
 availability of services;
- 3 (2) reduce the incidence of "defensive medi-4 cine" and lower the cost of health care liability in-5 surance, all of which contribute to the escalation of 6 health care costs;
 - (3) ensure that persons with meritorious health care injury claims receive fair and adequate compensation, including reasonable noneconomic damages;
 - (4) improve the fairness and cost-effectiveness of our current health care liability system to resolve disputes over, and provide compensation for, health care liability by reducing uncertainty in the amount of compensation provided to injured individuals;
- 16 (5) provide an increased sharing of information 17 in the health care system which will reduce unin-18 tended injury and improve patient care.

19 SEC. 103. ENCOURAGING SPEEDY RESOLUTION OF CLAIMS.

The time for the commencement of a health care law-21 suit shall be 3 years after the date of manifestation of 22 injury or 1 year after the claimant discovers, or through 23 the use of reasonable diligence should have discovered, the 24 injury, whichever occurs first. In no event shall the time 25 for commencement of a health care lawsuit exceed 3 years

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- 1 after the date of manifestation of injury unless tolled for
- 2 any of the following:
- 3 (1) Upon proof of fraud.
- 4 (2) Intentional concealment.
- 5 (3) The presence of a foreign body, which has
- 6 no therapeutic or diagnostic purpose or effect, in the
- 7 person of the injured person.
- 8 Actions by a minor shall be commenced within 3 years
- 9 from the date of the alleged manifestation of injury except
- 10 that actions by a minor under the full age of 6 years shall
- 11 be commenced within 3 years of manifestation of injury
- 12 or prior to the minor's 8th birthday, whichever provides
- 13 a longer period. Such time limitation shall be tolled for
- 14 minors for any period during which a parent or guardian
- 15 and a health care provider or health care organization
- 16 have committed fraud or collusion in the failure to bring
- 17 an action on behalf of the injured minor.
- 18 SEC. 104. COMPENSATING PATIENT INJURY.
- 19 (a) Unlimited Amount of Damages for Actual
- 20 Economic Losses in Health Care Lawsuits.—In any
- 21 health care lawsuit, the full amount of a claimant's eco-
- 22 nomic loss may be fully recovered without limitation.
- 23 (b) Additional Noneconomic Damages.—In any
- 24 health care lawsuit, the amount of noneconomic damages
- 25 recovered may be as much as \$250,000, regardless of the

- 1 number of parties against whom the action is brought or
- 2 the number of separate claims or actions brought with re-
- 3 spect to the same occurrence.
- 4 (c) No Discount of Award for Noneconomic
- 5 Damages.—In any health care lawsuit, an award for fu-
- 6 ture noneconomic damages shall not be discounted to
- 7 present value. The jury shall not be informed about the
- 8 maximum award for noneconomic damages. An award for
- 9 noneconomic damages in excess of \$250,000 shall be re-
- 10 duced either before the entry of judgment, or by amend-
- 11 ment of the judgment after entry of judgment, and such
- 12 reduction shall be made before accounting for any other
- 13 reduction in damages required by law. If separate awards
- 14 are rendered for past and future noneconomic damages
- 15 and the combined awards exceed \$250,000, the future
- 16 noneconomic damages shall be reduced first.
- 17 (d) Fair Share Rule.—In any health care lawsuit,
- 18 each party shall be liable for that party's several share
- 19 of any damages only and not for the share of any other
- 20 person. Each party shall be liable only for the amount of
- 21 damages allocated to such party in direct proportion to
- 22 such party's percentage of responsibility. A separate judg-
- 23 ment shall be rendered against each such party for the
- 24 amount allocated to such party. For purposes of this sec-

- 1 tion, the trier of fact shall determine the proportion of
- 2 responsibility of each party for the claimant's harm.

3 SEC. 105. MAXIMIZING PATIENT RECOVERY.

- 4 (a) Court Supervision of Share of Damages
- 5 ACTUALLY PAID TO CLAIMANTS.—In any health care law-
- 6 suit, the court shall supervise the arrangements for pay-
- 7 ment of damages to protect against conflicts of interest
- 8 that may have the effect of reducing the amount of dam-
- 9 ages awarded that are actually paid to claimants. In par-
- 10 ticular, in any health care lawsuit in which the attorney
- 11 for a party claims a financial stake in the outcome by vir-
- 12 tue of a contingent fee, the court shall have the power
- 13 to restrict the payment of a claimant's damage recovery
- 14 to such attorney, and to redirect such damages to the
- 15 claimant based upon the interests of justice and principles
- 16 of equity. In no event shall the total of all contingent fees
- 17 for representing all claimants in a health care lawsuit ex-
- 18 ceed the following limits:
- 19 (1) 40 percent of the first \$50,000 recovered by
- the claimant(s).
- 21 (2) $33\frac{1}{3}$ percent of the next \$50,000 recovered
- by the claimant(s).
- 23 (3) 25 percent of the next \$500,000 recovered
- by the claimant(s).

1	(4) 15 percent of any amount by which the re-	
2	covery by the claimant(s) is in excess of \$600,000.	
3	(b) Applicability.—The limitations in subsection	
4	(a) shall apply whether the recovery is by judgment, settle-	
5	ment, mediation, arbitration, or any other form of alter-	
6	native dispute resolution. In a health care lawsuit involv-	
7	ing a minor or incompetent person, a court retains the	
8	authority to authorize or approve a fee that is less than	
9	the maximum permitted under this section.	
10	(c) Expert Witnesses.—	
11	(1) Requirement.—No individual shall be	
12	qualified to testify as an expert witness concerning	
13	issues of negligence in any health care lawsuit	
14	against a defendant unless such individual—	
15	(A) except as required under paragraph	
16	(2), is a health care professional who—	
17	(i) is appropriately credentialed or li-	
18	censed in 1 or more States to deliver	
19	health care services; and	
20	(ii) typically treats the diagnosis or	
21	condition or provides the type of treatment	
22	under review; and	
23	(B) can demonstrate by competent evi-	
24	dence that, as a result of training, education,	
25	knowledge, and experience in the evaluation, di-	

agnosis, and treatment of the disease or injury which is the subject matter of the lawsuit against the defendant, the individual was substantially familiar with applicable standards of care and practice as they relate to the act or omission which is the subject of the lawsuit on the date of the incident.

- (2) Physician review.—In a health care lawsuit, if the claim of the plaintiff involved treatment that is recommended or provided by a physician (allopathic or osteopathic), an individual shall not be qualified to be an expert witness under this subsection with respect to issues of negligence concerning such treatment unless such individual is a physician.
- (3) SPECIALTIES AND SUBSPECIALTIES.—With respect to a lawsuit described in paragraph (1), a court shall not permit an expert in one medical specialty or subspecialty to testify against a defendant in another medical specialty or subspecialty unless, in addition to a showing of substantial familiarity in accordance with paragraph (1)(B), there is a showing that the standards of care and practice in the two specialty or subspecialty fields are similar.

- 1 (4) Limitation.—The limitations in this sub-
- 2 section shall not apply to expert witnesses testifying
- as to the degree or permanency of medical or phys-
- 4 ical impairment.

5 SEC. 106. ADDITIONAL HEALTH BENEFITS.

- 6 (a) IN GENERAL.—The amount of any damages re-
- 7 ceived by a claimant in any health care lawsuit shall be
- 8 reduced by the court by the amount of any collateral
- 9 source benefits to which the claimant is entitled, less any
- 10 insurance premiums or other payments made by the claim-
- 11 ant (or by the spouse, parent, child, or legal guardian of
- 12 the claimant) to obtain or secure such benefits.
- 13 (b) Preservation of Current Law.—Where a
- 14 payor of collateral source benefits has a right of recovery
- 15 by reimbursement or subrogation and such right is per-
- 16 mitted under Federal or State law, subsection (a) shall
- 17 not apply.
- 18 (c) Application of Provision.—This section shall
- 19 apply to any health care lawsuit that is settled or resolved
- 20 by a fact finder.

21 SEC. 107. PUNITIVE DAMAGES.

- 22 (a) In General.—Punitive damages may, if other-
- 23 wise permitted by applicable State or Federal law, be
- 24 awarded against any person in a health care lawsuit only
- 25 if it is proven by clear and convincing evidence that such

- 1 person acted with malicious intent to injure the claimant,
- 2 or that such person deliberately failed to avoid unneces-
- 3 sary injury that such person knew the claimant was sub-
- 4 stantially certain to suffer. In any health care lawsuit
- 5 where no judgment for compensatory damages is rendered
- 6 against such person, no punitive damages may be awarded
- 7 with respect to the claim in such lawsuit. No demand for
- 8 punitive damages shall be included in a health care lawsuit
- 9 as initially filed. A court may allow a claimant to file an
- 10 amended pleading for punitive damages only upon a mo-
- 11 tion by the claimant and after a finding by the court, upon
- 12 review of supporting and opposing affidavits or after a
- 13 hearing, after weighing the evidence, that the claimant has
- 14 established by a substantial probability that the claimant
- 15 will prevail on the claim for punitive damages. At the re-
- 16 quest of any party in a health care lawsuit, the trier of
- 17 fact shall consider in a separate proceeding—
- 18 (1) whether punitive damages are to be award-
- ed and the amount of such award; and
- 20 (2) the amount of punitive damages following a
- 21 determination of punitive liability.
- 22 If a separate proceeding is requested, evidence relevant
- 23 only to the claim for punitive damages, as determined by
- 24 applicable State law, shall be inadmissible in any pro-

1	ceeding to determine whether compensatory damages are
2	to be awarded.
3	(b) Determining Amount of Punitive Dam-
4	AGES.—
5	(1) Factors considered.—In determining
6	the amount of punitive damages, if awarded, in a
7	health care lawsuit, the trier of fact shall consider
8	only the following:
9	(A) the severity of the harm caused by the
10	conduct of such party;
11	(B) the duration of the conduct or any
12	concealment of it by such party;
13	(C) the profitability of the conduct to such
14	party;
15	(D) the number of products sold or med-
16	ical procedures rendered for compensation, as
17	the case may be, by such party, of the kind
18	causing the harm complained of by the claim-
19	ant;
20	(E) any criminal penalties imposed on such
21	party, as a result of the conduct complained of
22	by the claimant; and
23	(F) the amount of any civil fines assessed
24	against such party as a result of the conduct
25	complained of by the claimant.

- 1 (2) Maximum award.—The amount of punitive 2 damages, if awarded, in a health care lawsuit may 3 be as much as \$250,000 or as much as two times the amount of economic damages awarded, which-5 ever is greater. The jury shall not be informed of 6 this limitation. 7 (c) No Penalties for Providers in Compliance 8 WITH FDA STANDARDS.—A health care provider who
- 10 Food and Drug Administration shall not be named as a

prescribes a medical product approved or cleared by the

- party to a product liability lawsuit involving such product
- 12 and shall not be liable to a claimant in a class action law-
- 13 suit against the manufacturer, distributor, or seller of
- 14 such product.
- 15 SEC. 108. AUTHORIZATION OF PAYMENT OF FUTURE DAM-
- 16 AGES TO CLAIMANTS IN HEALTH CARE LAW-
- 17 SUITS.
- 18 (a) In General.—In any health care lawsuit, if an
- award of future damages, without reduction to present 19
- 20 value, equaling or exceeding \$50,000 is made against a
- 21 party with sufficient insurance or other assets to fund a
- periodic payment of such a judgment, the court shall, at
- the request of any party, enter a judgment ordering that
- the future damages be paid by periodic payments in ac-
- cordance with the Uniform Periodic Payment of Judg-

- 1 ments Act promulgated by the National Conference of
- 2 Commissioners on Uniform State Laws.
- 3 (b) APPLICABILITY.—This section applies to all ac-
- 4 tions which have not been first set for trial or retrial be-
- 5 fore the effective date of this Act.

6 SEC. 109. DEFINITIONS.

- 7 In this subtitle:
- 8 (1) ALTERNATIVE DISPUTE RESOLUTION SYS-9 TEM; ADR.—The term "alternative dispute resolution 10 system" or "ADR" means a system that provides 11 for the resolution of health care lawsuits in a man-
- ner other than through a civil action brought in a
- 13 State or Federal court.
- 14 (2) CLAIMANT.—The term "claimant" means
 15 any person who brings a health care lawsuit, includ16 ing a person who asserts or claims a right to legal
 17 or equitable contribution, indemnity or subrogation,
 18 arising out of a health care liability claim or action,
 19 and any person on whose behalf such a claim is as20 serted or such an action is brought, whether de-

ceased, incompetent, or a minor.

(3) Collateral source benefits" means any amount paid or reasonably likely to be paid in the future to or on behalf of the claimant, or any service, product

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1	or other benefit provided or reasonably likely to be
2	provided in the future to or on behalf of the claim-
3	ant, as a result of the injury or wrongful death, pur-
4	suant to—
5	(A) any State or Federal health, sickness,
6	income-disability, accident, or workers' com-
7	pensation law;
8	(B) any health, sickness, income-disability,
9	or accident insurance that provides health bene-
10	fits or income-disability coverage;
11	(C) any contract or agreement of any
12	group, organization, partnership, or corporation
13	to provide, pay for, or reimburse the cost of
14	medical, hospital, dental, or income disability
15	benefits; and
16	(D) any other publicly or privately funded
17	program.
18	(4) Compensatory damages.—The term

(4) Compensatory damages" means objectively verifiable monetary losses incurred as a result of the provision of, use of, or payment for (or failure to provide, use, or pay for) health care services or medical products, such as past and future medical expenses, loss of past and future earnings, cost of obtaining domestic services, loss of employment, and

- loss of business or employment opportunities, damages for physical and emotional pain, suffering, inconvenience, physical impairment, mental anguish, disfigurement, loss of enjoyment of life, loss of society and companionship, loss of consortium (other than loss of domestic service), hedonic damages, injury to reputation, and all other nonpecuniary losses of any kind or nature. The term "compensatory damages" includes economic damages and noneconomic damages, as such terms are defined in this section.
 - (5) Contingent fee" includes all compensation to any person or persons which is payable only if a recovery is effected on behalf of one or more claimants.
 - (6) Economic damages.—The term "economic damages" means objectively verifiable monetary losses incurred as a result of the provision of, use of, or payment for (or failure to provide, use, or pay for) health care services or medical products, such as past and future medical expenses, loss of past and future earnings, cost of obtaining domestic services, loss of employment, and loss of business or employment opportunities.

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(7)HEALTH LAWSUIT.—The CARE "health care lawsuit" means any health care liability claim concerning the provision of health care goods or services affecting interstate commerce, or any health care liability action concerning the provision of health care goods or services affecting interstate commerce, brought in a State or Federal court or pursuant to an alternative dispute resolution system, against a health care provider, a health care organization, or the manufacturer, distributor, supplier, marketer, promoter, or seller of a medical product, regardless of the theory of liability on which the claim is based, or the number of claimants, plaintiffs, defendants, or other parties, or the number of claims or causes of action, in which the claimant alleges a health care liability claim.

(8) Health care liability action" means a civil action brought in a State or Federal Court or pursuant to an alternative dispute resolution system, against a health care provider, a health care organization, or the manufacturer, distributor, supplier, marketer, promoter, or seller of a medical product, regardless of the theory of liability on which the claim is based, or the number of plaintiffs, defend-

- ants, or other parties, or the number of causes of action, in which the claimant alleges a health care liability claim.
 - (9) Health care liability claim" means a demand by any person, whether or not pursuant to ADR, against a health care provider, health care organization, or the manufacturer, distributor, supplier, marketer, promoter, or seller of a medical product, including, but not limited to, third-party claims, crossclaims, counter-claims, or contribution claims, which are based upon the provision of, use of, or payment for (or the failure to provide, use, or pay for) health care services or medical products, regardless of the theory of liability on which the claim is based, or the number of causes of action.
 - (10) HEALTH CARE ORGANIZATION.—The term "health care organization" means any person or entity which is obligated to provide or pay for health benefits under any health plan, including any person or entity acting under a contract or arrangement with a health care organization to provide or administer any health benefit.

- 1 (11) HEALTH CARE PROVIDER.—The term
 2 "health care provider" means any person or entity
 3 required by State or Federal laws or regulations to
 4 be licensed, registered, or certified to provide health
 5 care services, and being either so licensed, registered, or certified, or exempted from such require6 ment by other statute or regulation.
 - (12) Health care goods or services.—The term "health care goods or services" means any goods or services provided by a health care organization, provider, or by any individual working under the supervision of a health care provider, that relates to the diagnosis, prevention, or treatment of any human disease or impairment, or the assessment of the health of human beings.
 - (13) Malicious intent to injure" means intentionally causing or attempting to cause physical injury other than providing health care goods or services.
 - (14) MEDICAL PRODUCT.—The term "medical product" means a drug or device intended for humans, and the terms "drug" and "device" have the meanings given such terms in sections 201(g)(1) and 201(h) of the Federal Food, Drug and Cosmetic Act

- 1 (21 U.S.C. 321), respectively, including any compo-2 nent or raw material used therein, but excluding 3 health care services.
 - "noneconomic damages" means damages for physical and emotional pain, suffering, inconvenience, physical impairment, mental anguish, disfigurement, loss of enjoyment of life, loss of society and companionship, loss of consortium (other than loss of domestic service), hedonic damages, injury to reputation, and all other nonpecuniary losses of any kind or nature.
 - (16) Punitive damages.—The term "punitive damages" means damages awarded, for the purpose of punishment or deterrence, and not solely for compensatory purposes, against a health care provider, health care organization, or a manufacturer, distributor, or supplier of a medical product. Punitive damages are neither economic nor noneconomic damages.
 - (17) Recovery.—The term "recovery" means the net sum recovered after deducting any disbursements or costs incurred in connection with prosecution or settlement of the claim, including all costs paid or advanced by any person. Costs of health care

1	incurred by the plaintiff and the attorneys' office
2	overhead costs or charges for legal services are not
3	deductible disbursements or costs for such purpose.
4	(18) State.—The term "State" means each of
5	the several States, the District of Columbia, the
6	Commonwealth of Puerto Rico, the Virgin Islands,
7	Guam, American Samoa, the Northern Mariana Is-
8	lands, the Trust Territory of the Pacific Islands, and
9	any other territory or possession of the United
10	States, or any political subdivision thereof.
11	SEC. 110. EFFECT ON OTHER LAWS.
12	(a) VACCINE INJURY.—
13	(1) To the extent that title XXI of the Public
14	Health Service Act establishes a Federal rule of law
15	applicable to a civil action brought for a vaccine-re-
16	lated injury or death—
17	(A) this subtitle does not affect the appli-
18	cation of the rule of law to such an action; and
19	(B) any rule of law prescribed by this sub-
20	title in conflict with a rule of law of such title
21	XXI shall not apply to such action.
22	(2) If there is an aspect of a civil action
23	brought for a vaccine-related injury or death to
24	which a Federal rule of law under title XXI of the

Public Health Service Act does not apply, then this

1	subtitle or otherwise applicable law (as determined
2	under this subtitle) will apply to such aspect of such
3	action.
4	(b) Other Federal Law.—Except as provided in
5	this section, nothing in this subtitle shall be deemed to
6	affect any defense available to a defendant in a health care
7	lawsuit or action under any other provision of Federal law.
8	SEC. 111. STATE FLEXIBILITY AND PROTECTION OF
9	STATES' RIGHTS.
10	(a) Health Care Lawsuits.—The provisions gov-
11	erning health care lawsuits set forth in this subtitle pre-
12	empt, subject to subsections (b) and (c), State law to the
13	extent that State law prevents the application of any pro-
14	visions of law established by or under this subtitle. The
15	provisions governing health care lawsuits set forth in this
16	subtitle supersede chapter 171 of title 28, United States
17	Code, to the extent that such chapter—
18	(1) provides for a greater amount of damages
19	or contingent fees, a longer period in which a health
20	care lawsuit may be commenced, or a reduced appli-
21	cability or scope of periodic payment of future dam-
22	ages, than provided in this subtitle; or
23	(2) prohibits the introduction of evidence re-
24	garding collateral source benefits, or mandates or

- 1 permits subrogation or a lien on collateral source
- 2 benefits.
- 3 (b) Protection of States' Rights.—Any issue
- 4 that is not governed by any provision of law established
- 5 by or under this subtitle (including State standards of
- 6 negligence) shall be governed by otherwise applicable State
- 7 or Federal law. This subtitle does not preempt or super-
- 8 sede any law that imposes greater protections (such as a
- 9 shorter statute of limitations) for health care providers
- 10 and health care organizations from liability, loss, or dam-
- 11 ages than those provided by this subtitle.
- 12 (c) State Flexibility.—No provision of this sub-
- 13 title shall be construed to preempt—
- 14 (1) any State law (whether effective before, on,
- or after the date of the enactment of this subtitle)
- that specifies a particular monetary amount of com-
- pensatory or punitive damages (or the total amount
- of damages) that may be awarded in a health care
- 19 lawsuit, regardless of whether such monetary
- amount is greater or lesser than is provided for
- 21 under this subtitle, notwithstanding section 104(a);
- 22 or
- 23 (2) any defense available to a party in a health
- care lawsuit under any other provision of State or
- Federal law.

27 SEC. 112. APPLICABILITY; EFFECTIVE DATE. 2 This subtitle shall apply to any health care lawsuit 3 brought in a Federal or State court, or subject to an alternative dispute resolution system, that is initiated on or 4 5 after the date of the enactment of this Act, except that any health care lawsuit arising from an injury occurring 6

- 7 prior to the date of the enactment of this Act shall be
- governed by the applicable statute of limitations provisions
- in effect at the time the injury occurred. 9

Subtitle B—Health Information 10 **Technology** 11

CHAPTER 1—GENERAL PROVISIONS 12

- SEC. 121. IMPROVING HEALTH CARE, QUALITY, SAFETY,
- 14 AND EFFICIENCY.
- 15 The Public Health Service Act (42 U.S.C. 201 et
- seq.) is amended by adding at the end the following: 16

"TITLE XXIX—HEALTH 17

INFORMATION TECHNOLOGY 18

- 19 "SEC. 2901. DEFINITIONS.
- 20 "In this title:
- 21 "(1) Health care provider.—The term
- 22 'health care provider' means a hospital, skilled nurs-
- 23 ing facility, home health entity, health care clinic,
- 24 federally qualified health center, group practice (as
- 25 defined in section 1877(h)(4) of the Social Security
- 26 Act), a pharmacist, a pharmacy, a laboratory, a phy-

1	sician (as defined in section 1861(r) of the Social
2	Security Act), a health facility operated by or pursu-
3	ant to a contract with the Indian Health Service, a
4	rural health clinic, and any other category of facility
5	or clinician determined appropriate by the Secretary.
6	"(2) Health information.—The term 'health
7	information' has the meaning given such term in
8	section 1171(4) of the Social Security Act.
9	"(3) HEALTH INSURANCE PLAN.—The term
10	'health insurance plan' means—
11	"(A) a health insurance issuer (as defined
12	in section 2791(b)(2));
13	"(B) a group health plan (as defined in
14	section $2791(a)(1)$; and
15	"(C) a health maintenance organization
16	(as defined in section 2791(b)(3)).
17	"(4) Laboratory.—The term 'laboratory' has
18	the meaning given that term in section 353.
19	"(5) Pharmacist.—The term 'pharmacist' has
20	the meaning given that term in section 804 of the
21	Federal Food, Drug, and Cosmetic Act.
22	"(6) State.—The term 'State' means each of
23	the several States, the District of Columbia, Puerto
24	Rico, the Virgin Islands, Guam, American Samoa,
25	and the Northern Mariana Islands.

1	"SEC. 2902. OFFICE OF THE NATIONAL COORDINATOR OF
2	HEALTH INFORMATION TECHNOLOGY.
3	"(a) Office of National Health Information
4	TECHNOLOGY.—There is established within the Office of
5	the Secretary an Office of the National Coordinator of
6	Health Information Technology (referred to in this section
7	as the 'Office'). The Office shall be headed by a National
8	Coordinator who shall be appointed by the Secretary, in
9	consultation with the President, and shall report directly
10	to the Secretary.
11	"(b) Purpose.—It shall be the purpose of the Office
12	to coordinate with relevant Federal agencies and oversee
13	programs and activities to develop a nationwide interoper-
14	able health information technology infrastructure that—
15	"(1) ensures that patients' individually identifi-
16	able health information is secure and protected;
17	"(2) improves health care quality, reduces med-
18	ical errors, and advances the delivery of patient-cen-
19	tered medical care;
20	"(3) reduces health care costs resulting from
21	inefficiency, medical errors, inappropriate care, and
22	incomplete information;
23	"(4) ensures that appropriate information to
24	help guide medical decisions is available at the time
25	and place of care;

1	"(5) promotes a more effective marketplace,
2	greater competition, and increased choice through
3	the wider availability of accurate information or
4	health care costs, quality, and outcomes; and
5	"(6) improves the coordination of care and in-
6	formation among hospitals, laboratories, physician
7	offices, and other entities through an effective infra-
8	structure for the secure and authorized exchange of
9	health care information.
10	"(e) Duties of the National Coordi-
11	NATOR.—The National Coordinator shall—
12	"(1) provide support to the public-private
13	American Health Information Collaborative estab-
14	lished under section 2903;
15	"(2) serve as the principal advisor to the Sec-
16	retary concerning the development, application, and
17	use of health information technology, and coordinate
18	and oversee the health information technology pro-
19	grams of the Department;
20	"(3) facilitate the adoption of a nationwide
21	interoperable system for the electronic exchange of
22	health information;
23	"(4) ensure the adoption and implementation of

standards for the electronic exchange of health infor-

- 1 mation to reduce cost and improve health care qual-2 ity;
- 3 "(5) ensure that health information technology 4 policy and programs of the Department are coordi-5 nated with those of relevant executive branch agen-6 cies (including Federal commissions) with a goal of 7 avoiding duplication of efforts and of helping to en-8 sure that each agency undertakes health information 9 technology activities primarily within the areas of its 10 greatest expertise and technical capability;
 - "(6) to the extent permitted by law, coordinate outreach and consultation by the relevant executive branch agencies (including Federal commissions) with public and private parties of interest, including consumers, payers, employers, hospitals and other health care providers, physicians, community health centers, laboratories, vendors and other stakeholders;
 - "(7) advise the President regarding specific Federal health information technology programs; and
- "(8) submit the reports described under section
 23 2903(i) (excluding paragraph (4) of such section).
- 24 "(d) RULE OF CONSTRUCTION.—Nothing in this sec-25 tion shall be construed to require the duplication of Fed-

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1	eral efforts with respect to the establishment of the Office,
2	regardless of whether such efforts were carried out prior
3	to or after the enactment of this title.
4	"SEC. 2903. AMERICAN HEALTH INFORMATION COLLABO-
5	RATIVE.
6	"(a) Purpose.—The Secretary shall establish the
7	public-private American Health Information Collaborative
8	(referred to in this section as the 'Collaborative') to—
9	"(1) advise the Secretary and recommend spe-
10	cific actions to achieve a nationwide interoperable
11	health information technology infrastructure;
12	"(2) serve as a forum for the participation of
13	a broad range of stakeholders to provide input on
14	achieving the interoperability of health information
15	technology; and
16	"(3) recommend standards (including content,
17	communication, and security standards) for the elec-
18	tronic exchange of health information for adoption
19	by the Federal Government and voluntary adoption
20	by private entities.
21	"(b) Composition.—
22	"(1) In General.—The Collaborative shall be
23	composed of—
24	"(A) the Secretary, who shall serve as the
25	chairperson of the Collaborative:

1	"(B) the Secretary of Defense, or his or
2	her designee;
3	"(C) the Secretary of Veterans Affairs, or
4	his or her designee;
5	"(D) the Secretary of Commerce, or his or
6	her designee;
7	"(E) representatives of other relevant Fed-
8	eral agencies, as determined appropriate by the
9	Secretary; and
10	"(F) representatives from among the fol-
11	lowing categories to be appointed by the Sec-
12	retary from nominations submitted by the pub-
13	lie—
14	"(i) consumer and patient organizations;
15	"(ii) experts in health information privacy
16	and security;
17	"(iii) health care providers;
18	"(iv) health insurance plans or other third
19	party payors;
20	"(v) standards development organizations;
21	"(vi) information technology vendors;
22	"(vii) purchasers or employers; and
23	"(viii) State or local government agencies
24	or Indian tribe or tribal organizations.

1	"(2) Considerations.—In appointing
2	members under paragraph (1)(F), the Secretary
3	shall select individuals with expertise in—
4	"(A) health information privacy;
5	"(B) health information security;
6	"(C) health care quality and patient safety,
7	including those individuals with experience in
8	utilizing health information technology to im-
9	prove health care quality and patient safety;
10	"(D) data exchange; and
11	"(E) developing health information tech-
12	nology standards and new health information
13	technology.
14	"(3) Terms.—Members appointed under para-
15	graph (1)(G) shall serve for 2 year terms, except
16	that any member appointed to fill a vacancy for an
17	unexpired term shall be appointed for the remainder
18	of such term. A member may serve for not to exceed
19	180 days after the expiration of such member's term
20	or until a successor has been appointed.
21	"(c) Recommendations and Policies.—The Col-
22	laborative shall make recommendations to identify uni-
23	form national policies for adoption by the Federal Govern-
24	ment and voluntary adoption by private entities to support

1	the widespread adoption of health information technology,
2	including—
3	"(1) protection of individually identifiable
4	health information through privacy and security
5	practices;
6	"(2) measures to prevent unauthorized access
7	to health information;
8	"(3) methods to facilitate secure patient access
9	to health information;
10	"(4) the ongoing harmonization of industry-
11	wide health information technology standards;
12	"(5) recommendations for a nationwide inter-
13	operable health information technology infrastruc-
14	ture;
15	"(6) the identification and prioritization of spe-
16	cific use cases for which health information tech-
17	nology is valuable, beneficial, and feasible;
18	"(7) recommendations for the establishment of
19	an entity to ensure the continuation of the functions
20	of the Collaborative; and
21	"(8) other policies determined to be necessary
22	by the Collaborative.
23	"(d) Standards.—
24	"(1) Existing standards.—The standards
25	adopted by the Consolidated Health Informatics Ini-

1	tiative shall be deemed to have been recommended
2	by the Collaborative under this section.
3	"(2) First year review.—Not later than 1
4	year after the date of enactment of this title, the
5	Collaborative shall—
6	"(A) review existing standards (including
7	content, communication, and security stand-
8	ards) for the electronic exchange of health in-
9	formation, including such standards adopted by
10	the Secretary under paragraph (2)(A);
11	"(B) identify deficiencies and omissions in
12	such existing standards; and
13	"(C) identify duplication and overlap in
14	such existing standards;
15	and recommend modifications to such standards as
16	necessary.
17	"(3) Ongoing review.—Beginning 1 year
18	after the date of enactment of this title, and annu-
19	ally thereafter, the Collaborative shall—
20	"(A) review existing standards (including
21	content, communication, and security stand-
22	ards) for the electronic exchange of health in-
23	formation, including such standards adopted by
24	the Secretary under paragraph (2)(A);

1	"(B) identify deficiencies and omissions in
2	such existing standards; and
3	"(C) identify duplication and overlap in
4	such existing standards;
5	and recommend modifications to such standards as
6	necessary.
7	"(4) Limitation.—The standards described in
8	this section shall be consistent with any standards
9	developed pursuant to the Health Insurance Port-
10	ability and Accountability Act of 1996.
11	"(e) FEDERAL ACTION.—Not later than 60 days
12	after the issuance of a recommendation from the Collabo-
13	rative under subsection (d)(2), the Secretary of Health
14	and Human Services, in consultation with the Secretary
15	of Veterans Affairs, the Secretary of Defense, and rep-
16	resentatives of other relevant Federal agencies, as deter-
17	mined appropriate by the Secretary, shall review such rec-
18	ommendations. The Secretary shall provide for the adop-
19	tion by the Federal Government of any standard or stand-
20	ards contained in such recommendation.
21	"(f) Coordination of Federal Spending.—Not
22	later than 1 year after the adoption by the Federal Gov-
23	ernment of a recommendation as provided for in sub-
24	section (e), and in compliance with chapter 113 of title
25	40, United States Code, no Federal agency shall expend

- 1 Federal funds for the purchase of any form of health in-
- 2 formation technology or health information technology
- 3 system for clinical care or for the electronic retrieval, stor-
- 4 age, or exchange of health information that is not con-
- 5 sistent with applicable standards adopted by the Federal
- 6 Government under subsection (e).
- 7 "(g) Coordination of Federal Data Collec-
- 8 TION.—Not later than 3 years after the adoption by the
- 9 Federal Government of a recommendation as provided for
- 10 in subsection (e), all Federal agencies collecting health
- 11 data for the purposes of surveillance, epidemiology, ad-
- 12 verse event reporting, research, or for other purposes de-
- 13 termined appropriate by the Secretary shall comply with
- 14 standards adopted under subsection (e).
- 15 "(h) VOLUNTARY ADOPTION.—
- 16 "(1) IN GENERAL.—Any standards adopted by
- the Federal Government under subsection (e) shall
- be voluntary with respect to private entities.
- 19 "(2) Rule of Construction.—Nothing in
- this section shall be construed to require that a pri-
- vate entity that enters into a contract with the Fed-
- eral Government adopt the standards adopted by the
- Federal Government under section 2903 with re-
- spect to activities not related to the contract.

1	"(3) Limitation.—Private entities that enter
2	into a contract with the Federal Government shall
3	adopt the standards adopted under section 2903 for
4	the purpose of activities under such Federal con-
5	tract.
6	"(i) Effect on Other Provisions.—Nothing in
7	this title shall be construed to effect the scope or sub-
8	stance of—
9	"(1) section 264 of the Health Insurance Port-
10	ability and Accountability Act of 1996;
11	"(2) sections 1171 through 1179 of the Social
12	Security Act; and
13	"(3) any regulation issued pursuant to any such
14	section;
15	and such sections shall remain in effect and shall apply
16	to the implementation of standards, programs and activi-
17	ties under this title.
18	"(j) Reports.—The Secretary shall submit to the
19	Committee on Health, Education, Labor, and Pensions
20	and the Committee on Finance of the Senate and the
21	Committee on Energy and Commerce and the Committee
22	on Ways and Means of the House of Representatives, on
23	an annual basis, a report that—
24	"(1) describes the specific actions that have

been taken by the Federal Government and private

1	entities to facilitate the adoption of an interoperable
2	nationwide system for the electronic exchange of
3	health information;
4	"(2) describes barriers to the adoption of such
5	a nationwide system;
6	"(3) contains recommendations to achieve full
7	implementation of such a nationwide system; and
8	"(4) contains a plan and progress toward the
9	establishment of an entity to ensure the continuation
10	of the functions of the Collaborative.
11	"(k) Application of FACA.—The Federal Advisory
12	Committee Act (5 U.S.C. App.) shall apply to the Collabo-
13	rative, except that the term provided for under section
14	14(a)(2) shall be 5 years.
15	"(l) Rule of Construction.—Nothing in this sec-
16	tion shall be construed to require the duplication of Fed-
17	eral efforts with respect to the establishment of the Col-
18	laborative, regardless of whether such efforts were carried
19	out prior to or after the enactment of this title.
20	"SEC. 2904. IMPLEMENTATION AND CERTIFICATION OF
21	HEALTH INFORMATION STANDARDS.
22	"(a) Implementation.—
23	"(1) IN GENERAL.—The Secretary, based upon
24	the recommendations of the Collaborative, shall de-
25	velop criteria to ensure uniform and consistent im-

plementation of any standards for the electronic exchange of health information voluntarily adopted by private entities in technical conformance with such standards adopted under this title.

"(2) IMPLEMENTATION ASSISTANCE.—The Secretary may recognize a private entity or entities to assist private entities in the implementation of the standards adopted under this title using the criteria developed by the Secretary under this section.

"(b) Certification.—

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- "(1) IN GENERAL.—The Secretary, based upon the recommendations of the Collaborative, shall develop criteria to ensure and certify that hardware, software, and support services that claim to be in compliance with any standard for the electronic exchange of health information adopted under this title have established and maintained such compliance in technical conformance with such standards.
- "(2) CERTIFICATION ASSISTANCE.—The Secretary may recognize a private entity or entities to assist in the certification described under paragraph (1) using the criteria developed by the Secretary under this section.
- 24 "(c) Delegation Authority.—The Secretary, 25 through consultation with the Collaborative, may delegate

1	the development of the criteria under subsections (a) and
2	(b) to a private entity.
3	"SEC. 2905. STUDY OF STATE HEALTH INFORMATION LAWS
4	AND PRACTICES.
5	"(a) In General.—The Secretary shall carry out,
6	or contract with a private entity to carry out, a study that
7	examines—
8	"(1) the variation among State laws and prac-
9	tices that relate to the privacy, confidentiality, and
10	security of health information;
11	"(2) how such variation among State laws and
12	practices may impact the electronic exchange of
13	health information—
14	"(A) among the States;
15	"(B) between the States and the Federal
16	Government; and
17	"(C) among private entities; and
18	"(3) how such laws and practices may be har-
19	monized to permit the secure electronic exchange of
20	health information.
21	"(b) Report and Recommendations.—Not later
22	than 1 year after the date of enactment of this title, the
23	Secretary shall submit to Congress a report that—
24	"(1) describes the results of the study carried
25	out under subsection (a): and

1	"(2) makes recommendations based on the re-
2	sults of such study.
3	"SEC. 2906. SECURE EXCHANGE OF HEALTH INFORMATION;
4	INCENTIVE GRANTS.
5	"(a) In General.—The Secretary may make grants
6	to States to carry out programs under which such States
7	cooperate with other States to develop and implement
8	State policies that will facilitate the secure electronic ex-
9	change of health information utilizing the standards
10	adopted under section 2903—
11	"(1) among the States;
12	"(2) between the States and the Federal Gov-
13	ernment; and
14	"(3) among private entities.
15	"(b) Priority.—In awarding grants under sub-
16	section (a), the Secretary shall give priority to States that
17	provide assurance that any funding awarded under such
18	a grant shall be used to harmonize privacy laws and prac-
19	tices between the States, the States and the Federal Gov-
20	ernment, and among private entities related to the privacy,
21	confidentiality, and security of health information.
22	"(c) Dissemination of Information.—The Sec-
23	retary shall disseminate information regarding the efficacy
24	of efforts of a recipient of a grant under this section

1	"(d) Technical Assistance.—The Secretary may
2	provide technical assistance to recipients of a grant under
3	this section.
4	"(e) AUTHORIZATION OF APPROPRIATIONS.—For the
5	purpose of carrying out subsection (a), there are author-
6	ized to be appropriated such sums as may be necessary
7	for each of the fiscal years 2006 through 2010.
8	"SEC. 2907. LICENSURE AND THE ELECTRONIC EXCHANGE
9	OF HEALTH INFORMATION.
10	"(a) In General.—The Secretary shall carry out,
11	or contract with a private entity to carry out, a study that
12	examines—
13	"(1) the variation among State laws that relate
14	to the licensure, registration, and certification of
15	medical professionals; and
16	"(2) how such variation among State laws im-
17	pacts the secure electronic exchange of health infor-
18	mation—
19	"(A) among the States; and
20	"(B) between the States and the Federal
21	Government.
22	"(b) Report and Recommendations.—Not later
23	than 1 year after the date of enactment of this title, the
24	Secretary shall publish a report that—

1	"(1) describes the results of the study carried
2	out under subsection (a); and
3	"(2) makes recommendations to States regard-
4	ing the harmonization of State laws based on the re-
5	sults of such study.
6	"SEC. 2908. AUTHORIZATION OF APPROPRIATIONS.
7	"(a) In General.—For the purpose of carrying out
8	this title, there is authorized to be appropriated
9	\$125,000,000 for fiscal year 2006, and such sums as may
10	be necessary for each of fiscal years 2007 through 2010.
11	"(b) Availability.—Amounts appropriated under
12	subsection (a) shall remain available through fiscal year
13	2010.".
14	SEC. 122. HIPAA REPORT.
15	(a) STUDY.—Not later than 2 years after the date
16	of enactment of this Act, the Secretary of Health and
17	Human Services shall carry out, or contract with a private
18	entity to carry out, a study that examines the integration
19	of the standards adopted under the amendments made by
20	this subtitle with the standards adopted under the Health
21	Insurance Portability and Accountability Act of 1996
22	(Public Law 104–191).
23	(b) Plan; Report.—
24	(1) Plan.—Not later than 3 years after the
25	date of enactment of this Act, the Secretary of

- 1 Health and Human Services shall, based on the re-
- 2 sults of the study carried out under subsection (a),
- develop a plan for the integration of the standards
- 4 described under such subsection and submit a report
- 5 to Congress describing such plan.
- 6 (2) Periodic reports.—The Secretary shall
- 7 submit periodic reports to Congress that describe the
- 8 progress of the integration described under para-
- 9 graph (1).

10 SEC. 123. STUDY OF REIMBURSEMENT INCENTIVES.

- 11 The Secretary of Health and Human Services shall
- 12 carry out, or contract with a private entity to carry out,
- 13 a study that examines methods to create efficient reim-
- 14 bursement incentives for improving health care quality in
- 15 Federally qualified health centers, rural health clinics, and
- 16 free clinics.

17 SEC. 124. REAUTHORIZATION OF INCENTIVE GRANTS RE-

- 18 GARDING TELEMEDICINE.
- 19 Section 330L(b) of the Public Health Service Act (42
- 20 U.S.C. 254c–18(b)) is amended by striking "2002 through
- 21 2006" and inserting "2006 through 2010".
- 22 SEC. 125. SENSE OF THE SENATE ON PHYSICIAN PAYMENT.
- It is the sense of the Senate that modifications to
- 24 the medicare fee schedule for physicians' services under
- 25 section 1848 of the Social Security Act (42 U.S.C.

1	1394w-4) should include provisions based on the reporting
2	of quality measures pursuant to those adopted in section
3	2909 of the Public Health Service Act (as added by sec-
4	tion 121) and the overall improvement of healthcare qual-
5	ity through the use of the electronic exchange of health
6	information pursuant to the standards adopted under sec-
7	tion 2903 of such Act (as added by section 121).
8	SEC. 126. ESTABLISHMENT OF QUALITY MEASUREMENT
9	SYSTEMS FOR MEDICARE VALUE-BASED PUR
10	CHASING PROGRAMS.
11	(a) In General.—Title XVIII (42 U.S.C. 1395 et
12	seq.) is amended—
13	(1) by redesignating part E as part F; and
14	(2) by inserting after part D the following new
15	part:
16	"Part E—Value-Based Purchasing
17	"QUALITY MEASUREMENT SYSTEMS FOR VALUE-BASED
18	PURCHASING PROGRAMS
19	"Sec. 1860E-1. (a) Establishment.—
20	"(1) IN GENERAL.—The Secretary shall develop
21	quality measurement systems for purposes of pro-
22	viding value-based payments to—
23	"(A) hospitals pursuant to section 1860E-
24	2:

1	"(B) physicians and practitioners pursuant
2	to section 1860E-3;
3	"(C) plans pursuant to section 1860E-4;
4	"(D) end stage renal disease providers and
5	facilities pursuant to section 1860E-5; and
6	"(E) home health agencies pursuant to
7	section 1860E-6.
8	"(2) Quality.—The systems developed under
9	paragraph (1) shall measure the quality of the care
10	furnished by the provider involved.
11	"(3) High quality health care defined.—
12	In this part, the term 'high quality health care'
13	means health care that is safe, effective, patient-cen-
14	tered, timely, equitable, efficient, necessary, and ap-
15	propriate.
16	"(b) Requirements for Systems.—Under each
17	quality measurement system described in subsection
18	(a)(1), the Secretary shall do the following:
19	"(1) Measures.—
20	"(A) In General.—Subject to subpara-
21	graph (B), the Secretary shall select measures
22	of quality to be used by the Secretary under
23	each system.
24	"(B) REQUIREMENTS.—In selecting the
25	measures to be used under each system pursu-

1	ant to subparagraph (A), the Secretary shall, to
2	the extent feasible, ensure that—
3	"(i) such measures are evidence-
4	based, reliable and valid, and feasible to
5	collect and report;
6	"(ii) measures of process, structure,
7	outcomes, beneficiary experience, effi-
8	ciency, and equity are included;
9	"(iii) measures of overuse and
10	underuse of health care items and services
11	are included;
12	"(iv)(I) at least 1 measure of health
13	information technology infrastructure that
14	enables the provision of high quality health
15	care and facilitates the exchange of health
16	information, such as the use of one or
17	more elements of a qualified health infor-
18	mation system (as defined in subparagraph
19	(E)), is included during the first year each
20	system is implemented; and
21	"(II) additional measures of health in-
22	formation technology infrastructure are in-
23	cluded in subsequent years;
24	"(v) in the case of the system that is
25	used to provide value-based payments to

1	hospitals under section 1860E-2, by not
2	later than January 1, 2008, at least 5
3	measures that take into account the unique
4	characteristics of small hospitals located in
5	rural areas and frontier areas are included;
6	and
7	"(vi) measures that assess the quality
8	of care furnished to frail individuals over
9	the age of 75 and to individuals with mul-
10	tiple complex chronic conditions are in-
11	cluded.
12	"(C) REQUIREMENT FOR COLLECTION OF
13	DATA ON A MEASURE FOR 1 YEAR PRIOR TO
14	use under the systems.—Data on any
15	measure selected by the Secretary under sub-
16	paragraph (A) must be collected by the Sec-
17	retary for at least a 12-month period before
18	such measure may be used to determine wheth-
19	er a provider receives a value-based payment
20	under a program described in subsection $(a)(1)$.
21	"(D) AUTHORITY TO VARY MEASURES.—
22	"(i) Under system applicable to
23	HOSPITALS.—In the case of the system ap-
24	plicable to hospitals under section 1860E-
25	2. the Secretary may vary the measures se-

lected under subparagraph (A) by hospital depending on the size of, and the scope of services provided by, the hospital.

"(ii) Under System applicable to Physicians and practitioners under section 1860E-3, the Secretary may vary the measures selected under subparagraph (A) by physician or practitioner depending on the specialty of the physician, the type of practitioner, or the volume of services furnished to beneficiaries by the physician or practitioner.

"(iii) Under System applicable to providers and facilities.—In the case of the system applicable to providers of services and renal dialysis facilities under section 1860E–5, the Secretary may vary the measures selected under subparagraph (A) by provider or facility depending on the type of, the size of, and the scope of services provided by, the provider or facility.

1	"(iv) Under system applicable to
2	HOME HEALTH AGENCIES.—In the case of
3	the system applicable to home health agen-
4	cies under section 1860E-6, the Secretary
5	may vary the measures selected under sub-
6	paragraph (A) by agency depending on the
7	size of, and the scope of services provided
8	by, the agency.
9	"(E) QUALIFIED HEALTH INFORMATION
10	System defined.—For purposes of subpara-
11	graph (B)(iv)(I), the term 'qualified health in-
12	formation system' means a computerized sys-
13	tem (including hardware, software, and train-
14	ing) that—
15	"(i) protects the privacy and security
16	of health information and properly
17	encrypts such health information;
18	"(ii) maintains and provides access to
19	patients' health records in an electronic
20	format;
21	"(iii) incorporates decision support
22	software to reduce medical errors and en-
23	hance health care quality;

1	"(iv) is consistent with data standards
2	and certification processes recommended
3	by the Secretary;
4	"(v) allows for the reporting of quality
5	measures; and
6	"(vi) includes other features deter-
7	mined appropriate by the Secretary.
8	"(2) Weights of measures.—
9	"(A) IN GENERAL.—The Secretary shall
10	assign weights to the measures used by the Sec-
11	retary under each system.
12	"(B) Consideration.—If the Secretary
13	determines appropriate, in assigning the
14	weights under subparagraph (A)—
15	"(i) measures of clinical effectiveness
16	shall be weighted more heavily than meas-
17	ures of beneficiary experience; and
18	"(ii) measures of risk adjusted out-
19	comes shall be weighted more heavily than
20	measures of process; and
21	"(3) RISK ADJUSTMENT.—The Secretary shall
22	establish procedures, as appropriate, to control for
23	differences in beneficiary health status and bene-
24	ficiary characteristics. To the extent feasible, such

1	procedures may be based on existing models for con-
2	trolling for such differences.
3	"(4) Maintenance.—
4	"(A) IN GENERAL.—The Secretary shall,
5	as determined appropriate, but not more often
6	than once each 12-month period, update each
7	system, including through—
8	"(i) the addition of more accurate and
9	precise measures under the systems and
10	the retirement of existing outdated meas-
11	ures under the system;
12	"(ii) the refinement of the weights as-
13	signed to measures under the system; and
14	"(iii) the refinement of the risk ad-
15	justment procedures established pursuant
16	to paragraph (3) under the system.
17	"(B) UPDATE SHALL ALLOW FOR COM-
18	PARISON OF DATA.—Each update under sub-
19	paragraph (A) of a quality measurement system
20	shall allow for the comparison of data from one
21	year to the next for purposes of providing
22	value-based payments under the programs de-
23	scribed in subsection $(a)(1)$.
24	"(5) Use of most recent quality data.—

1	"(A) In general.—Except as provided in
2	subparagraph (B), the Secretary shall use the
3	most recent quality data with respect to the
4	provider involved that is available to the Sec-
5	retary.
6	"(B) Insufficient data due to low
7	VOLUME.—If the Secretary determines that
8	there is insufficient data with respect to a
9	measure or measures because of a low number
10	of services provided, the Secretary may aggre-
11	gate data across more than 1 fiscal or calendar
12	year, as the case may be.
13	"(c) Requirements for Developing and Updat-
14	ING THE SYSTEMS.—In developing and updating each
15	quality measurement system under this section, the Sec-
16	retary shall—
17	"(1) take into account the quality measures de-
18	veloped by nationally recognized quality measure-
19	ment organizations, researchers, health care provider
20	organizations, and other appropriate groups;
21	"(2) consult with, and take into account the
22	recommendations of, the entity that the Secretary
23	has an arrangement with under subsection (e);
24	"(3) consult with provider-based groups and
25	clinical specialty societies;

1	"(4) take into account existing quality measure-
2	ment systems that have been developed through a
3	rigorous process of validation and with the involve-
4	ment of entities and persons described in subsection
5	(e)(2)(B); and
6	"(5) take into account—
7	"(A) each of the reports by the Medicare
8	Payment Advisory Commission that are re-
9	quired under the Medicare Value Purchasing
10	Act of 2005;
11	"(B) the results of—
12	"(i) the demonstrations required
13	under such Act;
14	"(ii) the demonstration program
15	under section 1866A;
16	"(iii) the demonstration program
17	under section 1866C; and
18	"(iv) any other demonstration or pilot
19	program conducted by the Secretary relat-
20	ing to measuring and rewarding quality
21	and efficiency of care; and
22	"(C) the report by the Institute of Medi-
23	cine of the National Academy of Sciences under
24	section 238(b) of the Medicare Prescription

1	Drug, Improvement, and Modernization Act of
2	2003 (Public Law 108–173).
3	"(d) Requirements for Implementing the Sys-
4	TEMS.—In implementing each quality measurement sys-
5	tem under this section, the Secretary shall consult with
6	entities—
7	"(1) that have joined together to develop strate-
8	gies for quality measurement and reporting, includ-
9	ing the feasibility of collecting and reporting mean-
10	ingful data on quality measures; and
11	"(2) that involve representatives of health care
12	providers, health plans, consumers, employers, pur-
13	chasers, quality experts, government agencies, and
14	other individuals and groups that are interested in
15	quality of care.
16	"(e) Arrangement With an Entity To Provide
17	Advice and Recommendations.—
18	"(1) Arrangement.—On and after July 1,
19	2006, the Secretary shall have in place an arrange-
20	ment with an entity that meets the requirements de-
21	scribed in paragraph (2) under which such entity
22	provides the Secretary with advice on, and rec-
23	ommendations with respect to, the development and
24	updating of the quality measurement systems under

1	this section, including the assigning of weights to
2	the measures under subsection (b)(2).
3	"(2) Requirements described.—The re-
4	quirements described in this paragraph are the fol-
5	lowing:
6	"(A) The entity is a private nonprofit enti-
7	ty governed by an executive director and a
8	board.
9	"(B) The members of the entity include
10	representatives of—
11	"(i)(I) health plans and providers re-
12	ceiving reimbursement under this title for
13	the provision of items and services, includ-
14	ing health plans and providers with experi-
15	ence in the care of the frail elderly and in-
16	dividuals with multiple complex chronic
17	conditions; or
18	"(II) groups representing such health
19	plans and providers;
20	"(ii) groups representing individuals
21	receiving benefits under this title;
22	"(iii) purchasers and employers or
23	groups representing purchasers or employ-
24	ers;

1	"(iv) organizations that focus on qual-
2	ity improvement as well as the measure-
3	ment and reporting of quality measures;
4	"(v) State government health pro-
5	grams;
6	"(vi) persons skilled in the conduct
7	and interpretation of biomedical, health
8	services, and health economics research
9	and with expertise in outcomes and effec-
10	tiveness research and technology assess-
11	ment; and
12	"(vii) persons or entities involved in
13	the development and establishment of
14	standards and certification for health in-
15	formation technology systems and clinical
16	data.
17	"(C) The membership of the entity is rep-
18	resentative of individuals with experience
19	with—
20	"(i) urban health care issues;
21	"(ii) safety net health care issues; and
22	"(iii) rural and frontier health care
23	issues.
24	"(D) The entity does not charge a fee for
25	membership for participation in the work of the

entity related to the arrangement with the Secretary under paragraph (1). If the entity does require a fee for membership for participation in other functions of the entity, there shall be no linkage between such fee and participation in the work of the entity related to such arrangement with the Secretary.

"(E) The entity—

"(i) permits any member described in subparagraph (B) to vote on matters of the entity related to the arrangement with the Secretary under paragraph (1); and

"(ii) ensures that such members have an equal vote on such matters .

- "(F) With respect to matters related to the arrangement with the Secretary under paragraph (1), the entity conducts its business in an open and transparent manner and provides the opportunity for public comment.
- "(G) The entity operates as a voluntary consensus standards setting organization as defined for purposes of section 12(d) of the National Technology Transfer and Advancement Act of 1995 (Public Law 104–113) and Office of Management and Budget Revised Circular

1	A-119 (published in the Federal Register on
2	February 10, 1998).".
3	(b) Conforming References to Previous Part
4	E.—Any reference in law (in effect before the date of the
5	enactment of this Act) to part E of title XVIII of the So-
6	cial Security Act is deemed a reference to part F of such
7	title (as in effect after such date).
8	SEC. 127. EXCEPTION TO FEDERAL ANTI-KICKBACK AND
9	PHYSICIAN SELF REFERRAL LAWS FOR THE
10	PROVISION OF PERMITTED SUPPORT.
11	(a) Anti-Kickback.—Section 1128B(b) (42 U.S.C.
12	1320a-7b(b)(3)) is amended—
13	(1) in paragraph (3)—
14	(A) in subparagraph (G), by striking
15	"and" at the end;
16	(B) in subparagraph (H), as added by sec-
17	tion 237(d) of the Medicare Prescription Drug,
18	Improvement, and Modernization Act of 2003
19	(Public Law 108–173; 117 Stat. 2213)—
20	(i) by moving such subparagraph 2
21	ems to the left; and
22	(ii) by striking the period at the end
23	and inserting a semicolon;
24	(C) by redesignating subparagraph (H), as
25	added by section 431(a) of the Medicare Pre-

1	scription Drug, Improvement, and Moderniza-
2	tion Act of 2003 (Public Law 108–173; 117
3	Stat. 2287), as subparagraph (I);
4	(D) in subparagraph (I), as so redesig-
5	nated—
6	(i) by moving such subparagraph 2
7	ems to the left; and
8	(ii) by striking the period at the end
9	and inserting "; and"; and
10	(E) by adding at the end the following
11	new:
12	"(J) during the 5-year period beginning on
13	the date the Secretary issues the interim final
14	rule under section $801(c)(1)$ of the Medicare
15	Value Purchasing Act of 2005, the provision,
16	with or without charge, of any permitted sup-
17	port (as defined in paragraph (4))."; and
18	(2) by adding at the end the following new
19	paragraph:
20	"(4) Permitted support.—
21	"(A) Definition of Permitted Sup-
22	PORT.—Subject to subparagraph (B), in this
23	section, the term 'permitted support' means the
24	provision of any equipment, item, information,
25	right, license, intellectual property, software,

1	training, or service used for developing, imple-
2	menting, operating, or facilitating the use of
3	systems designed to improve the quality of
4	health care and to promote the electronic ex-
5	change of health information.
6	"(B) Exception.—The term 'permitted
7	support' shall not include the provision of—
8	"(i) any support that is determined in
9	a manner that is related to the volume or
10	value of any referrals or other business
11	generated between the parties for which
12	payment may be made in whole or in part
13	under a Federal health care program;
14	"(ii) any support that has more than
15	incidental utility or value to the recipient
16	beyond the exchange of health care infor-
17	mation; or
18	"(iii) any health information tech-
19	nology system, product, or service that is
20	not capable of exchanging health care in-
21	formation in compliance with data stand-
22	ards consistent with interoperability.
23	"(C) Determination.—In establishing
24	regulations with respect to the requirement

1	under subparagraph (B)(iii), the Secretary shall
2	take in account—
3	"(I) whether the health information
4	technology system, product, or service is
5	widely accepted within the industry and
6	whether there is sufficient industry experi-
7	ence to ensure successful implementation
8	of the system, product, or service; and
9	"(II) whether the health information
10	technology system, product, or service im-
11	proves quality of care, enhances patient
12	safety, or provides greater administrative
13	efficiencies.".
14	(b) Physician Self-Referral.—Section 1877(e)
15	(42 U.S.C. 1395nn(e)) is amended by adding at the end
16	the following new paragraph:
17	"(9) Permitted support.—During the 5-year
18	period beginning on the date the Secretary issues
19	the interim final rule under section $801(c)(1)$ of the
20	Medicare Value Purchasing Act of 2005, the provi-
21	sion, with or without charge, of any permitted sup-
22	port (as defined in section 1128B(b)(4)).".
23	(c) REGULATIONS.—In order to carry out the amend-
24	ments made by this section—

- 1 (1) the Secretary shall issue an interim final 2 rule with comment period by not later than the date 3 that is 180 days after the date of enactment of this 4 Act;
- 5 (2) the Secretary shall issue a final rule by not 6 later than the date that is 180 days after the date 7 that the interim final rule under paragraph (1) is 8 issued.

9 CHAPTER 2—VALUE BASED PURCHASING

- 10 SEC. 131. VALUE BASED PURCHASING PROGRAMS; SENSE
- 11 OF THE SENATE.
- 12 (a) Medicare Value Based Purchasing Pilot 13 Program.—
- 14 (1) IN GENERAL.—The Secretary of Health and 15 Human Services (referred to in this section as the "Secretary") shall establish under title XVIII of the 16 17 Social Security Act (42 U.S.C. 1395 et seq.) a value 18 based purchasing pilot program based on the report-19 ing of quality measures pursuant to those adopted in 20 section 1860E-1 of the Social Security Act (as 21 added by section 126). Such pilot program should be 22 based on experience gained through previous dem-23 onstration projects conducted by the Secretary, in-24 cluding demonstration projects conducted under sec-25 tions 1866A and 1866C of the Social Security Act

- 1 (42 U.S.C. 1395cc-1; 1395cc-3), section 649 of the
- 2 Medicare Prescription Drug, Improvement, and
- 3 Modernization Act of 2003 (Public Law 108–173;
- 4 117 Stat. 2322), and other relevant work conducted
- 5 by private entities.
- 6 (2) Expansion.—Not later than 2 years after
- 7 conducting the pilot program under paragraph (1),
- 8 the Secretary shall transition and implement such
- 9 program on a national basis.
- 10 (3) Information technology.—Providers re-
- 11 porting quality measurement data electronically
- under this section shall report such data pursuant to
- the standards adopted under title XXIX of the Pub-
- lic Health Service Act (as added by section 121).
- 15 (4) Funding.—The Secretary shall ensure that
- the total amount of expenditures under this Act in
- a year does not exceed the total amount of expendi-
- tures that would have been expended in such year
- under this Act if this subsection had not been en-
- acted.
- 21 (b) Medicaid Value Based Purchasing Pro-
- 22 Grams.—
- 23 (1) In General.—The Secretary shall author-
- ize waivers under section 1115 of the Social Security
- Act (42 U.S.C. 1315) for States to establish value

- based purchasing programs for State medicaid programs established under title XIX of such Act (42 U.S.C. 1396 et seq.). Such programs shall be based on the reporting of quality measures pursuant to those adopted in section 1860E-1 of the Social Security Act (as added by section 126).
 - (2) Information technology.—Providers reporting quality measurement data electronically under this section shall report such data pursuant to the standards adopted under title XXIX of the Public Health Service Act (as added by section 121).
- 12 (3) WAIVER.—In authorizing such waivers, the
 13 Secretary shall waive any provisions of title XI or
 14 XIX of the Social Security Act that would otherwise
 15 prevent a State from establishing a value based pur16 chasing program in accordance with paragraph (1).

Subtitle C—Patient Safety and Quality Improvement

- 19 SEC. 141. SHORT TITLE.
- This subtitle may be cited as the "Patient Safety and
- 21 Quality Improvement Act of 2005".
- 22 SEC. 142. FINDINGS AND PURPOSES.
- 23 (a) FINDINGS.—Congress makes the following find-
- 24 ings:

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- (1) In 1999, the Institute of Medicine released a report entitled To Err is Human that described medical errors as the eighth leading cause of death in the United States, with as many as 98,000 people dying as a result of medical errors each year.
 - (2) To address these deaths and injuries due to medical errors, the health care system must identify and learn from such errors so that systems of care can be improved.
 - (3) In their report, the Institute of Medicine called on Congress to provide legal protections with respect to information reported for the purposes of quality improvement and patient safety.
 - (4) The Health, Education, Labor, and Pensions Committee of the Senate held 4 hearings in the 106th Congress and 1 hearing in the 107th Congress on patient safety where experts in the field supported the recommendation of the Institute of Medicine for congressional action.
 - (5) Myriad public and private patient safety initiatives have begun. The Quality Interagency Coordination Taskforce has recommended steps to improve patient safety that may be taken by each Federal agency involved in health care and activities relating to these steps are ongoing.

- 1 (6) The research on patient safety unequivo-2 cally calls for a learning environment, rather than a 3 punitive environment, in order to improve patient 4 safety.
 - (7) Voluntary data gathering systems are more supportive than mandatory systems in creating the learning environment referred to in paragraph (6) as stated in the Institute of Medicine's report.
 - (8) Promising patient safety reporting systems have been established throughout the United States and the best ways to structure and use these systems are currently being determined, largely through projects funded by the Agency for Healthcare Research and Quality.
 - (9) Many organizations currently collecting patient safety data have expressed a need for legal protections that will allow them to review protected information and collaborate in the development and implementation of patient safety improvement strategies. Currently, the State peer review protections are inadequate to allow the sharing of information to promote patient safety.
- 23 (b) Purposes.—It is the purpose of this subtitle 24 to—

1	(1) encourage a culture of safety and quality in
2	the United States health care system by providing
3	for legal protection of information reported volun-
4	tarily for the purposes of quality improvement and
5	patient safety; and
6	(2) ensure accountability by raising standards
7	and expectations for continuous quality improve-
8	ments in patient safety.
9	SEC. 143. AMENDMENTS TO PUBLIC HEALTH SERVICE ACT.
10	Title IX of the Public Health Service Act (42 U.S.C.
11	299 et seq.) is amended—
12	(1) in section 912(e), by inserting ", in accord-
13	ance with part C," after "The Director shall";
14	(2) by redesignating part C as part D;
15	(3) by redesignating sections 921 through 928,
16	as sections 931 through 938, respectively;
17	(4) in 934(d) (as so redesignated), by striking
18	the second sentence and inserting the following:
19	"Penalties provided for under this section shall be
20	imposed and collected by the Secretary using the ad-
21	ministrative and procedural processes used to impose
22	and collect civil money penalties under section
23	1128A of the Social Security Act (other than sub-
24	sections (a) and (b), the second sentence of sub-
25	section (f), and subsections (i), (m), and (n)), unless

1	the Secretary determines that a modification of pro-
2	cedures would be more suitable or reasonable to
3	carry out this subsection and provides for such
4	modification by regulation.";
5	(5) in section 938(1) (as so redesignated), by
6	striking "921" and inserting "931"; and
7	(6) by inserting after part B the following:
8	"PART C—PATIENT SAFETY IMPROVEMENT
9	"SEC. 921. DEFINITIONS.
10	"In this part:
11	"(1) Non-identifiable information.—
12	"(A) IN GENERAL.—The term 'non-identi-
13	fiable information' means, with respect to infor-
14	mation, that the information is presented in a
15	form and manner that prevents the identifica-
16	tion of a provider, a patient, or a reporter of
17	patient safety data.
18	"(B) Identifiability of patient.—For
19	purposes of subparagraph (A), the term 'pre-
20	sented in a form and manner that prevents the
21	identification of a patient' means, with respect
22	to information that has been subject to rules
23	promulgated pursuant to section 264(e) of the
24	Health Insurance Portability and Accountability
25	Act of 1996 (42 U.S.C. 1320d-2 note), that the

1	information has been de-identified so that it is
2	no longer individually identifiable health infor-
3	mation as defined in such rules.
4	"(2) Patient Safety Data.—
5	"(A) In General.—The term 'patient
6	safety data' means—
7	"(i) any data, reports, records, memo-
8	randa, analyses (such as root cause anal-
9	yses), or written or oral statements that
10	are—
11	"(I) collected or developed by a
12	provider for reporting to a patient
13	safety organization, provided that they
14	are reported to the patient safety or-
15	ganization within 60 days;
16	"(II) requested by a patient safe-
17	ty organization (including the con-
18	tents of such request), if they are re-
19	ported to the patient safety organiza-
20	tion within 60 days;
21	"(III) reported to a provider by a
22	patient safety organization; or
23	"(IV) collected by a patient safe-
24	ty organization from another patient

1	safety organization, or developed by a
2	patient safety organization;
3	that could result in improved patient safe-
4	ty, health care quality, or health care out-
5	comes; or
6	"(ii) any deliberative work or process
7	with respect to any patient safety data de-
8	scribed in clause (i).
9	"(B) Limitation.—
10	"(i) Collection.—If the original
11	material from which any data, reports,
12	records, memoranda, analyses (such as
13	root case analyses), or written or oral
14	statements referred to in subclause (I) or
15	(IV) of subparagraph (A)(i) are collected
16	and is not patient safety data, the act of
17	such collection shall not make such original
18	material patient safety data for purposes
19	of this part.
20	"(ii) Separate data.—The term 'pa-
21	tient safety data' shall not include infor-
22	mation (including a patient's medical
23	record, billing and discharge information
24	or any other patient or provider record)

that is collected or developed separately

1	from and that exists separately from pa-
2	tient safety data. Such separate informa-
3	tion or a copy thereof submitted to a pa-
4	tient safety organization shall not itself be
5	considered as patient safety data. Nothing
6	in this part, except for section 922(f)(1),
7	shall be construed to limit—
8	"(I) the discovery of or admissi-
9	bility of information described in this
10	subparagraph in a criminal, civil, or
11	administrative proceeding;
12	"(II) the reporting of information
13	described in this subparagraph to a
14	Federal, State, or local governmental
15	agency for public health surveillance,
16	investigation, or other public health
17	purposes or health oversight purposes;
18	or
19	"(III) a provider's recordkeeping
20	obligation with respect to information
21	described in this subparagraph under
22	Federal, State, or local law.
23	"(3) Patient Safety organization.—The
24	term 'patient safety organization' means a private or

1	public entity or component thereof that is currently
2	listed by the Secretary pursuant to section 924(c).
3	"(4) Patient Safety organization activi-
4	TIES.—The term 'patient safety organization activi-
5	ties' means the following activities, which are
6	deemed to be necessary for the proper management
7	and administration of a patient safety organization:
8	"(A) The conduct, as its primary activity,
9	of efforts to improve patient safety and the
10	quality of health care delivery.
11	"(B) The collection and analysis of patient
12	safety data that are submitted by more than
13	one provider.
14	"(C) The development and dissemination
15	of information to providers with respect to im-
16	proving patient safety, such as recommenda-
17	tions, protocols, or information regarding best
18	practices.
19	"(D) The utilization of patient safety data
20	for the purposes of encouraging a culture of
21	safety and of providing direct feedback and as-
22	sistance to providers to effectively minimize pa-
23	tient risk.

1	"(E) The maintenance of procedures to
2	preserve confidentiality with respect to patient
3	safety data.
4	"(F) The provision of appropriate security
5	measures with respect to patient safety data.
6	"(G) The utilization of qualified staff.
7	"(5) Person.—The term 'person' includes Fed-
8	eral, State, and local government agencies.
9	"(6) Provider.—The term 'provider' means—
10	"(A) a person licensed or otherwise author-
11	ized under State law to provide health care
12	services, including—
13	"(i) a hospital, nursing facility, com-
14	prehensive outpatient rehabilitation facil-
15	ity, home health agency, hospice program,
16	renal dialysis facility, ambulatory surgical
17	center, pharmacy, physician or health care
18	practitioner's office, long term care facility,
19	behavior health residential treatment facil-
20	ity, clinical laboratory, or health center; or
21	"(ii) a physician, physician assistant,
22	nurse practitioner, clinical nurse specialist,
23	certified registered nurse anesthetist, cer-
24	tified nurse midwife, psychologist, certified
25	social worker registered dietitian or nutri-

1	tion professional, physical or occupational
2	therapist, pharmacist, or other individual
3	health care practitioner; or
4	"(B) any other person specified in regula-
5	tions promulgated by the Secretary.
6	"SEC. 922. PRIVILEGE AND CONFIDENTIALITY PROTEC-
7	TIONS.
8	"(a) Privilege.—Notwithstanding any other provi-
9	sion of Federal, State, or local law, patient safety data
10	shall be privileged and, subject to the provisions of sub-
11	section (c)(1), shall not be—
12	"(1) subject to a Federal, State, or local civil,
13	criminal, or administrative subpoena;
14	"(2) subject to discovery in connection with a
15	Federal, State, or local civil, criminal, or administra-
16	tive proceeding;
17	"(3) disclosed pursuant to section 552 of title
18	5, United States Code (commonly known as the
19	Freedom of Information Act) or any other similar
20	Federal, State, or local law;
21	"(4) admitted as evidence or otherwise disclosed
22	in any Federal, State, or local civil, criminal, or ad-
23	ministrative proceeding; or
24	"(5) utilized in a disciplinary proceeding
25	against a provider.

1	"(b) Confidentiality.—Notwithstanding any other
2	provision of Federal, State, or local law, and subject to
3	the provisions of subsections (c) and (d), patient safety
4	data shall be confidential and shall not be disclosed.
5	"(c) Exceptions to Privilege and Confiden-
6	TIALITY.—Nothing in this section shall be construed to
7	prohibit one or more of the following uses or disclosures:
8	"(1) Disclosure by a provider or patient safety
9	organization of relevant patient safety data for use
10	in a criminal proceeding only after a court makes an
11	in camera determination that such patient safety
12	data contains evidence of a wanton and criminal act
13	to directly harm the patient.
14	"(2) Voluntary disclosure of non-identifiable pa-
15	tient safety data by a provider or a patient safety
16	organization.
17	"(d) Protected Disclosure and Use of Infor-
18	MATION.—Nothing in this section shall be construed to
19	prohibit one or more of the following uses or disclosures:
20	"(1) Disclosure of patient safety data by a per-
21	son that is a provider, a patient safety organization,
22	or a contractor of a provider or patient safety orga-
23	nization, to another such person, to carry out pa-

tient safety organization activities.

- "(2) Disclosure of patient safety data by a provider or patient safety organization to grantees or contractors carrying out patient safety research, evaluation, or demonstration projects authorized by the Director.
 - "(3) Disclosure of patient safety data by a provider to an accrediting body that accredits that provider.
 - "(4) Voluntary disclosure of patient safety data by a patient safety organization to the Secretary for public health surveillance if the consent of each provider identified in, or providing, such data is obtained prior to such disclosure. Nothing in the preceding sentence shall be construed to prevent the release of patient safety data that is provided by, or that relates solely to, a provider from which the consent described in such sentence is obtained because one or more other providers do not provide such consent with respect to the disclosure of patient safety date that relates to such nonconsenting providers. Consent for the future release of patient safety data for such purposes may be requested by the patient safety organization at the time the data is submitted.

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"(5) Voluntary disclosure of patient safety data 1 2 by a patient safety organization to State of local 3 government agencies for public health surveillance if 4 the consent of each provider identified in, or pro-5 viding, such data is obtained prior to such disclo-6 sure. Nothing in the preceding sentence shall be con-7 strued to prevent the release of patient safety data 8 that is provided by, or that relates solely to, a pro-9 vider from which the consent described in such sen-10 tence is obtained because one or more other pro-11 viders do not provide such consent with respect to 12 the disclosure of patient safety date that relates to 13 such nonconsenting providers. Consent for the fu-14 ture release of patient safety data for such purposes 15 may be requested by the patient safety organization 16 at the time the data is submitted.

17 "(e) Continued Protection of Information 18 After Disclosure.—

"(1) IN GENERAL.—Except as provided in paragraph (2), patient safety data that is used or disclosed shall continue to be privileged and confidential as provided for in subsections (a) and (b), and the provisions of such subsections shall apply to such data in the possession or control of—

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1	"(A) a provider or patient safety organiza-
2	tion that possessed such data before the use or
3	disclosure; or
4	"(B) a person to whom such data was dis-
5	closed.
6	"(2) Exception.—Notwithstanding paragraph
7	(1), and subject to paragraph (3)—
8	"(A) if patient safety data is used or dis-
9	closed as provided for in subsection (c)(1), and
10	such use or disclosure is in open court, the con-
11	fidentiality protections provided for in sub-
12	section (b) shall no longer apply to such data;
13	and
14	"(B) if patient safety data is used or dis-
15	closed as provided for in subsection (c)(2), the
16	privilege and confidentiality protections pro-
17	vided for in subsections (a) and (b) shall no
18	longer apply to such data.
19	"(3) Construction.—Paragraph (2) shall not
20	be construed as terminating or limiting the privilege
21	or confidentiality protections provided for in sub-
22	section (a) or (b) with respect to data other than the
23	specific data used or disclosed as provided for in
24	subsection (c).
25	"(f) Limitation on Actions.—

"(1) Patient safety organizations.—Ex-cept to enforce disclosures pursuant to subsection (c)(1), no action may be brought or process served against a patient safety organization to compel dis-closure of information collected or developed under this part whether or not such information is patient safety data unless such information is specifically identified, is not patient safety data, and cannot oth-erwise be obtained.

"(2) Providers.—An accrediting body shall not take an accrediting action against a provider based on the good faith participation of the provider in the collection, development, reporting, or maintenance of patient safety data in accordance with this part. An accrediting body may not require a provider to reveal its communications with any patient safety organization established in accordance with this part.

"(g) REPORTER PROTECTION.—

"(1) IN GENERAL.—A provider may not take an adverse employment action, as described in paragraph (2), against an individual based upon the fact that the individual in good faith reported information—

1	"(A) to the provider with the intention of
2	having the information reported to a patient
3	safety organization; or
4	"(B) directly to a patient safety organiza-
5	tion.
6	"(2) Adverse employment action.—For
7	purposes of this subsection, an 'adverse employment
8	action' includes—
9	"(A) loss of employment, the failure to
10	promote an individual, or the failure to provide
11	any other employment-related benefit for which
12	the individual would otherwise be eligible; or
13	"(B) an adverse evaluation or decision
14	made in relation to accreditation, certification,
15	credentialing, or licensing of the individual.
16	"(h) Enforcement.—
17	"(1) Prohibition.—Except as provided in sub-
18	sections (c) and (d) and as otherwise provided for in
19	this section, it shall be unlawful for any person to
20	negligently or intentionally disclose any patient safe-
21	ty data, and any such person shall, upon adjudica-
22	tion, be assessed in accordance with section 934(d).
23	"(2) Relation to Hipaa.—The penalty pro-
24	vided for under paragraph (1) shall not apply if the
25	defendant would otherwise be subject to a penalty

under the regulations promulgated under section 264(c) of the Health Insurance Portability and Accountability Act of 1996 (42 U.S.C. 1320d–2 note) or under section 1176 of the Social Security Act (42 U.S.C. 1320d–5) for the same disclosure.

"(3) Equitable relief.—

"(A) IN GENERAL.—Without limiting remedies available to other parties, a civil action may be brought by any aggrieved individual to enjoin any act or practice that violates subsection (g) and to obtain other appropriate equitable relief (including reinstatement, back pay, and restoration of benefits) to redress such violation.

- "(B) AGAINST STATE EMPLOYEES.—An entity that is a State or an agency of a State government may not assert the privilege described in subsection (a) unless before the time of the assertion, the entity or, in the case of and with respect to an agency, the State has consented to be subject to an action as described by this paragraph, and that consent has remained in effect.
- 24 "(i) Rule of Construction.—Nothing in this sec-25 tion shall be construed to—

- "(1) limit other privileges that are available under Federal, State, or local laws that provide greater confidentiality protections or privileges than the privilege and confidentiality protections provided for in this section;
 - "(2) limit, alter, or affect the requirements of Federal, State, or local law pertaining to information that is not privileged or confidential under this section;
 - "(3) alter or affect the implementation of any provision of section 264(c) of the Health Insurance Portability and Accountability Act of 1996 (Public Law 104–191; 110 Stat. 2033), section 1176 of the Social Security Act (42 U.S.C. 1320d–5), or any regulation promulgated under such sections;
 - "(4) limit the authority of any provider, patient safety organization, or other person to enter into a contract requiring greater confidentiality or delegating authority to make a disclosure or use in accordance with subsection (c) or (d); and
 - "(5) prohibit a provider from reporting a crime to law enforcement authorities, regardless of whether knowledge of the existence of, or the description of, the crime is based on patient safety data, so long as

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- 1 the provider does not disclose patient safety data in
- 2 making such report.

3 "SEC. 923. PATIENT SAFETY NETWORK OF DATABASES.

- 4 "(a) In General.—The Secretary shall maintain a
- 5 patient safety network of databases that provides an inter-
- 6 active evidence-based management resource for providers,
- 7 patient safety organizations, and other persons. The net-
- 8 work of databases shall have the capacity to accept, aggre-
- 9 gate, and analyze nonidentifiable patient safety data vol-
- 10 untarily reported by patient safety organizations, pro-
- 11 viders, or other persons.
- 12 "(b) Network of Database Standards.—The
- 13 Secretary may determine common formats for the report-
- 14 ing to the patient safety network of databases maintained
- 15 under subsection (a) of nonidentifiable patient safety data,
- 16 including necessary data elements, common and consistent
- 17 definitions, and a standardized computer interface for the
- 18 processing of such data. To the extent practicable, such
- 19 standards shall be consistent with the administrative sim-
- 20 plification provisions of Part C of title XI of the Social
- 21 Security Act.
- 22 "SEC. 924. PATIENT SAFETY ORGANIZATION CERTIFI-
- 23 CATION AND LISTING.
- 24 "(a) Certification.—

1	"(1) Initial certification.—Except as pro-
2	vided in paragraph (2), an entity that seeks to be a
3	patient safety organization shall submit an initial
4	certification to the Secretary that the entity intends
5	to perform the patient safety organization activities.
6	"(2) Delayed Certification of Collection
7	FROM MORE THAN ONE PROVIDER.—An entity that
8	seeks to be a patient safety organization may—
9	"(A) submit an initial certification that it
10	intends to perform patient safety organization
11	activities other than the activities described in
12	subparagraph (B) of section 921(4); and
13	"(B) within 2 years of submitting the ini-
14	tial certification under subparagraph (A), sub-
15	mit a supplemental certification that it per-
16	forms the patient safety organization activities
17	described in subparagraphs (A) through (F) of
18	section $921(4)$.
19	"(3) Expiration and renewal.—
20	"(A) Expiration.—An initial certification
21	under paragraph (1) or (2)(A) shall expire on
22	the date that is 3 years after it is submitted.
23	"(B) Renewal.—
24	"(i) In general.—An entity that
25	seeks to remain a patient safety organiza-

1 tion after the expiration of an initial cer-2 tification under paragraph (1) or (2)(A) 3 shall, within the 3-year period described in 4 subparagraph (A), submit a renewal certification to the Secretary that the entity 6 performs the patient safety organization 7 activities described in section 921(4). 8 "(ii) Term of renewal.—A renewal 9 certification under clause (i) shall expire 10 on the date that is 3 years after the date 11 on which it is submitted, and may be re-12 newed in the same manner as an initial 13 certification. 14 "(b) ACCEPTANCE OF CERTIFICATION.—Upon the 15 submission by an organization of an initial certification pursuant to subsection (a)(1) or (a)(2)(A), a supplemental 16 17 certification pursuant to subsection (a)(2)(B), or a re-18 newal certification pursuant to subsection (a)(3)(B), the 19 Secretary shall review such certification and— 20 "(1) if such certification meets the require-21 ments of subsection (a)(1), (a)(2)(A), (a)(2)(B), or 22 (a)(3)(B), as applicable, the Secretary shall notify 23 the organization that such certification is accepted;

or

1 "(2) if such certification does not meet such re-2 quirements, as applicable, the Secretary shall notify 3 the organization that such certification is not accepted and the reasons therefor. 4 5 "(c) Listing.— 6 "(1) In general.—Except as otherwise pro-7 vided in this subsection, the Secretary shall compile 8 and maintain a current listing of patient safety or-9 ganizations with respect to which the Secretary has 10 accepted a certification pursuant to subsection (b). 11 "(2) Removal from listing.—The Secretary 12 shall remove from the listing under paragraph (1)— "(A) an entity with respect to which the 13 14 Secretary has accepted an initial certification 15 pursuant to subsection (a)(2)(A) and which does not submit a supplemental certification 16 17 pursuant to subsection (a)(2)(B) that is accept-18 ed by the Secretary; 19 "(B) an entity whose certification expires 20 and which does not submit a renewal applica-21 tion that is accepted by the Secretary; and 22 "(C) an entity with respect to which the 23 Secretary revokes the Secretary's acceptance of 24 the entity's certification, pursuant to subsection 25 (d).

1	"(d) REVOCATION OF ACCEPTANCE.—
2	"(1) In general.—Except as provided in para-
3	graph (2), if the Secretary determines (through a re-
4	view of patient safety organization activities) that a
5	patient safety organization does not perform one of
6	the patient safety organization activities described in
7	subparagraph (A) through (F) of section 921(4), the
8	Secretary may, after notice and an opportunity for
9	a hearing, revoke the Secretary's acceptance of the
10	certification of such organization.
11	"(2) Delayed certification of collection
12	FROM MORE THAN ONE PROVIDER.—A revocation
13	under paragraph (1) may not be based on a deter-
14	mination that the organization does not perform the
15	activity described in section 921(4)(B) if—
16	"(A) the listing of the organization is
17	based on its submittal of an initial certification
18	under subsection (a)(2)(A);
19	"(B) the organization has not submitted a
20	supplemental certification under subsection
21	(a)(2)(B); and
22	"(C) the 2-year period described in sub-
23	section (a)(2)(B) has not expired.
24	"(e) Notification of Revocation or Removal
25	FROM LISTING.—

1 "(1) Supplying confirmation of notifica-2 TION TO PROVIDERS.—Within 15 days of a revoca-3 tion under subsection (d)(1), a patient safety organi-4 zation shall submit to the Secretary a confirmation 5 that the organization has taken all reasonable ac-6 tions to notify each provider whose patient safety 7 data is collected or analyzed by the organization of 8 such revocation.

- "(2) Publication.—Upon the revocation of an acceptance of an organization's certification under subsection (d)(1), or upon the removal of an organization from the listing under subsection (c)(2), the Secretary shall publish notice of the revocation or removal in the Federal Register.
- 15 "(f) Status of Data After Removal from List-16 ing.—
- 17 "(1) NEW DATA.—With respect to the privilege 18 and confidentiality protections described in section 19 922, data submitted to an organization within 30 20 days after the organization is removed from the list-21 ing under subsection (c)(2) shall have the same sta-22 tus as data submitted while the organization was 23 still listed.
- 24 "(2) PROTECTION TO CONTINUE TO APPLY.—If 25 the privilege and confidentiality protections de-

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- 1 scribed in section 922 applied to data while an orga-
- 2 nization was listed, or during the 30-day period de-
- 3 scribed in paragraph (1), such protections shall con-
- 4 tinue to apply to such data after the organization is
- 5 removed from the listing under subsection (c)(2).
- 6 "(g) DISPOSITION OF DATA.—If the Secretary re-
- 7 moves an organization from the listing as provided for in
- 8 subsection (c)(2), with respect to the patient safety data
- 9 that the organization received from providers, the organi-
- 10 zation shall—
- "(1) with the approval of the provider and an-
- other patient safety organization, transfer such data
- to such other organization;
- 14 "(2) return such data to the person that sub-
- mitted the data; or
- 16 "(3) if returning such data to such person is
- 17 not practicable, destroy such data.
- 18 "SEC. 925. TECHNICAL ASSISTANCE.
- 19 "The Secretary, acting through the Director, may
- 20 provide technical assistance to patient safety organiza-
- 21 tions, including convening annual meetings for patient
- 22 safety organizations to discuss methodology, communica-
- 23 tion, data collection, or privacy concerns.

1 "SEC. 926. PROMOTING THE INTEROPERABILITY	OF	O]
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- 2 HEALTH CARE INFORMATION TECHNOLOGY
- 3 **SYSTEMS.**
- 4 "(a) Development.—Not later than 36 months
- 5 after the date of enactment of the Patient Safety and
- 6 Quality Improvement Act of 2005, the Secretary shall de-
- 7 velop or adopt voluntary standards that promote the elec-
- 8 tronic exchange of health care information.
- 9 "(b) UPDATES.—The Secretary shall provide for the
- 10 ongoing review and periodic updating of the standards de-
- 11 veloped under subsection (a).
- 12 "(c) DISSEMINATION.—The Secretary shall provide
- 13 for the dissemination of the standards developed and up-
- 14 dated under this section.
- 15 "SEC. 927. AUTHORIZATION OF APPROPRIATIONS.
- 16 "There is authorized to be appropriated such sums
- 17 as may be necessary to carry out this part.".
- 18 SEC. 144. STUDIES AND REPORTS.
- 19 (a) IN GENERAL.—The Secretary of Health and
- 20 Human Services shall enter into a contract (based upon
- 21 a competitive contracting process) with an appropriate re-
- 22 search organization for the conduct of a study to assess
- 23 the impact of medical technologies and therapies on pa-
- 24 tient safety, patient benefit, health care quality, and the
- 25 costs of care as well as productivity growth. Such study
- 26 shall examine—

- 1 (1) the extent to which factors, such as the use 2 of labor and technological advances, have contrib-3 uted to increases in the share of the gross domestic 4 product that is devoted to health care and the im-5 pact of medical technologies and therapies on such 6 increases;
 - (2) the extent to which early and appropriate introduction and integration of innovative medical technologies and therapies may affect the overall productivity and quality of the health care delivery systems of the United States; and
- 12 (3) the relationship of such medical technologies 13 and therapies to patient safety, patient benefit, 14 health care quality, and cost of care.
- 15 (b) REPORT.—Not later than 18 months after the 16 date of enactment of this Act, the Secretary of Health and 17 Human Services shall prepare and submit to the appropriate committees of Congress a report containing the results of the study conducted under subsection (a).

20 Subtitle D—Fraud and Abuse

- 21 SEC. 151. NATIONAL EXPANSION OF THE MEDICARE-MED-
- 22 ICAID DATA MATCH PILOT PROGRAM.
- 23 (a) Requirement of the Medicare Integrity
- 24 Program.—Section 1893 of the Social Security Act (42)
- 25 U.S.C. 1395ddd) is amended—

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1	(1) in subsection (b), by adding at the end the
2	following:
3	"(6) The Medicare-Medicaid data match pro-
4	gram in accordance with subsection (g)."; and
5	(2) by adding at the end the following:
6	"(g) Medicare-Medicaid Data Match Pro-
7	GRAM.—
8	"(1) Expansion of Program.—
9	"(A) IN GENERAL.—The Secretary shall
10	enter into contracts with eligible entities for the
11	purpose of ensuring that, beginning with 2006,
12	the Medicare-Medicaid data match program
13	(commonly referred to as the 'Medi-Medi Pro-
14	gram') is conducted with respect to the pro-
15	gram established under this title and the appli-
16	cable number of State Medicaid programs
17	under title XIX for the purpose of—
18	"(i) identifying vulnerabilities in both
19	such programs;
20	"(ii) assisting States, as appropriate,
21	to take action to protect the Federal share
22	of expenditures under the Medicaid pro-
23	gram; and
24	"(iii) increasing the effectiveness and
25	efficiency of both such programs through

1	cost avoidance, savings, and recoupments
2	of fraudulent, wasteful, or abusive expendi-
3	tures.
4	"(B) Applicable number.—For pur-
5	poses of subparagraph (A), the term 'applicable
6	number' means—
7	"(i) in the case of fiscal year 2006, 10
8	State Medicaid programs;
9	"(ii) in the case of fiscal year 2007,
10	12 State Medicaid programs; and
11	"(iii) in the case of fiscal year 2008,
12	15 State Medicaid programs.
13	"(2) Limited waiver authority.—The Sec-
14	retary shall waive only such requirements of this sec-
15	tion and of titles XI and XIX as are necessary to
16	carry out paragraph (1).".
17	(b) Funding.—Section 1817(k)(4) of the Social Se-
18	curity Act (42 U.S.C. 1395i(k)(4)) is amended—
19	(1) in subparagraph (A), by striking "subpara-
20	graph (B)" and inserting "subparagraphs (B) and
21	(C)"; and
22	(2) by adding at the end the following:
23	"(C) Expansion of the medicare-med-
24	ICAID DATA MATCH PROGRAM.—Of the amount
25	appropriated under subparagraph (A) for a fis-

1	cal year, the following amounts shall be used to
2	carry out section 1893(b)(6) for that year:
3	"(i) \$10,000,000 of the amount ap-
4	propriated for fiscal year 2006.
5	"(ii) \$12,200,000 of the amount ap-
6	propriated for fiscal year 2007.
7	"(iii) \$15,800,000 of the amount ap-
8	propriated for fiscal year 2008.".
9	Subtitle E—Miscellaneous
10	Provisions
11	SEC. 161. SENSE OF THE SENATE ON ESTABLISHING A MAN-
12	DATED BENEFITS COMMISSION.
13	It is the sense of the Senate that—
14	(1) there should be established an independent
15	Federal entity to study and provide advice to Con-
16	gress on existing and proposed federally mandated
17	health insurance benefits offered by employer-spon-
18	sored health plans and insurance issuers; and
19	(2) advice provided under paragraph (1) should
20	be evidence- and actuarially-based, and take into
21	consideration the population costs and benefits, in-
22	cluding the health, financial, and social impact on
23	affected populations, safety and medical efficacy, the
24	impact on costs and access to insurance generally,
25	and to different types of insurance products, the im-

1	pact on labor costs and jobs, and any other relevant
2	factors.
3	SEC. 162. ENFORCEMENT OF REIMBURSEMENT PROVI-
4	SIONS BY FIDUCIARIES.
5	Section 502(a)(3) of the Employee Retirement In-
6	come Security Act of 1974 (29 U.S.C. 1132(a)(3)) is
7	amended by inserting before the semicolon the following:
8	"(which may include the recovery of amounts on behalf
9	of the plan by a fiduciary enforcing the terms of the plan
10	that provide a right of recovery by reimbursement or sub-
11	rogation with respect to benefits provided to a participant
12	or beneficiary)".
13	TITLE II—EXPANDING ACCESS
14	TO AFFORDABLE HEALTH
15	COVERAGE THROUGH TAX IN-
16	CENTIVES AND OTHER INI-
17	TIATIVES
18	Subtitle A Defundable Health
4.0	Subtitle A—Refundable Health
19	Insurance Credit
19 20	
	Insurance Credit
20	Insurance Credit SEC. 201. REFUNDABLE HEALTH INSURANCE COSTS CRED-
20 21	Insurance Credit SEC. 201. REFUNDABLE HEALTH INSURANCE COSTS CREDIT.
202122	Insurance Credit SEC. 201. REFUNDABLE HEALTH INSURANCE COSTS CREDIT. (a) Allowance of Credit.—

1	amended by redesignating section 36 as section 37
2	and by inserting after section 35 the following new
3	section:
4	"SEC. 36. HEALTH INSURANCE COSTS FOR UNINSURED IN-
5	DIVIDUALS.
6	"(a) Allowance of Credit.—In the case of an in-
7	dividual, there shall be allowed as a credit against the tax
8	imposed by this subtitle for the taxable year an amount
9	equal to the amount paid by the taxpayer during such tax-
10	able year for qualified health insurance for the taxpayer
11	and the taxpayer's spouse and dependents.
12	"(b) Limitations.—
13	"(1) In general.—Except as provided in para-
14	graphs (2) and (3), the amount allowed as a credit
15	under subsection (a) to the taxpayer for the taxable
16	year shall not exceed the lesser of—
17	"(A) 90 percent of the sum of the amounts
18	paid by the taxpayer for qualified health insur-
19	ance for each individual referred to in sub-
20	section (a) for coverage months of the indi-
21	vidual during the taxable year, or
22	"(B) \$3,000.
23	"(2) Monthly Limitation.—
24	"(A) In general.—For purposes of para-
25	graph (1), amounts paid by the taxpayer for

1	qualified health insurance for an individual for
2	any coverage month of such individual during
3	the taxable year shall not be taken into account
4	to the extent such amounts exceed the amount
5	equal to $\frac{1}{12}$ of—
6	"(i) \$1,111 if such individual is the
7	taxpayer,
8	"(ii) \$1,111 if—
9	"(I) such individual is the spouse
10	of the taxpayer,
11	"(II) the taxpayer and such
12	spouse are married as of the first day
13	of such month, and
14	"(III) the taxpayer files a joint
15	return for the taxable year,
16	"(iii) \$1,111 if such individual has at-
17	tained the age of 24 as of the close of the
18	taxable year and is a dependent of the tax-
19	payer for such taxable year, and
20	"(iv) one-half of the amount described
21	in clause (i) if such individual has not at-
22	tained the age of 24 as of the close of the
23	taxable year and is a dependent of the tax-
24	payer for such taxable year.

1	"(B) Limitation to 2 young depend-
2	ENTS.—If there are more than 2 individuals de-
3	scribed in subparagraph (A)(iv) with respect to
4	the taxpayer for any coverage month, the aggre-
5	gate amounts paid by the taxpayer for qualified
6	health insurance for such individuals which may
7	be taken into account under paragraph (1) shall
8	not exceed 1/12 of the dollar amount in effect
9	under subparagraph (A)(i) for the coverage
10	month.
11	"(C) Special rule for married indi-
12	VIDUALS.—In the case of a taxpayer—
13	"(i) who is married (within the mean-
14	ing of section 7703) as of the close of the
15	taxable year but does not file a joint return
16	for such year, and
17	"(ii) who does not live apart from
18	such taxpayer's spouse at all times during
19	the taxable year,
20	any dollar limitation imposed under this para-
21	graph on amounts paid for qualified health in-
22	surance for individuals described in subpara-
23	graph (A)(iv) shall be divided equally between
24	the taxpayer and the taxpayer's spouse unless
25	they agree on a different division.

1	"(3) Income phaseout of credit percent-
2	AGE FOR ONE-PERSON COVERAGE.—
3	"(A) Phaseout for unmarried individ-
4	UALS (OTHER THAN SURVIVING SPOUSES AND
5	HEADS OF HOUSEHOLDS).—In the case of an
6	individual (other than a surviving spouse, the
7	head of a household, or a married individual)
8	with one-person coverage, if such individual has
9	modified adjusted gross income—
10	"(i) in excess of \$15,000 for a taxable
11	year but not in excess of \$20,000, the 90
12	percent under paragraph (1)(B) shall be
13	reduced by the number of percentage
14	points which bears the same ratio to 40
15	percentage points as—
16	"(I) the excess of modified ad-
17	justed gross income in excess of
18	\$15,000, bears to
19	"(II) $$5,000$, or
20	"(ii) in excess of \$20,000 for a tax-
21	able year, the 90 percent under paragraph
22	(1)(B) shall be reduced by the sum of 40
23	percentage points plus the number of per-
24	centage points which bears the same ratio
25	to 50 percentage points as—

1	"(I) the excess of modified ad-
2	justed gross income in excess of
3	\$20,000, bears to
4	"(II) \$10,000.
5	"(B) Phaseout for other individ-
6	UALS.—In the case of a taxpayer (other than
7	an individual described in subparagraph (A) or
8	(C)) with one-person coverage, if the taxpayer
9	has modified adjusted gross income in excess of
10	\$25,000 for a taxable year, the 90 percent
11	under paragraph (1)(B) shall be reduced by the
12	number of percentage points which bears the
13	same ratio to 90 percentage points as—
14	"(i) the excess of modified adjusted
15	gross income in excess of \$25,000, bears to
16	"(ii) \$15,000.
17	"(C) Married filing separate re-
18	TURN.—In the case of a taxpayer who is mar-
19	ried filing a separate return for the taxable year
20	and who has one-person coverage, if the tax-
21	payer has modified adjusted gross income in ex-
22	cess of \$12,500 for the taxable year, the 90
23	percent under paragraph (1)(B) shall be re-
24	duced by the number of percentage points

1	which bears the same ratio to 90 percentage
2	points as—
3	"(i) the excess of modified adjusted
4	gross income in excess of \$12,500, bears to
5	"(ii) \$7,500.
6	"(4) Income phaseout of credit percent-
7	AGE FOR COVERAGE OF MORE THAN ONE PERSON.—
8	"(A) IN GENERAL.—Except as provided in
9	subparagraph (B), in the case of a taxpayer
10	with coverage of more than one person, if the
11	taxpayer has modified adjusted gross income in
12	excess of \$25,000 for a taxable year, the 90
13	percent under paragraph (1)(B) shall be re-
14	duced by the number of percentage points
15	which bears the same ratio to 90 percentage
16	points as—
17	"(i) the excess of modified adjusted
18	gross income in excess of \$25,000, bears to
19	"(ii) \$35,000.
20	"(B) Married filing separate re-
21	TURN.—In the case of a taxpayer who is mar-
22	ried filing a separate return for the taxable year
23	and who has coverage of more than one person,
24	if the taxpayer has modified adjusted gross in-
25	come in excess of \$12,500 for the taxable year,

1	the 90 percent under paragraph (1)(B) shall be
2	reduced by the number of percentage points
3	which bears the same ratio to 90 percentage
4	points as—
5	"(i) the excess of modified adjusted
6	gross income in excess of \$12,500, bears to
7	"(ii) \$17,500.
8	"(5) ROUNDING.—Any percentage resulting
9	from a reduction under paragraphs (3) and (4) shall
10	be rounded to the nearest one-tenth of a percent.
11	"(6) Modified adjusted gross income.—
12	The term 'modified adjusted gross income' means
13	adjusted gross income determined—
14	"(A) without regard to this section and
15	sections 911, 931, and 933, and
16	"(B) after application of sections 86, 135,
17	137, 219, 221, and 469.
18	"(c) Coverage Month.—For purposes of this sec-
19	tion—
20	"(1) IN GENERAL.—The term 'coverage month'
21	means, with respect to an individual, any month if—
22	"(A) as of the first day of such month
23	such individual is covered by qualified health in-
24	surance, and

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of such month, such individual—

1	"(A) is entitled to any benefits under part
2	A of title XVIII of the Social Security Act or
3	is enrolled under part B of such title, or
4	"(B) is enrolled in the program under title
5	XIX or XXI of such Act (other than under sec-
6	tion 1928 of such Act).
7	"(5) CERTAIN OTHER COVERAGE.—The term
8	'coverage month' shall not include any month during
9	a taxable year with respect to an individual if, as of
10	the first day of such month at any time during such
11	month, such individual is enrolled in a program
12	under—
13	"(A) chapter 89 of title 5, United States
14	Code, or
15	"(B) chapter 55 of title 10, United States
16	Code.
17	"(6) Prisoners.—The term 'coverage month'
18	shall not include any month with respect to an indi-
19	vidual if, as of the first day of such month, such in-
20	dividual is imprisoned under Federal, State, or local
21	authority.
22	"(7) Insufficient presence in united
23	STATES.—The term 'coverage month' shall not in-
24	clude any month during a taxable year with respect
25	to an individual if such individual is present in the

1	United States on fewer than 183 days during such
2	year (determined in accordance with section
3	7701(b)(7)).
4	"(d) Qualified Health Insurance.—For pur-
5	poses of this section—
6	"(1) In general.—The term 'qualified health
7	insurance' means health insurance coverage (as de-
8	fined in section 9832(b)(1)) which—
9	"(A) is coverage described in paragraph
10	(2), and
11	"(B) meets the requirements of paragraph
12	(3).
13	"(2) Eligible Coverage.—Coverage described
14	in this paragraph is the following:
15	"(A) Coverage under individual health in-
16	surance.
17	"(B) Coverage through a private sector
18	health care coverage purchasing pool.
19	"(C) Coverage through a State care cov-
20	erage purchasing pool.
21	"(D) Coverage under a State high-risk
22	pool described in subparagraph (C) of section
23	35(e)(1).
24	"(E) Coverage after December 31, 2006,
25	under an eligible State buy in program.

1	"(3) Requirements.—The requirements of
2	this paragraph are as follows:
3	"(A) Cost limits.—The coverage meets
4	the requirements of section 223(c)(2)(A)(ii).
5	"(B) MAXIMUM BENEFITS.—Under the
6	coverage, the annual and lifetime maximum
7	benefits are not less than \$700,000.
8	"(C) Broad Coverage.—The coverage in-
9	cludes inpatient and outpatient care, emergency
10	benefits, and physician care.
11	"(D) GUARANTEED RENEWABILITY.—Such
12	coverage is guaranteed renewable by the pro-
13	vider.
14	"(4) Eligible state buy in program.—For
15	purposes of paragraph (2)(E)—
16	"(A) IN GENERAL.—The term 'eligible
17	State buy in program' means a State program
18	under which an individual who—
19	"(i) is not eligible for assistance under
20	the State medicaid program under title
21	XIX of the Social Security Act,
22	"(ii) is not eligible for assistance
23	under the State children's health insurance
24	program under title XXI of such Act, or
25	"(iii) is not a State employee,

1	is able to buy health insurance coverage
2	through a purchasing arrangement entered into
3	between the State and a private sector health
4	care purchasing group or health plan.
5	"(B) REQUIREMENTS.—Subparagraph (A)
6	shall only apply to a State program if—
7	"(i) the program uses private sector
8	health care purchasing groups or health
9	plans, and
10	"(ii) the State maintains separate risk
11	pools for participants under the State buy
12	in program and other participants.
13	"(C) Subsidies.—
14	"(i) In General.—A State program
15	shall not fail to be treated as an eligible
16	State buy in program merely because the
17	State subsidizes the costs of an individual
18	in buying health insurance coverage under
19	the program.
20	"(ii) Exception.—Clause (i) shall
21	not apply if the State subsidy under the
22	program for any adult for any consecutive
23	12-month period exceeds the applicable
24	dollar amount.

1	"(iii) Applicable dollar
2	AMOUNT.—
3	"(I) In general.—For purposes
4	of clause (ii), the applicable dollar
5	amount is \$2,000.
6	"(II) REDUCTION.—In the case
7	of a family with annual income in ex-
8	cess of 133 percent of the applicable
9	poverty line (as determined in accord-
10	ance with criteria established by the
11	Director of the Office of Management
12	and Budget) but not in excess of 200
13	percent of such line, the dollar
14	amount under clause (i) shall be rat-
15	ably reduced (but not below zero) for
16	each dollar of such excess. In the case
17	of a family with annual income in ex-
18	cess of 200 percent of such line, the
19	applicable dollar amount shall be zero.
20	"(e) Arrangements Under Which Insurers
21	CONTRIBUTE TO HSA.—
22	"(1) In general.—For purposes of this sec-
23	tion, health insurance shall not be treated as quali-
24	fied health insurance if the insurer makes contribu-
25	tions to a health savings account of the taxpayer un-

1	less such insurance is provided under an arrange-
2	ment described in paragraph (2).
3	"(2) Arrangements described.—
4	"(A) Amounts paid for coverage ex-
5	CEED MONTHLY LIMITATION.—In the case of
6	amounts paid under an arrangement for health
7	insurance for a coverage month in excess of the
8	amount in effect under subsection $(b)(2)(A)$ for
9	such month, an arrangement is described in
10	this subparagraph if under the arrangement—
11	"(i) the aggregate amount contributed
12	by the insurer to any health savings ac-
13	count of the taxpayer does not exceed 90
14	percent of the excess of—
15	"(I) the amount paid by the tax-
16	payer for qualified health insurance
17	under such arrangement for such
18	month, over
19	"(II) the amount in effect under
20	subsection (b)(2)(A) for such month,
21	and
22	"(ii) the amount contributed by the
23	insurer to a qualified health savings ac-
24	count of the taxpayer, reduced by the
25	amount of the excess under clause (i), does

1	not exceed 27 percent of the amount in ef-
2	fect under subsection (b)(2)(A) for such
3	month.
4	"(B) Amounts paid for coverage less
5	THAN MONTHLY LIMITATION.—In the case of
6	an arrangement under which the amount paid
7	for qualified health insurance for a coverage
8	month does not exceed the amount in effect
9	under subsection (b)(2)(A) for such month, an
10	arrangement is described in this subparagraph
11	if—
12	"(i) under the arrangement the value
13	of the insured benefits (excluding over-
14	head) exceeds 65 percent of the amount
15	paid for qualified health insurance for such
16	month, and
17	"(ii) the amount contributed by the
18	insurer to a qualified health savings ac-
19	count of the taxpayer does not exceed 27
20	percent of the amount in effect under sub-
21	section (b)(2)(A) for such month.
22	"(3) Qualified health savings account.—
23	"(A) IN GENERAL.—The term 'qualified
24	health savings account' means a health savings
25	account (as defined in section 223(d))—

1	"(i) which is designated (in such form
2	as the Secretary may prescribe) as a quali-
3	fied account for purposes of this section,
4	"(ii) which may not include any
5	amount other than contributions described
6	in this subsection and earnings on such
7	contributions, and
8	"(iii) with respect to which section
9	223(f)(4)(A) is applied by substituting
10	'100 percent' for '10 percent'.
11	"(B) Subaccounts and separate ac-
12	COUNTING.—The Secretary may prescribe rules
13	under which a subaccount within a health sav-
14	ings account, or separate accounting with re-
15	spect to contributions and earnings described in
16	subparagraph (A)(ii), may be treated in the
17	same manner as a qualified health savings ac-
18	count.
19	"(C) Rollovers.—A contribution of a
20	distribution from a qualified health savings ac-
21	count to another health savings account shall be
22	treated as a rollover contribution for purposes
23	of section 223(f)(5) only if the other account is
24	a qualified health savings account.
25	"(f) Dependents.—For purposes of this section—

- 1 "(1) DEPENDENT DEFINED.—The term 'de-2 pendent' has the meaning given such term by section 3 152 (determined without regard to subsections 4 (b)(1), (b)(2), and (d)(1)(B) thereof). 5 "(2) Special by Ependent Child of
 - "(2) SPECIAL RULE FOR DEPENDENT CHILD OF DIVORCED PARENTS.—An individual who is a child to whom section 152(e) applies shall be treated as a dependent of the custodial parent for a coverage month unless the custodial and noncustodial parent provide otherwise.
 - "(3) Denial of credit to dependents.—No credit shall be allowed under this section to any individual with respect to whom a deduction under section 151(c) is allowable to another taxpayer for a taxable year beginning in the calendar year in which such individual's taxable year begins.

"(g) Inflation Adjustments.—

- "(1) CREDIT AND HEALTH INSURANCE AMOUNTS.—In the case of any taxable year beginning after 2006, each dollar amount referred to in subsections (b)(1)(B), (b)(2)(A), (d)(3)(B), and (d)(4)(C)(iii)(I) shall be increased by an amount equal to—
- 24 "(A) such dollar amount, multiplied by

1	"(B) the cost-of-living adjustment deter-
2	mined under section 213(d)(10)(B)(ii) for the
3	calendar year in which the taxable year begins,
4	determined by substituting '2005' for '1996' in
5	subclause (II) thereof.
6	If any amount as adjusted under the preceding sen-
7	tence is not a multiple of \$10, such amount shall be
8	rounded to the nearest multiple of \$10.
9	"(2) Income phaseout amounts.—In the
10	case of any taxable year beginning after 2006, each
11	dollar amount referred to in paragraph (3) and (4)
12	of subsection (b) shall be increased by an amount
13	equal to—
14	"(A) such dollar amount, multiplied by
14 15	"(A) such dollar amount, multiplied by "(B) the cost-of-living adjustment deter-
15	"(B) the cost-of-living adjustment deter-
15 16	"(B) the cost-of-living adjustment determined under section $1(f)(3)$ for the calendar
15 16 17	"(B) the cost-of-living adjustment determined under section $1(f)(3)$ for the calendar year in which the taxable year begins, deter-
15 16 17 18	"(B) the cost-of-living adjustment determined under section 1(f)(3) for the calendar year in which the taxable year begins, determined by substituting 'calendar year 2005' for
15 16 17 18 19	"(B) the cost-of-living adjustment determined under section 1(f)(3) for the calendar year in which the taxable year begins, determined by substituting 'calendar year 2005' for 'calendar year 1992' in subparagraph (B)
15 16 17 18 19 20	"(B) the cost-of-living adjustment determined under section 1(f)(3) for the calendar year in which the taxable year begins, determined by substituting 'calendar year 2005' for 'calendar year 1992' in subparagraph (B) thereof.
15 16 17 18 19 20 21	"(B) the cost-of-living adjustment determined under section 1(f)(3) for the calendar year in which the taxable year begins, determined by substituting 'calendar year 2005' for 'calendar year 1992' in subparagraph (B) thereof. If any amount as adjusted under the preceding sen-
15 16 17 18 19 20 21 22	"(B) the cost-of-living adjustment determined under section 1(f)(3) for the calendar year in which the taxable year begins, determined by substituting 'calendar year 2005' for 'calendar year 1992' in subparagraph (B) thereof. If any amount as adjusted under the preceding sentence is not a multiple of \$50, such amount shall be

- 1 tion 220 to the taxpayer for a payment for the taxable
- 2 year to the Archer MSA of an individual or under section
- 3 223 to the taxpayer for a payment for the taxable year
- 4 to the Health Savings Account of such individual, sub-
- 5 section (a) shall not apply to the taxpayer for any month
- 6 during such taxable year for which the taxpayer, spouse,
- 7 or dependent is an eligible individual for purposes of either
- 8 such section.
- 9 "(i) Other Rules.—For purposes of this section—
- 10 "(1) Coordination with medical expense
- AND PREMIUM DEDUCTIONS FOR HIGH DEDUCTIBLE
- 12 HEALTH PLANS.—The amount which would (but for
- this paragraph) be taken into account by the tax-
- payer under section 213 or 224 for the taxable year
- shall be reduced by the credit (if any) allowed by
- this section to the taxpayer for such year.
- 17 "(2) COORDINATION WITH DEDUCTION FOR
- 18 HEALTH INSURANCE COSTS OF SELF-EMPLOYED IN-
- 19 DIVIDUALS.—No credit shall be allowable under this
- section for a taxable year if a deduction is allowed
- 21 under section 162(l) for the taxable year.
- 22 "(3) Coordination with advance pay-
- MENT.—Rules similar to the rules of section
- 35(g)(1) shall apply to any credit to which this sec-
- 25 tion applies.

1	"(4) Coordination with section 35.—If a
2	taxpayer is eligible for the credit allowed under this
3	section and section 35 for any taxable year, the tax-
4	payer shall elect which credit is to be allowed.
5	"(j) Expenses Must Be Substantiated.—A pay-
6	ment for insurance to which subsection (a) applies may
7	be taken into account under this section only if the tax-
8	payer substantiates such payment in such form as the Sec-
9	retary may prescribe.
10	"(k) Regulations.—The Secretary shall prescribe
11	such regulations as may be necessary to carry out the pur-
12	poses of this section.".
13	(b) Information Reporting.—
14	(1) In general.—Subpart B of part III of
15	subchapter A of chapter 61 of the Internal Revenue
16	Code of 1986 (relating to information concerning
17	transactions with other persons) is amended by in-
18	serting after section 6050T the following:
19	"SEC. 6050U. RETURNS RELATING TO PAYMENTS FOR
20	QUALIFIED HEALTH INSURANCE.
21	"(a) In General.—Any person who, in connection
22	with a trade or business conducted by such person, re-
23	ceives payments during any calendar year from any indi-
24	vidual for coverage of such individual or any other indi-
25	vidual under creditable health insurance shall make the

1	return described in subsection (b) (at such time as the
2	Secretary may by regulations prescribe) with respect to
3	each individual from whom such payments were received.
4	"(b) Form and Manner of Returns.—A return
5	is described in this subsection if such return—
6	"(1) is in such form as the Secretary may pre-
7	scribe, and
8	"(2) contains—
9	"(A) the name, address, and TIN of the
10	individual from whom payments described in
11	subsection (a) were received,
12	"(B) the name, address, and TIN of each
13	individual who was provided by such person
14	with coverage under creditable health insurance
15	by reason of such payments and the period of
16	such coverage,
17	"(C) the aggregate amount of payments
18	described in subsection (a), and
19	"(D) such other information as the Sec-
20	retary may reasonably prescribe.
21	"(c) Creditable Health Insurance.—For pur-
22	poses of this section, the term 'creditable health insurance'
23	means qualified health insurance (as defined in section
24	36(d)).

- 1 "(d) Statements To Be Furnished to Individ-
- 2 Uals With Respect to Whom Information Is Re-
- 3 QUIRED.—Every person required to make a return under
- 4 subsection (a) shall furnish to each individual whose name
- 5 is required under subsection (b)(2)(A) to be set forth in
- 6 such return a written statement showing—
- 7 "(1) the name and address of the person re-
- 8 quired to make such return and the phone number
- 9 of the information contact for such person,
- 10 "(2) the aggregate amount of payments de-
- scribed in subsection (a) received by the person re-
- 12 quired to make such return from the individual to
- whom the statement is required to be furnished, and
- 14 "(3) the information required under subsection
- (b)(2)(B) with respect to such payments.
- 16 The written statement required under the preceding sen-
- 17 tence shall be furnished on or before January 31 of the
- 18 year following the calendar year for which the return
- 19 under subsection (a) is required to be made.
- 20 "(e) Returns Which Would Be Required To Be
- 21 Made by 2 or More Persons.—Except to the extent
- 22 provided in regulations prescribed by the Secretary, in the
- 23 case of any amount received by any person on behalf of
- 24 another person, only the person first receiving such

1	amount shall be required to make the return under sub-
2	section (a).".
3	(2) Assessable penalties.—
4	(A) Subparagraph (B) of section
5	6724(d)(1) of such Code (relating to defini-
6	tions) is amended by redesignating clauses (xiii)
7	through (xviii) as clauses (xiv) through (xix),
8	respectively, and by inserting after clause (xii)
9	the following:
10	"(xiii) section 6050U (relating to re-
11	turns relating to payments for qualified
12	health insurance),".
13	(B) Paragraph (2) of section 6724(d) of
14	such Code is amended by striking "or" at the
15	end of subparagraph (AA), by striking the pe-
16	riod at the end of the subparagraph (BB) and
17	inserting ", or", and by adding at the end the
18	following:
19	"(CC) section 6050U(d) (relating to re-
20	turns relating to payments for qualified health
21	insurance).".
22	(3) CLERICAL AMENDMENT.—The table of sec-
23	tions for subpart B of part III of subchapter A of
24	chapter 61 of such Code is amended by inserting

1	after the item relating to section 6050T the fol-
2	lowing:
	"Sec. 6050U. Returns relating to payments for qualified health insurance.".
3	(c) Criminal Penalty for Fraud.—Subchapter B
4	of chapter 75 of the Internal Revenue Code of 1986 (relat-
5	ing to other offenses) is amended by adding at the end
6	the following:
7	"SEC. 7276. PENALTIES FOR OFFENSES RELATING TO
8	HEALTH INSURANCE TAX CREDIT.
9	"Any person who knowingly misuses Department of
10	the Treasury names, symbols, titles, or initials to convey
11	the false impression of association with, or approval or en-
12	dorsement by, the Department of the Treasury of any in-
13	surance products or group health coverage in connection
14	with the credit for health insurance costs under section
15	36 shall on conviction thereof be fined not more than
16	\$10,000, or imprisoned not more than 1 year, or both.".
17	(d) Conforming Amendments.—
18	(1) Section 162(l) of the Internal Revenue Code
19	of 1986 is amended by adding at the end the fol-
20	lowing:
21	"(6) Election to have subsection
22	APPLY.—No deduction shall be allowed under para-
23	graph (1) for a taxable year unless the taxpayer
24	elects to have this subsection apply for such year.".

1	(2) Paragraph (2) of section 1324(b) of title
2	31, United States Code, is amended by inserting be-
3	fore the period ", or from section 36 of such Code".
4	(3) The table of sections for subpart C of part
5	IV of subchapter A of chapter 1 of the Internal Rev-
6	enue Code of 1986 is amended by striking "35" and
7	inserting "36" and by inserting after the item relat-
8	ing to section 35 the following:
	"Sec. 36. Health insurance costs for uninsured individuals.".
9	(4) The table of sections for subchapter B of
10	chapter 75 of such Code is amended by adding at
11	the end the following:
	"Sec. 7276. Penalties for offenses relating to health insurance tax credit.".
12	(e) Effective Dates.—
13	(1) In general.—Except as provided in para-
14	graph (2), the amendments made by this section
15	shall apply to taxable years beginning after Decem-
16	ber 31, 2005.
17	(2) Penalties.—The amendments made by
18	subsections (c) and (d)(4) shall take effect on the
19	date of the enactment of this Act.
20	SEC. 202. ADVANCE PAYMENT OF CREDIT TO ISSUERS OF
21	QUALIFIED HEALTH INSURANCE.
22	(a) In General.—Chapter 77 of the Internal Rev-
23	enue Code of 1986 (relating to miscellaneous provisions)
24	is amended by adding at the end the following:

1	"SEC. 7529. ADVANCE PAYMENT OF CREDIT FOR HEALTH
2	INSURANCE COSTS OF ELIGIBLE INDIVID-
3	UALS.
4	"Not later than July 1, 2007, the Secretary shall es-
5	tablish a program for making payments to providers of
6	qualified health insurance (as defined in section 36(d)) on
7	behalf of individuals eligible for the credit under section
8	36. Such payments shall be made on the basis of modified
9	adjusted gross income of eligible individuals for the pre-
10	ceding taxable year.".
11	(b) CLERICAL AMENDMENT.—The table of sections
12	for chapter 77 of the Internal Revenue Code of 1986 is
13	amended by adding at the end the following:
	"Sec. 7529. Advance payment of health insurance credit for purchasers of qualified health insurance.".
14	Subtitle B—High Deductible Health
15	Plans and Health Savings Accounts
16	SEC. 211. DEDUCTION OF PREMIUMS FOR HIGH DEDUCT-
17	IBLE HEALTH PLANS.
18	(a) IN GENERAL.—Part VII of subchapter B of chap-
19	ter 1 of the Internal Revenue Code of 1986 (relating to
20	additional itemized deductions for individuals) is amended
21	by redesignating section 224 as section 225 and by insert-
22	ing after section 223 the following new section:

1	"SEC. 224. PREMIUMS FOR HIGH DEDUCTIBLE HEALTH
2	PLANS.
3	"(a) Deduction Allowed.—In the case of an indi-
4	vidual, there shall be allowed as a deduction for the tax-
5	able year the aggregate amount paid by or on behalf of
6	such individual as premiums under a high deductible
7	health plan with respect to months during such year for
8	which such individual is an eligible individual with respect
9	to such health plan.
0	"(b) Definitions.—For purposes of this section—
1	"(1) Eligible individual.—The term 'eligible
2	individual' has the meaning given such term by sec-
3	tion $223(e)(1)$.
4	"(2) High deductible health plan.—The
5	term 'high deductible health plan' has the meaning
6	given such term by section 223(c)(2).
7	"(c) Special Rules.—
8	"(1) DEDUCTION ALLOWABLE FOR ONLY 1
9	PLAN.—For purposes of this section, in the case of
20	an individual covered by more than 1 high deductible
21	health plan for any month, the individual may only
22	take into account amounts paid for 1 of such plans
23	for such month.
24	"(2) Group Health Plan Coverage.—
25	"(A) IN GENERAL.—No deduction shall be
6	allowed to an individual under subsection (a)

- for any amount paid for coverage under a high deductible health plan for a month if, as of the first day of that month, that individual participates in any coverage under a group health plan (within the meaning of section 5000 without regard to section 5000(d)).
 - "(B) EXCEPTION FOR CERTAIN PER-MITTED COVERAGE.—Subparagraph (A) shall not apply to an individual if the individual's only coverage under a group health plan for a month is coverage described in clause (i) or (ii) of section 223(c)(1)(B).
 - "(3) Medicare eligible individuals.—No deduction shall be allowed under subsection (a) with respect to any individual for any month if the individual is entitled to benefits under title XVIII of the Social Security Act for the month.
 - "(4) Health savings account required.—
 A deduction shall not be allowed under subsection
 (a) for a taxable year with respect to an individual unless the individual is an account beneficiary of a health savings account during a portion of the taxable year.
- 24 "(5) Medical and health savings ac-25 counts.—Subsection (a) shall not apply with re-

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- 1 spect to any amount which is paid or distributed out
- 2 of an Archer MSA or a health savings account which
- 3 is not included in gross income under section 220(f)
- 4 or 223(f), as the case may be.
- 5 "(6) Coordination with deduction for
- 6 HEALTH INSURANCE OF SELF-EMPLOYED INDIVID-
- 7 UALS.—The amount taken into account by the tax-
- 8 payer in computing the deduction under section
- 9 162(1) shall not be taken into account under this
- section.
- 11 "(7) COORDINATION WITH MEDICAL EXPENSE
- DEDUCTION.—The amount taken into account by
- the taxpayer in computing the deduction under this
- section shall not be taken into account under section
- 15 213.".
- 16 (b) Deduction Allowed Whether or Not Indi-
- 17 VIDUAL ITEMIZES OTHER DEDUCTIONS.—Subsection (a)
- 18 of section 62 of the Internal Revenue Code of 1986 (defin-
- 19 ing adjusted gross income) is amended by inserting before
- 20 the last sentence at the end the following new paragraph:
- 21 "(21) Premiums for high deductible
- 22 HEALTH PLANS.—The deduction allowed by section
- 23 224.".
- (c) Coordination With Health Insurance
- 25 Costs Credit.—Section 35(g)(2) of the Internal Rev-

- 1 enue Code of 1986 is amended by striking "or 213" and
- 2 inserting ",213, or 224".
- 3 (d) Clerical Amendment.—The table of sections
- 4 for part VII of subchapter B of chapter 1 of the Internal
- 5 Revenue Code of 1986 is amended by redesignating sec-
- 6 tion 224 as section 225 and by inserting before such item
- 7 the following new item:
 - "Sec. 224. Premiums for high deductible health plans.".
- 8 (e) Effective Date.—The amendments made by
- 9 this section shall apply to taxable years beginning after
- 10 December 31, 2005.
- 11 SEC. 212. REFUNDABLE CREDIT FOR CONTRIBUTIONS TO
- 12 HEALTH SAVINGS ACCOUNTS OF SMALL BUSI-
- 13 NESS EMPLOYEES.
- 14 (a) IN GENERAL.—Subpart C of part IV of sub-
- 15 chapter A of chapter 1 of the Internal Revenue Code of
- 16 1986, as amended by subtitle A, is amended by inserting
- 17 after section 36 the following new section:
- 18 "SEC. 36A. SMALL EMPLOYER CONTRIBUTIONS TO HEALTH
- 19 SAVINGS ACCOUNTS.
- 20 "(a) GENERAL RULE.—In the case of an eligible em-
- 21 ployer, there shall be allowed as a credit against the tax
- 22 imposed by this subtitle an amount equal to the lesser of—
- 23 "(1) the amount contributed by such employer
- to any qualified health savings account of any em-

1	ployee who is an eligible individual (as defined in
2	section 223(e)(1)) during the taxable year, or
3	"(2) an amount equal to the product of—
4	"(A) \$200 (\$500 if coverage for all months
5	described in subparagraph (B)(i) is family cov-
6	erage), and
7	"(B) a fraction—
8	"(i) the numerator of which is the
9	number of months that the employee was
10	covered under a high deductible health
11	plan maintained by the employer, and
12	"(ii) the denominator of which is the
13	number of months in the taxable year.
14	"(b) Eligible Employer.—For purposes of this
15	section—
16	"(1) In General.—The term 'eligible em-
17	ployer' means, with respect to any taxable year, an
18	employer which—
19	"(A) is a small employer, and
20	"(B) maintains a high deductible health
21	plan under which all employees of the employer
22	reasonably expected to receive at least \$5,000
23	of compensation during the taxable year are eli-
24	gible to participate.

An employer may exclude from consideration under subparagraph (B) employees who are covered by an agreement described in section 410(b)(3)(A) if there is evidence that health benefits were the subject of good faith bargaining.

"(2) EXCEPTION FOR GOVERNMENTAL AND TAX-EXEMPT EMPLOYERS.—The term 'eligible employer' shall not include the Federal Government or any employer described in section 457(e)(1).

"(3) SMALL EMPLOYER.—

"(A) IN GENERAL.—The term 'small employer' means, with respect to any calendar year, any employer if such employer employed an average of 100 or fewer employees on business days during either of the 2 preceding calendar years. For purposes of the preceding sentence, a preceding calendar year may be taken into account only if the employer was in existence throughout such year.

"(B) EMPLOYERS NOT IN EXISTENCE IN PRECEDING YEAR.—In the case of an employer which was not in existence throughout the 1st preceding calendar year, the determination under subparagraph (A) shall be based on the average number of employees that it is reason-

1	ably expected such employer will employ on
2	business days in the current calendar year.
3	"(C) Special rule.—Any reference in
4	this paragraph to an employer shall include a
5	reference to any predecessor of such employer.
6	"(c) Definitions.—For purposes of this section—
7	"(1) High deductible health plan.—The
8	term 'high deductible health plan' has the meaning
9	given such term by section 223(c)(2).
10	"(2) Qualified health savings account.—
11	"(A) In General.—The term 'qualified
12	health savings account' means a health savings
13	account (as defined in section 223(d))—
14	"(i) which is designated (in such form
15	as the Secretary may prescribe) as a quali-
16	fied account for purposes of this section,
17	"(ii) which may not include any
18	amount other than contributions described
19	in subsection (a) and earnings on such
20	contributions, and
21	"(iii) with respect to which section
22	223(f)(4)(A) is applied by substituting
23	'100 percent' for '10 percent'.
24	"(B) Subaccounts and separate ac-
25	COUNTING.—The Secretary may prescribe rules

under which a subaccount within a health savings account, or separate accounting with respect to contributions and earnings described in subparagraph (A)(ii), may be treated in the same manner as a qualified health savings account.

- "(C) Rollovers.—A contribution of a distribution from a qualified health savings account to another health savings account shall be treated as a rollover contribution for purposes of section 223(f)(5) only if the other account is a qualified health savings account.
- 13 "(d) Special Rules.—For purposes of this sec-14 tion—
 - "(1) AGGREGATION RULES.—All persons treated as a single employer under subsection (a) or (b) of section 52, or subsection (n) or (o) of section 414, shall be treated as one person.
 - "(2) DISALLOWANCE OF DEDUCTION.—No deduction shall be allowed for that portion of contributions to any health savings accounts for the taxable year which is equal to the credit determined under subsection (a).
- 24 "(3) Election not to claim credit.—This 25 section shall not apply to a taxpayer for any taxable

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1	year if such taxpayer elects to have this section not
2	apply for such taxable year.".
3	(b) Conforming Amendments.—
4	(1) Paragraph (2) of section 1324(b) of title
5	31, United States Code, is amended by inserting be-
6	fore the period ", or from section 36A of such
7	Code".
8	(2) The table of sections for subpart C of part
9	IV of chapter 1 of the Internal Revenue Code of
10	1986, as amended by subtitle A, is amended by in-
11	serting after the item relating to section 36 the fol-
12	lowing new item:
	"Sec. 36A. Small employer contributions to health savings accounts.".
13	(e) Effective Date.—The amendments made by
14	this section shall apply to contributions made in taxable
15	years beginning after December 31, 2005.
16	Subtitle C—Improvement of the
17	Health Coverage Tax Credit
18	SEC. 221. CHANGE IN STATE-BASED COVERAGE RULES RE-
19	LATED TO PREEXISTING CONDITIONS.
20	(a) In General.—Section 35(e)(2) of the Internal
21	Revenue Code of 1986 (relating to requirements for State-
22	based coverage) is amended by adding at the end the fol-
23	lowing:
24	"(C) Limitation on preexisting condi-
25	TION EXCLUSION PERIOD.—The term 'qualified

1	health insurance' does not include any coverage
2	described in subparagraphs (C) through (H) of
3	paragraph (1) that imposes a pre-existing con-
4	dition exclusion with respect to any individual
5	unless—
6	"(i) such exclusion relates to a phys-
7	ical or mental condition, regardless of the
8	cause of the condition, for which medical
9	advice, diagnosis, care, or treatment was
10	recommended or received within the 6-
11	month period ending on the date the indi-
12	vidual seeks to enroll in the coverage,
13	"(ii) such exclusion extends for a pe-
14	riod of not more than 12 months after the
15	individual seeks to enroll in the coverage,
16	"(iii) the period of any such pre-
17	existing condition exclusion is reduced by
18	the length of the aggregate of the periods
19	of creditable coverage (as defined in sec-
20	tion 9801(c)) applicable to the individual
21	as of the enrollment date, and
22	"(iv) such exclusion is not an exclu-
23	sion described in section 9801(d).".
24	(b) Conforming Amendments.—

1	(1) Internal revenue code of 1986.—Sub-
2	paragraph (A) of section 35(e)(2) of such Code is
3	amended—
4	(A) by striking clause (ii); and
5	(B) by redesignating clauses (iii) and (iv)
6	as clauses (ii) and (iii), respectively.
7	(2) Workforce investment act of 1998
8	AMENDMENTS.—Section 173(f)(2)(B) of the Work-
9	force Investment Act of 1998 (29 U.S.C.
10	2918(f)(2)(B)) is amended—
11	(A) in clause (i)—
12	(i) by striking subclause (II); and
13	(ii) by redesignating subclauses (III)
14	and (IV) as subclauses (II) and (III), re-
15	spectively; and
16	(B) by adding at the end the following:
17	"(iii) Limitation on preexisting
18	CONDITION EXCLUSION PERIOD.—The
19	term 'qualified health insurance' does not
20	include any coverage described in clauses
21	(iii) through (ix) of subparagraph (A) that
22	imposes a pre-existing condition exclusion
23	with respect to any individual unless—
24	"(I) such exclusion relates to a
25	physical or mental condition, regard-

1	less of the cause of the condition, for
2	which medical advice, diagnosis, care
3	or treatment was recommended or re-
4	ceived within the 6-month period end-
5	ing on the date the individual seeks to
6	enroll in the coverage;
7	"(II) such exclusion extends for a
8	period of not more than 12 months
9	after the individual seeks to enroll in
10	the coverage;
11	"(III) the period of any such pre-
12	existing condition exclusion is reduced
13	by the length of the aggregate of the
14	periods of creditable coverage (as de-
15	fined in section 9801(c) of the Inter-
16	nal Revenue Code of 1986) applicable
17	to the individual as of the enrollment
18	date; and
19	"(IV) such exclusion is not an ex-
20	clusion described in section 9801(d) of
21	such Code.".
22	(c) Effective Date.—The amendments made by
23	this section apply to taxable years beginning after Decem-
24	ber 31, 2005.

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П	SEC	222	ELIGIBILITY	\mathbf{OF}	SPOUSE	\mathbf{OF}	CERTAIN	INDIVID

- 2 UALS ENTITLED TO MEDICARE.
- 3 (a) In General.—Subsection (b) of section 35 of
- 4 such Code (defining eligible coverage month) is amended
- 5 by adding at the end the following:
- 6 "(3) Special rule for spouse of indi-
- 7 VIDUAL ENTITLED TO MEDICARE.—Any month
- 8 which would be an eligible coverage month with re-
- 9 spect to a taxpayer (determined without regard to
- subsection (f)(2)(A) shall be an eligible coverage
- 11 month for any spouse of such taxpayer, provided the
- spouse has attained age 55 and meets the require-
- ments of clauses (ii), (iii), and (iv) of paragraph
- 14 (1)(A).".
- 15 (b) Effective Date.—The amendment made by
- 16 subsection (a) applies to taxable years beginning after De-
- 17 cember 31, 2005.
- 18 SEC. 223. ELIGIBLE PBGC PENSION RECIPIENT.
- 19 (a) In General.—Subparagraph (B) of section
- 20 35(c)(4) of such Code (relating to eligible PBGC pension
- 21 recipients) is amended by inserting before the period the
- 22 following ", or, after August 6, 2002, received from such
- 23 Corporation a one-time single-sum pension payment in
- 24 lieu of an annuity".
- 25 (b) Effective Date.—The amendment made by
- 26 subsection (a) shall take effect as if included in the enact-

1	ment of section 201 of the Trade Act of 2002 (Public Law
2	107–210, 116 Stat. 954).
3	SEC. 224. APPLICATION OF OPTION TO OFFER STATE-
4	BASED COVERAGE TO PUERTO RICO, NORTH-
5	ERN MARIANA ISLANDS, AMERICAN SAMOA,
6	GUAM, AND THE UNITED STATES VIRGIN IS-
7	LANDS.
8	(a) In General.—Section 35(e) of such Code (relat-
9	ing to requirements for qualified health insurance) is
10	amended by adding at the end the following:
11	"(4) Application to puerto rico, north-
12	ERN MARIANA ISLANDS, AMERICAN SAMOA, GUAM,
13	AND THE UNITED STATES VIRGIN ISLANDS.—For
14	purposes of this section, Puerto Rico, Northern Mar-
15	iana Islands, American Samoa, Guam, and the
16	United States Virgin Islands shall be considered
17	States.".
18	(b) Conforming Amendment.—Section 173(f)(2)
19	of the Workforce Investment Act of 1998 (29 U.S.C.
20	2918(f)(2)) is amended by adding at the end the following:
21	"(D) Application to Northern Mar-
22	IANA ISLANDS, AMERICAN SAMOA, GUAM, AND
23	THE UNITED STATES VIRGIN ISLANDS.—For
24	purposes of subsection (a)(4)(A) and this sub-
25	section, the term 'State' shall include the

- 1 Northern Mariana Islands, American Samoa,
- Guam, and the United States Virgin Islands.".
- 3 (c) Effective Date.—The amendments made by
- 4 this section apply to taxable years beginning after Decem-
- 5 ber 31, 2005.

6 SEC. 225. CLARIFICATION OF DISCLOSURE RULES.

- 7 (a) In General.—Subsection (k) of section 6103 of
- 8 such Code (relating to disclosure of certain returns and
- 9 return information for tax administration purposes) is
- 10 amended by adding at the end the following:
- 11 "(10) Disclosure of Certain Return in-
- 12 FORMATION FOR PURPOSES OF CARRYING OUT A
- PROGRAM FOR ADVANCE PAYMENT OF CREDIT FOR
- 14 HEALTH INSURANCE COSTS OF ELIGIBLE INDIVID-
- 15 UALS.—The Secretary may disclose to providers of
- health insurance, administrators of health plans, or
- 17 contractors of such providers or administrators, for
- any certified individual (as defined in section
- 19 7527(c)) the taxpayer identity and health insurance
- 20 member and group numbers of the certified indi-
- vidual (and any qualifying family member as defined
- in section 35(d), if applicable) and the amount and
- period of the payment, to the extent the Secretary
- deems necessary for the administration of the pro-
- gram established by section 7527 (relating to ad-

1	vance payment of credit for health insurance costs of
2	eligible individuals).".
3	(b) Conforming Amendments.—
4	(1) Section 6103 of such Code (relating to con-
5	fidentiality and disclosure of returns and return in-
6	formation) is amended—
7	(A) in subsection (a)(3), by inserting
8	"(k)(10)," after "(e)(1)(D)(iii),";
9	(B) in subsection (l), by striking para-
10	graph (18); and
11	(C) in subsection (p)—
12	(i) in paragraph (3)(A)—
13	(I) by striking "or (9)" and in-
14	serting "(9), or (10)"; and
15	(II) by striking "(17), or (18)"
16	and inserting "or (17)"; and
17	(ii) in paragraph (4), by striking
18	"(18)" after "(l)(16)" each place it ap-
19	pears.
20	(2) Section 7213(a)(2) of such Code (relating
21	to unauthorized disclosure of information) is amend-
22	ed by inserting " $(k)(10)$ " before " $(l)(6)$ ".
23	(3) Section 7213A(a)(1)(B) of such Code (re-
24	lating to unauthorized inspection of returns or re-
25	turn information) is amended by striking "sub-

1	section (l)(18) or (n) of section 6103" and inserting
2	"section 6103(n)".
3	(c) Effective Date.—The amendments made by
4	this section apply to taxable years beginning after Decem-
5	ber 31, 2005.
6	SEC. 226. CLARIFICATION THAT STATE-BASED COBRA CON-
7	TINUATION COVERAGE IS SUBJECT TO SAME
8	RULES AS FEDERAL COBRA.
9	(a) In General.—Section 35(e)(2) of such Code (re-
10	lating to state-based coverage requirements) is amended—
11	(1) in subparagraph (A), in the matter pre-
12	ceding clause (i), by striking "(B)" and inserting
13	"(C)"; and
14	(2) in subparagraph(B)(i), by striking "(B)"
15	and inserting "(C)".
16	(b) Conforming Amendments.—Section
17	$173(\mathrm{f})(2)(\mathrm{B})$ of the Workforce Investment Act of 1998 (29
18	U.S.C. 2918(f)(2)(B)) is amended—
19	(1) in clause (i), in the matter preceding sub-
20	clause (I), by striking "(ii)" and inserting "(iii)";
21	and
22	(2) in clause (ii)(I), by striking "(ii)" and in-
23	serting "(iii)".
24	(c) Effective Date.—The amendments made by
25	this section shall take effect as if included in the enact-

1	ment of sections 201 and 203, respectively, of the Trade
2	Act of 2002 (Public Law 107–210, 116 Stat. 954).
3	SEC. 227. APPLICATION OF RULES FOR OTHER SPECIFIED
4	COVERAGE TO ELIGIBLE ALTERNATIVE TAA
5	RECIPIENTS CONSISTENT WITH RULES FOR
6	OTHER ELIGIBLE INDIVIDUALS.
7	(a) In General.—Section 35(f)(1) of such Code (re-
8	lating to subsidized coverage) is amended by striking sub-
9	paragraph (B) and redesignating subparagraph (C) as
10	subparagraph (B).
11	(b) Conforming Amendments.—Section
12	$173(\mathrm{f})(7)(\mathrm{A})$ of the Workforce Investment Act of 1998 (29
13	U.S.C. 2918(f)(7)(A)) is amended by striking clause (ii)
14	and redesignating clause (iii) as clause (ii).
15	Subtitle D—Long-Term Care
16	Insurance
17	SEC. 231. SENSE OF THE SENATE CONCERNING LONG-TERM
18	CARE.
19	It is the sense of the Senate that Congress should
20	take steps to make long-term care more affordable by pro-
21	viding tax incentives for the purchase of long-term care
22	insurance, support for family caregivers, and making nec-
23	essary public program reforms.

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Subtitle E—Other Provisions

SEC. 241. DISPOSITION OF UNUSED HEALTH BENEFITS IN 3 CAFETERIA PLANS AND FLEXIBLE SPENDING 4 ARRANGEMENTS. 5 (a) IN GENERAL.—Section 125 of the Internal Revenue Code of 1986 (relating to cafeteria plans) is amended 7 by redesignating subsections (h) and (i) as subsections (i) 8 and (j), respectively, and by inserting after subsection (g) 9 the following: 10 "(h) Contributions of Certain Unused Health 11 Benefits.— 12 "(1) In general.—For purposes of this title, 13 a plan or other arrangement shall not fail to be 14 treated as a cafeteria plan solely because qualified 15 benefits under such plan include a health flexible 16 spending arrangement under which not more than 17 \$500 of unused health benefits may be— 18 "(A) carried forward to the succeeding 19 plan year of such health flexible spending ar-20 rangement, or "(B) to the extent permitted by section 21 22 106(c), contributed by the employer to a health 23 savings account (as defined in section 223(d)) 24 maintained for the benefit of the employee.

1	"(2) Health flexible spending arrange-
2	MENT.—
3	"(A) In general.—For purposes of this
4	subsection, the term 'health flexible spending
5	arrangement' means a flexible spending ar-
6	rangement (as defined in section 106(c)) that is
7	a qualified benefit and only permits reimburse-
8	ment for expenses for medical care (as defined
9	in section $213(d)(1)$, without regard to subpara-
10	graphs (C) and (D) thereof).
11	"(B) Flexible spending arrange-
12	MENT.—A flexible spending arrangement is a
13	benefit program which provides employees with
14	coverage under which—
15	"(i) specified incurred expenses may
16	be reimbursed (subject to reimbursement
17	maximums and other reasonable condi-
18	tions), and
19	"(ii) the maximum amount of reim-
20	bursement which is reasonably available to
21	a participant for such coverage is less than
22	500 percent of the value of such coverage.
23	In the case of an insured plan, the maximum
24	amount reasonably available shall be deter-
25	mined on the basis of the underlying coverage.

1	"(3) Unused health benefits.—For pur-
2	poses of this subsection, with respect to an em-
3	ployee, the term 'unused health benefits' means the
4	excess of—
5	"(A) the maximum amount of reimburse-
6	ment allowable to the employee for a plan year
7	under a health flexible spending arrangement,
8	over
9	"(B) the actual amount of reimbursement
10	for such year under such arrangement.".
11	(b) Effective Date.—The amendments made by
12	subsection (a) shall apply to taxable years beginning after
13	December 31, 2004.
14	SEC. 242. MICROENTREPRENEURS.
15	(Section 404(8) of the Assets for Independence Act
16	(42 U.S.C. 604 note) is amended by adding at the end
17	the following:
18	"(F) High deductible health insur-
19	ANCE.—
20	"(i) In general.—The eligible indi-
21	vidual's contribution (as an employer or
22	employee) for coverage under a high de-
23	ductible health plan (as defined in section
24	223(c)(2) of the Internal Revenue Code of
25	1986).

1	"(ii) Definition of Employee.—
2	For purposes of clause (i), the term 'em-
3	ployee' includes an individual described in
4	section 401(c)(1) of the Internal Revenue
5	Code of 1986.".
6	SEC. 243. STUDY ON ACCESS TO AFFORDABLE HEALTH IN-
7	SURANCE FOR FULL-TIME COLLEGE AND UNI-
8	VERSITY STUDENTS.
9	(a) Sense of the Senate.—It is the sense of the
10	Senate that, because a considerable number of the United
11	States' uninsured population are young adults who are en-
12	rolled full-time at an institution of higher education, Con-
13	gress should determine whether health care coverage pro-
14	posals targeting this population would be effective.
15	(b) STUDY REQUIRED.—The Government Account-
16	ability Office shall provide for the conduct of a study to
17	evaluate existing and potential sources of affordable health
18	insurance coverage for graduate and undergraduate stu-
19	dents enrolled at an institution of higher education (as de-
20	fined in section 1201 of the Higher Education Act of 1965
21	(20 U.S.C. 1141)).
22	(c) Required Elements of Study.—In con-
23	ducting the study under subsection (b), the Government
24	Accountability Office shall, at a minimum, examine the
25	following:

1	(1) Student demographics.—
2	(A) In general.—The size and character-
3	istics of the insured and uninsured population
4	of undergraduate and graduate students en-
5	rolled at institutions of higher education. Such
6	data shall be differentiated as provided for in
7	subparagraphs (B) and (C).
8	(B) STATISTICAL BREAKDOWN.—The data
9	concerning the uninsured student population
10	collected under subparagraph (A) shall be dif-
11	ferentiated by—
12	(i) the full-time, full-time equivalent,
13	and part-time enrollment status of the stu-
14	dents involved;
15	(ii) the type of institution involved
16	(such as a public, private, non-profit, or
17	community institution);
18	(iii) the length and type of educational
19	program involved (such as a certificate or
20	diploma program, a 2-year or 4-year de-
21	gree program, a masters degree program,
22	or a doctoral degree program); and
23	(iv) the undergraduate and graduate
24	student populations involved.

1	(C) COVERAGE.—The data concerning the
2	insured student population collected under sub-
3	paragraph (A) shall be differentiated by the
4	sources of coverage for such students, including
5	the number and percentage of such insured stu-
6	dents who lose parental (or other) coverage dur-
7	ing the course of their enrollment at such insti-
8	tutions and the age at which such coverage is
9	lost.
10	(2) IMPACT ANALYSIS.—The financial and other
11	impact of uninsured students at such institutions, as
12	compared to insured students, on—
13	(A) the health of students;
14	(B) the student's family;
15	(C) the student's educational progress; and
16	(D) education and health care institutions
17	and facilities.
18	(3) Assessment of existing programs.—
19	The effect of mandatory and voluntary programs on
20	the access of students to health insurance coverage,
21	including—
22	(A) the level and type of coverage provided
23	through mandatory and voluntary State and in-
24	stitutionally-sponsored health care programs

1	currently providing health care insurance cov-
2	erage to students;
3	(B) the average premium paid with respect
4	to students covered under such plans;
5	(C) the extent to which any State or insti-
6	tutional health insurance plan may serve as a
7	model for the expansion of access to health in-
8	surance for all full-time undergraduate and
9	graduate students attending an institution of
10	higher education; and
11	(D) whether such programs targeted to the
12	student population would be more effective in
13	reducing the overall rate of uninsured relative
14	to proposals targeted to broader populations.
15	(4) Incentives and disincentives.—The ex-
16	istence of incentives and disincentives offered to in-
17	stitutions of higher education to expand access to
18	health care coverage for students, including—
19	(A) an assessment of the types of incen-
20	tives and disincentives that may be used to en-
21	courage or require an institution of higher edu-
22	cation to include health care coverage for all of
23	its students on a mandatory basis, including fi-
24	nancial, regulatory, administrative, and other
25	incentives or disincentives.

- 1 (B) a list of burdensome regulatory or ad-2 ministrative reporting and other requirements 3 (from the Department of Education or other 4 governmental agencies) that could be waived without compromising program integrity as a 5 6 means of encouraging institutions of higher 7 education to provide uninsured students with 8 access to health care coverage;
 - (C) other incentives or disincentives that would increase the level of institutional participation in health care coverage programs; and
 - (D) an analysis of the costs and effectiveness (to reduce the number of uninsured students) of including the cost of health insurance as an allowable cost of attendance under the Higher Education Act of 1965, and the impact of such inclusion on the student's financial aid package.
- 19 (e) Consultation With Congress.—In carrying 20 out the study under subsection (b), the Government Ac-21 countability Office shall consult on a regular basis with 22 the Secretary of Education, the Secretary of Health and 23 Human Services, the Committee on the Budget of the 24 Senate, the Committee on Health, Education, Labor, and

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- 1 Pensions of the Senate, and the Committee on Education
- 2 and the Workforce of the House of Representatives.
- 3 (f) Report.—Not later than 1 year after the date
- 4 of enactment of this Act, the Government Accountability
- 5 Office shall prepare and submit to the Committee on the
- 6 Budget and the Committee on Health, Education, Labor,
- 7 and Pensions of the Senate, and the Committee on Edu-
- 8 cation and the Workforce of the House of Representatives,
- 9 a report concerning the results of the study conducted
- 10 under this section.
- 11 SEC. 244. EXTENSION OF FUNDING FOR OPERATION OF
- 12 STATE HIGH RISK HEALTH INSURANCE
- Pools.
- 14 Section 2745 of the Public Health Service Act (42
- 15 U.S.C. 300gg-45) is amended to read as follows:
- 16 "SEC. 2745. PROMOTION OF QUALIFIED HIGH RISK POOLS.
- 17 "(a) Extension of Seed Grants to States.—
- 18 The Secretary shall provide from the funds appropriated
- 19 under subsection (d)(1)(A) a grant of up to \$1,000,000
- 20 to each State that has not created a qualified high risk
- 21 pool as of the date of enactment of this section for the
- 22 State's costs of creation and initial operation of such a
- 23 pool.
- 24 "(b) Grants for Operational Losses.—

1	"(1) IN GENERAL.—In the case of a State that
2	has established a qualified high risk pool that—
3	"(A) restricts premiums charged under the
4	pool to no more than 150 percent of the pre-
5	mium for applicable standard risk rates;
6	"(B) offers a choice of two or more cov-
7	erage options through the pool; and
8	"(C) has in effect a mechanism reasonably
9	designed to ensure continued funding of losses
10	incurred by the State after the end of fiscal
11	year 2004 in connection with operation of the
12	pool;
13	the Secretary shall provide, from the funds appro-
14	priated under subsection $(d)(1)(B)(i)$ and allotted to
15	the State under paragraph (2), a grant for the losses
16	incurred by the State in connection with the oper-
17	ation of the pool.
18	"(2) Allotment.—The amounts appropriated
19	under subsection $(d)(1)(B)(i)$ for a fiscal year shall
20	be made available to the States (or the entities that
21	operate the high risk pool under applicable State
22	law) as follows:
23	"(A) An amount equal to 50 percent of the
24	appropriated amount for the fiscal year shall be
25	allocated in equal amounts among each eligible

1	State that applies for assistance under this sub-
2.	section.

"(B) An amount equal to 25 percent of the appropriated amount for the fiscal year shall be allocated among the States so that the amount provided to a State bears the same ratio to such available amount as the number of uninsured individuals in the State bears to the total number of uninsured individuals in all States (as determined by the Secretary).

"(C) An amount equal to 25 percent of the appropriated amount for the fiscal year shall be allocated among the States so that the amount provided to a State bears the same ratio to such available amount as the number of individuals enrolled in health care coverage through the qualified high risk pool of the State bears to the total number of individuals so enrolled through qualified high risk pools in all States (as determined by the Secretary).

21 "(c) Bonus Grants for Supplemental Con-22 sumer Benefits.—

"(1) IN GENERAL.—In the case of a State that has established a qualified high risk pool, the Secretary shall provide, from the funds appropriated

1	under subsection (d)(1)(B)(ii) and allotted to the
2	State under paragraph (3), a grant to be used to
3	provide supplemental consumer benefits to enrollees
4	or potential enrollees (or defined subsets of such en-
5	rollees or potential enrollees) in qualified high risk
6	pools.
7	"(2) Benefits.—A State shall use amounts re-
8	ceived under a grant under this subsection to pro-
9	vide one or more of the following benefits:
10	"(A) Low-income premium subsidies.
11	"(B) A reduction in premium trends, ac-
12	tual premiums, or other cost-sharing require-
13	ments.
14	"(C) An expansion or broadening of the
15	pool of individuals eligible for coverage, includ-
16	ing eliminating waiting lists, increasing enroll-
17	ment caps, or providing flexibility in enrollment
18	rules.
19	"(D) Less stringent rules, or additional
20	waiver authority, with respect to coverage of
21	pre-existing conditions.
22	"(E) Increased benefits.
23	"(F) The establishment of disease manage-
24	ment programs.

1	"(3) Limitation.—In allotting amounts under
2	this subsection, the Secretary shall ensure that no
3	State receives an amount that exceeds 10 percent of
4	the amount appropriated for the fiscal year involved
5	under subsection (d)(1)(B)(ii).
6	"(4) Rule of Construction.—Nothing in
7	this subsection shall be construed to prohibit States
8	that, on the date of enactment of the State High
9	Risk Pool Funding Extension Act of 2005, are in
10	the process of implementing programs to provide
11	benefits of the type described in paragraph (2), from
12	being eligible for a grant under this subsection.
13	"(d) Funding.—
14	"(1) In general.—Out of any money in the
15	Treasury of the United States not otherwise appro-
16	priated, there are authorized and appropriated—
17	"(A) \$15,000,000 for the period of fiscal
18	years 2005 and 2006 to carry out subsection
19	(a); and
20	"(B) \$75,000,000 for each of fiscal years
21	2005 through 2009, of which—
22	"(i) two-thirds of the amount appro-
23	priated for a fiscal year shall be made
24	available for allotments under subsection
25	(b)(2); and

1	"(ii) one-third of the amount appro-
2	priated for a fiscal year shall be made
3	available for allotments under subsection
4	(e)(2).
5	"(2) AVAILABILITY.—Funds appropriated
6	under this subsection for a fiscal year shall remain
7	available for obligation through the end of the fol-
8	lowing fiscal year.
9	"(3) Reallotment.—If, on June 30 of each
10	fiscal year, the Secretary determines that all
11	amounts appropriated under paragraph (1)(B)(ii)
12	for the fiscal year are not allotted, such remaining
13	amounts shall be allotted among States receiving
14	grants under subsection (b) for the fiscal year in
15	amounts determined appropriate by the Secretary.
16	"(4) No entitlement.—Nothing in this sec-
17	tion shall be construed as providing a State with an
18	entitlement to a grant under this section.
19	"(e) APPLICATIONS.—To be eligible for a grant under
20	this section, a State shall submit to the Secretary an appli-
21	cation at such time, in such manner, and containing such
22	information as the Secretary may require.
23	"(f) Definitions.—In this section:
24	"(1) Qualified high risk pool.—

1	"(A) In General.—The term 'qualified
2	high risk pool' has the meaning given such term
3	in section 2744(c)(2), except that with respect
4	to subparagraph (A) of such section a State
5	may elect to provide for the enrollment of eligi-
6	ble individuals through—
7	"(i) a combination of a qualified high
8	risk pool and an acceptable alternative
9	mechanism; or
10	"(ii) other health insurance coverage
11	described in subparagraph (B).
12	"(B) HEALTH INSURANCE COVERAGE.—
13	Health insurance coverage described in this
14	subparagraph is individual health insurance
15	coverage—
16	"(i) that meets the requirements of
17	section 2741;
18	"(ii) that is subject to limits on the
19	rates charged to individuals;
20	"(iii) that is available to all individ-
21	uals eligible for health insurance coverage
22	under this title who are not able to partici-
23	pate in a qualified high risk pool; and
24	"(iv) the defined rate limit of which
25	does not exceed the limit allowed for a

1	qualified risk pool that is otherwise eligible
2	to receive assistance under a grant under
3	this section.
4	"(C) Other Coverage.—In addition to
5	coverage described in subparagraph (B), a
6	State may provide for the offering of health in-
7	surance coverage that provides first dollar cov-
8	erage, limits on cost-sharing, and comprehen-
9	sive medical, hospital and surgical coverage, if
10	the limits on rates for such coverage do not ex-
11	ceed 125 percent of the limit described in sub-
12	paragraph (B)(iv).
13	"(2) Standard risk rate.—The term 'stand-
14	ard risk rate' means a rate—
15	"(A) determined under the State high risk
16	pool by considering the premium rates charged
17	by other health insurers offering health insur-
18	ance coverage to individuals in the insurance
19	market served;
20	"(B) that is established using reasonable
21	actuarial techniques; and
22	"(C) that reflects anticipated claims expe-
23	rience and expenses for the coverage involved.
24	"(3) State.—The term 'State' means any of
25	the 50 States and the District of Columbia.".

1	SEC. 245. SENSE OF THE SENATE ON AFFORDABLE HEALTH
2	COVERAGE FOR SMALL EMPLOYERS.
3	It is the sense of the Senate that Congress should
4	pass legislation to support expanded, affordable health
5	coverage options for individuals, particularly those who
6	work for small businesses, by streamlining and reducing
7	regulations and expanding the role of associations and
8	other group purchasing arrangements.
9	Subtitle F—Covering Kids
10	SEC. 251. SHORT TITLE.
11	This subtitle may be cited as the "Covering Kids Act
12	of 2005".
13	SEC. 252. GRANTS TO PROMOTE INNOVATIVE OUTREACH
14	AND ENROLLMENT UNDER MEDICAID AND
15	SCHIP.
16	(a) Grants for Expanded Outreach Activi-
17	TIES.—Title XXI of the Social Security Act (42 U.S.C.
18	1397aa et seq.) is amended by adding at the end the fol-
19	lovein o
20	lowing:
20	"SEC. 2111. EXPANDED OUTREACH ACTIVITIES.
20	
	"SEC. 2111. EXPANDED OUTREACH ACTIVITIES.
21	"SEC. 2111. EXPANDED OUTREACH ACTIVITIES. "(a) Grants To Conduct Innovative Outreach
21 22	"SEC. 2111. EXPANDED OUTREACH ACTIVITIES. "(a) GRANTS TO CONDUCT INNOVATIVE OUTREACH AND ENROLLMENT EFFORTS.—
212223	"SEC. 2111. EXPANDED OUTREACH ACTIVITIES. "(a) Grants To Conduct Innovative Outreach and Enrollment Efforts.— "(1) In General.—The Secretary shall award

1	the enrollment and participation of eligible chil-
2	dren under this title and title XIX; and
3	"(B) promote understanding of the impor-
4	tance of health insurance coverage for prenatal
5	care and children.
6	"(2) Performance Bonuses.—The Secretary
7	may reserve a portion of the funds appropriated
8	under subsection (g) for a fiscal year for the purpose
9	of awarding performance bonuses during the suc-
10	ceeding fiscal year to eligible entities that meet en-
11	rollment goals or other criteria established by the
12	Secretary.
13	"(b) Priority for Award of Grants.—
14	"(1) In General.—In making grants under
15	subsection (a)(1), the Secretary shall give priority
16	to—
17	"(A) eligible entities that propose to target
18	geographic areas with high rates of—
19	"(i) eligible but unenrolled children,
20	including such children who reside in rural
21	areas; or
22	"(ii) racial and ethnic minorities and
23	health disparity populations, including
24	those proposals that address cultural and
25	linguistic barriers to enrollment; and

1	"(B) eligible entities that plan to engage in
2	outreach efforts with respect to individuals de-
3	scribed in subparagraph (A) and that are—
4	"(i) Federal health safety net organi-
5	zations; or
6	"(ii) faith-based organizations or con-
7	sortia.
8	"(2) 10 percent set aside for outreach
9	TO INDIAN CHILDREN.—An amount equal to 10 per-
10	cent of the funds appropriated under subsection (g)
11	for a fiscal year shall be used by the Secretary to
12	award grants to Indian Health Service providers and
13	urban Indian organizations receiving funds under
14	title V of the Indian Health Care Improvement Act
15	(25 U.S.C. 1651 et seq.) for outreach to, and enroll-
16	ment of, children who are Indians.
17	"(c) Application.—An eligible entity that desires to
18	receive a grant under subsection (a)(1) shall submit an
19	application to the Secretary in such form and manner, and
20	containing such information, as the Secretary may decide.
21	Such application shall include—
22	"(1) quality and outcomes performance meas-
23	ures to evaluate the effectiveness of activities funded
24	by a grant awarded under this section to ensure that
25	the activities are meeting their goals; and

1	"(2) an assurance that the entity shall—
2	"(A) conduct an assessment of the effec-
3	tiveness of such activities against such perform-
4	ance measures; and
5	"(B) cooperate with the collection and re-
6	porting of enrollment data and other informa-
7	tion determined as a result of conducting such
8	assessments to the Secretary, in such form and
9	manner as the Secretary shall require.
10	"(d) Dissemination of Enrollment Data and
11	Information Determined From Effectiveness As-
12	SESSMENTS; ANNUAL REPORT.—The Secretary shall—
13	"(1) disseminate to eligible entities and make
14	publicly available the enrollment data and informa-
15	tion collected and reported in accordance with sub-
16	section $(c)(2)(B)$; and
17	"(2) submit an annual report to Congress on
18	the outreach activities funded by grants awarded
19	under this section.
20	"(e) Supplement, Not Supplant.—Federal funds
21	awarded under this section shall be used to supplement,
22	not supplant, non-Federal funds that are otherwise avail-
23	able for activities funded under this section.
24	"(f) Definitions.—In this section:

1	"(1) ELIGIBLE ENTITY.—The term 'eligible en-
2	tity' means any of the following:
3	"(A) A State or local government.
4	"(B) A Federal health safety net organiza-
5	tion.
6	"(C) A national, local, or community-based
7	public or nonprofit private organization.
8	"(D) A faith-based organization or con-
9	sortia, to the extent that a grant awarded to
10	such an entity is consistent with the require-
11	ments of section 1955 of the Public Health
12	Service Act (42 U.S.C. 300x-65) relating to a
13	grant award to non-governmental entities.
14	"(E) An elementary or secondary school.
15	"(2) Federal Health Safety Net Organi-
16	ZATION.—The term 'Federal health safety net orga-
17	nization' means—
18	"(A) an Indian tribe, tribal organization,
19	or an urban Indian organization receiving funds
20	under title V of the Indian Health Care Im-
21	provement Act (25 U.S.C. 1651 et seq.), or an
22	Indian Health Service provider;
23	"(B) a Federally-qualified health center
24	(as defined in section 1905(l)(2)(B));

1	"(C) a hospital defined as a dispropor-
2	tionate share hospital for purposes of section
3	1923;
4	"(D) a covered entity described in section
5	340B(a)(4) of the Public Health Service Act
6	(42 U.S.C. 256b(a)(4)); and
7	"(E) any other entity or a consortium that
8	serves children under a federally-funded pro-
9	gram, including the special supplemental nutri-
10	tion program for women, infants, and children
11	(WIC) established under section 17 of the Child
12	Nutrition Act of 1966 (42 U.S.C. 1786), the
13	head start and early head start programs under
14	the Head Start Act (42 U.S.C. 9801 et seq.),
15	the school lunch program established under the
16	Richard B. Russell National School Lunch Act,
17	and an elementary or secondary school.
18	"(3) Indians; indian tribe; tribal organi-
19	ZATION; URBAN INDIAN ORGANIZATION.—The terms
20	'Indian', 'Indian tribe', 'tribal organization', and
21	'urban Indian organization' have the meanings given
22	such terms in section 4 of the Indian Health Care
23	Improvement Act (25 U.S.C. 1603).
24	"(g) Appropriation.—There is appropriated, out of
25	any money in the Treasury not otherwise appropriated,

- 1 \$50,000,000 for each of fiscal years 2006 and 2007 for
- 2 the purpose of awarding grants under this section.
- 3 Amounts appropriated and paid under the authority of
- 4 this section shall be in addition to amounts appropriated
- 5 under section 2104 and paid to States in accordance with
- 6 section 2105, including with respect to expenditures for
- 7 outreach activities in accordance with subsection
- 8 (a)(1)(D)(iii) of that section.".
- 9 (b) Extending Use of Outstationed Workers
- 10 TO ACCEPT TITLE XXI APPLICATIONS.—Section
- 11 1902(a)(55) of the Social Security Act (42 U.S.C.
- $12 \quad 1396a(a)(55))$ is amended by striking "or
- 13 (a)(10)(A)(ii)(IX)" and inserting "(a)(10)(A)(ii)(IX), or
- 14 (a)(10)(A)(ii)(XIV), and applications for child health as-
- 15 sistance under title XXI".
- 16 SEC. 253. STATE OPTION TO PROVIDE FOR SIMPLIFIED DE-
- 17 TERMINATIONS OF A CHILD'S FINANCIAL ELI-
- 18 GIBILITY FOR MEDICAL ASSISTANCE UNDER
- 19 MEDICAID OR CHILD HEALTH ASSISTANCE
- 20 UNDER SCHIP.
- 21 (a) Medicaid.—Section 1902(e) of the Social Secu-
- 22 rity Act (42 U.S.C. 1396a(e)) is amended by adding at
- 23 the end the following:
- 24 "(13)(A) At the option of the State, the plan
- 25 may provide that financial eligibility requirements

1 for medical assistance are met for a child who is 2 under an age specified by the State (not to exceed 21 years of age) by using a determination made 3 within a reasonable period (as determined by the 5 State) before its use for this purpose, of the child's 6 family or household income, or if applicable for pur-7 poses of determining eligibility under this title or 8 title XXI, assets or resources, by a Federal or State 9 agency, or a public or private entity making such de-10 termination on behalf of such agency, specified by 11 the plan, including (but not limited to) an agency 12 administering the State program funded under part 13 A of title IV, the Food Stamp Act of 1977, the 14 Richard B. Russell National School Lunch Act, or 15 the Child Nutrition Act of 1966, notwithstanding 16 any differences in budget unit, disregard, deeming, 17 or other methodology, but only if—

- "(i) the agency has fiscal liabilities or responsibilities affected or potentially affected by such determination; and
- "(ii) any information furnished by the agency pursuant to this subparagraph is used solely for purposes of determining financial eligibility for medical assistance under this title or for child health assistance under title XXI.

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1	"(B) Nothing in subparagraph (A) shall be con-
2	strued—
3	"(i) to authorize the denial of medical as-
4	sistance under this title or of child health as-
5	sistance under title XXI to a child who, without
6	the application of this paragraph, would qualify
7	for such assistance;
8	"(ii) to relieve a State of the obligation
9	under subsection (a)(8) to furnish medical as-
10	sistance with reasonable promptness after the
11	submission of an initial application that is eval-
12	uated or for which evaluation is requested pur-
13	suant to this paragraph;
14	"(iii) to relieve a State of the obligation to
15	determine eligibility for medical assistance
16	under this title or for child health assistance
17	under title XXI on a basis other than family or
18	household income (or, if applicable, assets or re-
19	sources) if a child is determined ineligible for
20	such assistance on the basis of information fur-
21	nished pursuant to this paragraph; or
22	"(iv) as affecting the applicability of any
23	non-financial requirements for eligibility for
24	medical assistance under this title or child
25	health assistance under title XXI.".

1	(b) SCHIP.—Section 2107(e)(1) of the Social Secu-
2	rity Act (42 U.S.C. 1397gg(e)(1)) is amended by adding
3	at the end the following:
4	"(E) Section 1902(e)(13) (relating to the
5	State option to base a determination of child's
6	financial eligibility for assistance on financial
7	determinations made by a program providing
8	nutrition or other public assistance).".
9	(c) Effective Date.—The amendments made by
10	this section take effect on October 1, 2005.
11	TITLE III—IMPROVING CARE
12	AND STRENGTHENING THE
13	SAFETY NET
14	Subtitle A—High Needs Areas
15	SEC. 301. PURPOSE.
16	It is the purpose of this subtitle to enhance the qual-
17	ity of life of residents of high need areas by increasing
18	their access to the preventive and primary healthcare serv-
19	ices provided by community health centers and rural
20	health centers.
21	SEC. 302. HIGH NEED COMMUNITY HEALTH CENTERS.
22	Section 330 of the Public Health Service Act (42
23	U.S.C. 254b) is amended—
24	(1) by redesignating subsections (k) through (r)
25	as subsections (l) through (s), respectively;

1	(2) by inserting after subsection (j), the fol-
2	lowing:
3	"(k) Priority for Residents of High Need
4	Areas.—
5	"(1) In general.—In awarding grants under
6	this section, the Secretary shall give priority to eligi-
7	ble health centers in high need areas.
8	"(2) Eligible Health Centers.—A health
9	center is described in this paragraph if such health
10	center—
11	"(A) is a health center as defined under
12	subsection (a) or a rural health clinic that re-
13	ceives funds under section 330A;
14	"(B) agrees to use grant funds to provide
15	preventive and primary healthcare services to
16	residents of high need areas;
17	"(C) specifically requests such priority in
18	the grant application;
19	"(D) describes how the community to be
20	served meets the definition of high need area;
21	and
22	"(E) otherwise meets all other grant re-
23	quirements.
24	"(3) High need area.—

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"(A) IN GENERAL.—In this subsection, the
term 'high need area' means a county or a re-
gional area identified by the Secretary pursuant
to the regulations promulgated under subpara-
graph (B).

"(B) REGULATIONS.—The Secretary shall promulgate regulations that define the term 'high need area' for purposes of this subsection. Such regulations shall specify procedures that the Department shall follow in determining estimates on a periodic basis in the United States of the number of medically uninsured persons and the national percentage of medically uninsured persons served by health centers (referred to in this subsection as the 'ENP') and for the designation of an area as a 'high need area' if the estimated percentage of medically uninsured individuals in the area is higher than the national average and the estimated percentage of medically uninsured individuals in the area served by health centers in the area is below the ENP.

"(C) Medically underserved area.—
The Secretary shall designate residents of high

1	need areas as medically underserved for pur-
2	poses of this section.
3	"(4) Funding preference.—The Secretary
4	may limit the amount of grants awarded to appli-
5	cants from high need areas as provided for in this
6	subsection to not less than 25 percent of the total
7	amount of grants awarded under this subsection for
8	each grant category for each grant period.";
9	(3) in subsection (e)(1)(B), by striking "sub-
10	section (k)(3)" and inserting "subsection (l)(3)";
11	(4) in subsection (l)(3)(H)(iii) (as so redesig-
12	nated), by striking "or (p)" and inserting "or (q)";
13	(5) in subsection (m) (as so redesignated), by
14	striking "subsection (k)(3)" and inserting "sub-
15	section (l)(3)";
16	(6) in subsection (q) (as so redesignated), by
17	striking "subsection (k)(3)(G)" and inserting "sub-
18	section $(1)(3)(G)$ "; and
19	(7) in subsection (s)(2)(A) (as so redesignated),
20	by striking "subsection (k)" each place that such ap-
21	pears and inserting "subsection (l)".
22	SEC. 303. GRANT APPLICATION PROCESS.
23	Section 330(k) of the Public Health Service Act (42
24	U.S.C. 254b(k)) is amended by adding at the end the fol-
25	lowing:

"(A) IN GENERAL.—In considering applications under this section, the Secretary shall ensure that an application that demonstrates economic viability, consistent with funding guidelines established by the Secretary for purposes of this section, is not disadvantaged in the evaluation process on the basis that it relies solely on Federal funding.

"(B) QUALIFICATION OF INDIVIDUALS RE-VIEWING APPLICATIONS.—The Secretary shall require verification that all individuals who are evaluating community health center grant applications have completed within the 3-year period ending on the date on which the application is being evaluated a training course on the community health center program which addresses the purposes served by community health centers, the critical role of community health centers in the safety net, expectations for the evaluation of applications, and the criteria for awarding grant funding.

"(C) MEDICALLY UNDERSERVED DESIGNATIONS.—Not later than 6 months after the date of enactment of this paragraph, the Adminis-

1 trator of the Health Resources and Services Ad-2 ministration shall submit to the appropriate 3 committees of Congress a report concerning the 4 process for designating an area or population as 5 medically underserved. Such report shall con-6 tain recommendations for ensuring that such 7 designations are current within the last 3 years. 8 The report shall also detail plans for ensuring 9 subsequent review to maintain an accurate re-10 flection of community needs in areas and popu-11 lations designated as medically underserved. 12 Not later than 1 year after such date of enact-13 ment, the Secretary shall promulgate regula-14 tions based on the recommendations contained 15 in the report.".

Subtitle B—Qualified Integrated Health Care systems

- 18 SEC. 321. GRANTS TO QUALIFIED INTEGRATED HEALTH
 19 CARE SYSTEMS.
- 20 (a) Eligibility for Grants Under PHSA.—Part
- 21 D of title III of the Public Health Service Act (42 U.S.C.
- 22 254b et seq.) is amended by adding at the end the fol-
- 23 lowing new subpart:

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1	"Subpart XI—Promotion of Integrated Health Care
2	Systems Serving Medically Underserved Populations
3	"SEC. 340H. GRANTS TO QUALIFIED INTEGRATED HEALTH
4	CARE SYSTEMS.
5	"(a) Definitions.—For purposes of this section:
6	"(1) Qualified integrated health care
7	SYSTEM.—The term 'qualified integrated health care
8	system' means an integrated health care system
9	that—
10	"(A) has a demonstrated capacity and
11	commitment to provide a full range of primary,
12	specialty, and hospital care to a medically un-
13	derserved population in both inpatient and out-
14	patient settings, as appropriate;
15	"(B) is organized to provide such care in
16	a coordinated fashion;
17	"(C) operates one or more integrated
18	health centers meeting the requirements of sec-
19	tion 340I;
20	"(D) meets the requirements of subsection
21	(e)(3); and
22	"(E) agrees to use any funds received
23	under this section to supplement and not to
24	supplant amounts received from other sources
25	for the provision of such care.

1	"(2) Medically underserved popu-
2	LATION.—The term 'medically underserved popu-
3	lation' has the meaning given such term in section
4	330(b)(3).
5	"(b) Operating Grants.—
6	"(1) AUTHORITY.—The Secretary may make
7	grants to private nonprofit entities for the costs of
8	the operation of qualified integrated health care sys-
9	tems that provide primary, specialty, and hospital
10	care to medically underserved populations.
11	"(2) Amount.—
12	"(A) In general.—The amount of any
13	grant made in any fiscal year under paragraph
14	(1) to an integrated health care system shall be
15	determined by the Secretary (taking into ac-
16	count the full range of care, including specialty
17	services, provided by the system), but may not
18	exceed the amount by which the costs of oper-
19	ation of the system in such fiscal year exceed
20	the total of—
21	"(i) State, local, and other operational
22	funding provided to the system; and
23	"(ii) the fees, premiums, and third-
24	party reimbursements which the system

1	may reasonably be expected to receive for
2	its operations in such fiscal year.
3	"(B) Payments.—Payments under grants
4	under paragraph (1) shall be made in advance
5	or by way of reimbursement and in such install-
6	ments as the Secretary finds necessary and ad-
7	justments may be made for overpayments or
8	underpayments.
9	"(C) USE OF NONGRANT FUNDS.—
10	Nongrant funds described in clauses (i) and (ii)
11	of subparagraph (A), including any such funds
12	in excess of those originally expected, shall be
13	used as permitted under this section, and may
14	be used for such other purposes as are not spe-
15	cifically prohibited under this section if such
16	use furthers the objectives of the project.
17	"(c) Applications.—
18	"(1) Submission.—No grant may be made
19	under this section unless an application therefore is
20	submitted to, and approved by, the Secretary. Such
21	an application shall be submitted in such form and
22	manner and shall contain such information as the

Secretary shall prescribe.

"(2) Description of Need.—

23

1	"(A) In general.—An application for a
2	grant under subsection (b)(1) for an integrated
3	health care system shall include—
4	"(i) a description of the need for
5	health care services in the area served by
6	the integrated health care system;
7	"(ii) a demonstration by the applicant
8	that the area or the population group to be
9	served by the applicant has a shortage of
10	personal health services; and
11	"(iii) a demonstration that the health
12	care system will be located so that it will
13	provide services to the greatest number of
14	individuals residing in such area or in-
15	cluded in such population group.
16	"(B) Demonstrations.—A demonstra-
17	tion shall be made under clauses (ii) or (iii) of
18	subparagraph (A) on the basis of the criteria
19	prescribed by the Secretary under section
20	330(b)(3) or on the basis of any other criteria
21	which the Secretary may prescribe to determine
22	if the area or population group to be served by
23	the applicant has a shortage of personal health
24	services.

1	"(C) Condition of Approval.—In con-
2	sidering an application for a grant under sub-
3	section (b)(1), the Secretary may require as a
4	condition to the approval of such application an
5	assurance that any integrated health center op-
6	erated by the applicant will provide any re-
7	quired primary health services and any addi-
8	tional health services (as defined in section
9	340I) that the Secretary finds are needed to
10	meet specific health needs of the area to be
11	served by the applicant. Such a finding shall be
12	made in writing and a copy shall be provided to
13	the applicant.
14	"(3) Requirements.—The Secretary shall ap-
15	prove an application for a grant under subsection
16	(b)(1) if the Secretary determines that the entity for
17	which the application is submitted is an integrated
18	health care system (within the meaning of subsection
19	(a)) and that—
20	"(A) the primary, specialty, and hospital
21	care provided by the system will be available
22	and accessible in the service area of the system
23	promptly, as appropriate, and in a manner

which assures continuity;

1	"(B) the system is participating (or will
2	participate) in a community consortium of safe-
3	ty net providers serving such area (unless other
4	such safety net providers do not exist in a com-
5	munity, decline or refuse to participate, or place
6	unreasonable conditions on their participation);
7	"(C) all of the centers operated by the sys-
8	tem are accredited by a national accreditation
9	body recognized by the Secretary;
10	"(D) the system will demonstrate its finan-
11	cial responsibility by the use of such accounting
12	procedures and other requirements as may be
13	prescribed by the Secretary;
14	"(E) the system provides or will provide
15	services to individuals who are eligible for med-
16	ical assistance under title XIX of the Social Se-
17	curity Act and to individuals who are eligible
18	for assistance under title XXI of such Act;
19	"(F) the system—
20	"(i) has prepared a schedule of fees or
21	payments for the provision of its services
22	consistent with locally prevailing rates or
23	charges and designed to cover its reason-
24	able costs of operation and has prepared a
25	corresponding schedule of discounts to be

1	applied to the payment of such fees or pay-
2	ments, and which discounts are adjusted
3	on the basis of the patient's ability to pay
4	"(ii)(I) will assure that no patient will
5	be denied health care services due to an in-
6	dividual's inability to pay for such services;
7	and
8	"(II) will assure that any fees or pay-
9	ments required by the system for such
10	services will be reduced or waived to enable
11	the system to fulfill the assurance de-
12	scribed in subclause (I); and
13	"(iii) has submitted to the Secretary
14	such reports as the Secretary may require
15	to determine compliance with this subpara-
16	graph;
17	"(G) the system has established a gov-
18	erning board that selects the services to be pro-
19	vided by the center, approves the center's an-
20	nual budget, approves the selection of a director
21	for the center, and establishes general policies
22	for the center;
23	"(H) the system has developed—

1	"(i) an overall plan and budget that
2	meets the requirements of the Secretary;
3	and
4	"(ii) an effective procedure for com-
5	piling and reporting to the Secretary such
6	statistics and other information as the Sec-
7	retary may require relating to—
8	"(I) the costs of its operations;
9	"(II) the patterns of use of its
10	services;
11	"(III) the availability, accessi-
12	bility, and acceptability of its services;
13	and
14	"(IV) such other matters relating
15	to operations of the applicant as the
16	Secretary may require;
17	"(I) the system will review periodically its
18	service area to—
19	"(i) ensure that the size of such area
20	is such that the services to be provided
21	through the system (including any sat-
22	ellite) are available and accessible to the
23	residents of the area promptly and as ap-
24	propriate;

1	"(ii) ensure that the boundaries of
2	such area conform, to the extent prac-
3	ticable, to relevant boundaries of political
4	subdivisions, school districts, and Federal
5	and State health and social service pro-
6	grams; and
7	"(iii) ensure that the boundaries of
8	such area eliminate, to the extent possible,
9	barriers to access to the services of the
10	system, including barriers resulting from
11	the area's physical characteristics, its resi-
12	dential patterns, its economic and social
13	grouping, and available transportation;
14	"(J) in the case of a system which serves
15	a substantial proportion of individuals of lim-
16	ited English-speaking ability, the system has—
17	"(i) developed a plan and made ar-
18	rangements for providing services, to the
19	extent practicable, in the predominant lan-
20	guage or languages of such individuals and
21	in the cultural context most appropriate to
22	such individuals; and
23	"(ii) identified one or more individuals
24	on its staff who are fluent in such pre-
25	dominant language or languages and in

1	English and whose responsibilities shall in-
2	clude providing guidance to such individ-
3	uals and to other appropriate staff mem-
4	bers with respect to cultural sensitivities
5	and bridging linguistic and cultural dif-
6	ferences;
7	"(K) the system maintains appropriate re-
8	ferral relationships between its hospitals, its
9	physicians with hospital privileges, and any in-
10	tegrated health center operated by the system
11	so that primary, specialty care, and hospital
12	care is provided in a continuous and coordi-
13	nated way; and
14	"(L) the system encourages persons receiv-
15	ing or seeking health services from the system
16	to participate in any public or private (includ-
17	ing employer-offered) health programs or plans
18	for which the persons are eligible, so long as the
19	center, in complying with this paragraph, does
20	not violate the requirements of subparagraph
21	(F)(ii)(I).
22	"(d) Authorization of Appropriations.—
23	"(1) In General.—There are authorized to be
24	appropriated to carry out this section such sums as

1 may be necessary for each of fiscal years 2006 2 through 2010.

"(2) Funding report.—The Secretary shall annually prepare and submit to the appropriate committees of Congress a report concerning the distribution of funds under this section that are provided to meet the health care needs of medically underserved populations, and the appropriateness of the delivery systems involved in responding to the needs of the particular populations. Such report shall include an assessment of the relative health care access needs of the targeted populations and the rationale for any substantial changes in the distribution of funds.

"(e) Records.—

- "(1) IN GENERAL.—Each entity which receives a grant under subsection (b)(1) shall establish and maintain such records as the Secretary shall require.
- "(2) AVAILABILITY.—Each entity which is required to establish and maintain records under this subsection shall make such books, documents, papers, and records available to the Secretary or the Comptroller General of the United States, or any of their duly authorized representatives, for examination, copying, or mechanical reproduction on or off the premises of such entity upon a reasonable re-

quest therefore. The Secretary and the Comptroller
General of the United States, or any of their duly
authorized representatives, shall have the authority
to conduct such examination, copying, and reproduction.

"(f) Audits.—

"(1) IN GENERAL.—Each entity which receives a grant under this section shall provide for an independent annual financial audit of any books, accounts, financial records, files, and other papers and property which relate to the disposition or use of the funds received under such grant and such other funds received by or allocated to the project for which such grant was made. For purposes of assuring accurate, current, and complete disclosure of the disposition or use of the funds received, each such audit shall be conducted in accordance with generally accepted accounting principles. Each audit shall evaluate—

- "(A) the entity's implementation of the guidelines established by the Secretary respecting cost accounting;
- "(B) the processes used by the entity to meet the financial and program reporting requirements of the Secretary; and

1 "(C) the billing and collection procedures 2 of the entity and the relation of the procedures 3 to its fee schedule and schedule of discounts 4 and to the availability of health insurance and 5 public programs to pay for the health services 6 it provides.

A report of each such audit shall be filed with the Secretary at such time and in such manner as the Secretary may require.

- "(2) Records.—Each entity which receives a grant under this section shall establish and maintain such records as the Secretary shall by regulation require to facilitate the audit required by paragraph (1). The Secretary may specify by regulation the form and manner in which such records shall be established and maintained.
- "(3) AVAILABILITY OF RECORDS.—Each entity which is required to establish and maintain records or to provide for an audit under this subsection shall make such books, documents, papers, and records available to the Secretary or the Comptroller General of the United States, or any of their duly authorized representatives, for examination, copying, or mechanical reproduction on or off the premises of such entity upon a reasonable request therefore. The

- 1 Secretary and the Comptroller General of the United
- 2 States, or any of their duly authorized representa-
- 3 tives, shall have the authority to conduct such exam-
- 4 ination, copying, and reproduction.
- 5 "(4) WAIVER.—The Secretary may, under ap-
- 6 propriate circumstances, waive the application of all
- 7 or part of the requirements of this subsection with
- 8 respect to an entity.

9 "SEC. 340I. INTEGRATED HEALTH CENTER.

- 10 "(a) Integrated Health Center.—The term 'in-
- 11 tegrated health center' means an health center that is op-
- 12 erated by an integrated health care system and that serves
- 13 a medically underserved population (as defined for pur-
- 14 poses of section 330(b)(3)) by providing, either through
- 15 the staff and supporting resources of the center or through
- 16 contracts or cooperative arrangements—
- 17 "(1) required primary health services (as de-
- 18 fined in subsection (b)(1); and
- 19 "(2) as may be appropriate for particular cen-
- ters additional health services (as defined in sub-
- section (b)(2)) necessary for the adequate support of
- the primary health services required under para-
- 23 graph (1);
- 24 for all residents of the area served by the center.
- 25 "(b) Definitions.—For purposes of this section:

1	"(1) Required primary health services.—
2	The term 'required primary health services' means—
3	"(A) basic health services which, for pur-
4	poses of this section, shall consist of—
5	"(i) health services related to family
6	medicine, internal medicine, pediatrics, ob-
7	stetrics, or gynecology that are furnished
8	by physicians and where appropriate, phy-
9	sician assistants, nurse practitioners, and
10	nurse midwives;
11	"(ii) diagnostic laboratory and
12	radiologic services;
13	"(iii) preventive health services, in-
14	cluding—
15	"(I) prenatal and perinatal serv-
16	ices;
17	"(II) appropriate cancer screen-
18	ing;
19	"(III) well-child services;
20	"(IV) immunizations against vac-
21	cine-preventable diseases;
22	"(V) screenings for elevated
23	blood lead levels, communicable dis-
24	eases, and cholesterol;

1	"(VI) pediatric eye, ear, and den-
2	tal screenings to determine the need
3	for vision and hearing correction and
4	dental care;
5	"(VII) voluntary family planning
6	services; and
7	"(VIII) preventive dental serv-
8	ices;
9	"(iv) emergency medical services; and
10	"(v) pharmaceutical services and
11	medication therapy management services
12	as may be appropriate for particular cen-
13	ters;
14	"(B) referrals to providers of medical serv-
15	ices (including specialty and hospital care refer-
16	rals when medically indicated) and other health-
17	related services (including substance abuse and
18	mental health services);
19	"(C) patient case management services (in-
20	cluding counseling, referral, and follow-up serv-
21	ices) and other services designed to assist
22	health center patients in establishing eligibility
23	for and gaining access to Federal, State, and
24	local programs that provide or financially sup-

I	port the provision of medical, social, housing,
2	educational, or other related services;
3	"(D) services that enable individuals to use
4	the services of the center (including outreach
5	and transportation services and, if a substantial
6	number of the individuals in the population
7	served by a center are of limited English-speak-
8	ing ability, the services of appropriate personnel
9	fluent in the languages spoken by a predomi-
10	nant number of such individuals); and
11	"(E) education of patients and the general
12	population served by the center regarding the
13	availability and proper use of health services.
14	"(2) Additional Health Services.—The
15	term 'additional health services' means services that
16	are not included as required primary health services
17	and that are appropriate to meet the health needs
18	of the population served by the center involved. Such
19	term may include—
20	"(A) behavioral and mental health and
21	substance abuse services;
22	"(B) recuperative care services; and
23	"(C) environmental health services.".
24	(b) Coverage Under the Medicare Program.—

1	(1) Part B benefit.—Section $1861(s)(2)(E)$
2	of the Social Security Act (42 U.S.C.
3	1395x(s)(2)(E)) is amended—
4	(A) by striking "services and" and insert-
5	ing "services,"; and
6	(B) by striking "services" the second place
7	it appears and inserting "services, and inte-
8	grated health center services".
9	(2) Definitions.—Section 1861(aa) of the So-
10	cial Security Act (42 U.S.C. 1395x(aa)) is amend-
11	ed—
12	(A) in the heading—
13	(i) by striking "Services and" and
14	inserting "Services,"; and
15	(ii) by striking "Services" the sec-
16	ond place it appears and inserting "Serv-
17	ICES, AND INTEGRATED HEALTH CENTER
18	Services";
19	(B) in paragraph (1)(B), by striking
20	"paragraph (5))" and inserting "paragraph
21	(7));
22	(C) by redesignating paragraphs (5), (6),
23	and (7) as paragraphs (7), (8), and (9), respec-
24	tively; and

1	(D) by inserting after paragraph (4) the
2	following new paragraph:
3	"(5) The term 'integrated health center services'
4	means—
5	"(A) services of the type described in subpara-
6	graphs (A) through (C) of paragraph (1); and
7	"(B) preventive primary health services that a
8	center is required to provide under section 340I of
9	the Public Health Service Act,
10	when furnished to an individual as an outpatient of an
11	integrated health center, and for this purpose, any ref-
12	erence to a rural health clinic or a physician described in
13	paragraph (2)(B) is deemed a reference to an integrated
14	health center or a physician at the center, respectively.
15	"(6) The term 'integrated health center' means a cen-
16	ter that is operated by a qualified integrated health care
17	system (as defined in section 340H(a)(1) of the Public
18	Health Service Act that—
19	"(A) is receiving a grant under section 340H of
20	such Act; or
21	"(B) is determined by the Secretary to meet the
22	requirements for receiving such a grant.".
23	(3) Payment.—

1	(A) In General.—Section 1832(a)(2)(D)
2	of the Social Security Act (42 U.S.C.
3	1395k(a)(2)(D)) is amended—
4	(i) by striking "and (ii)" and inserting
5	", (ii)"; and
6	(ii) by striking "services" the second
7	place it appears and inserting "services,
8	and (iii) integrated health center serv-
9	ices.".
10	(B) Part b deductible does not
11	APPLY.—Section 1833(b)(4) of the Social Secu-
12	rity Act (42 U.S.C. 13951(b)(4)) is amended by
13	inserting "or integrated health center services"
14	after "Federally qualified health center serv-
15	ices".
16	(C) EXCLUSION FROM PAYMENT RE-
17	MOVED.—The second sentence of section
18	1862(a) of the Social Security Act (42 U.S.C.
19	1395y(a)) is amended by inserting "or inte-
20	grated health center services described in sec-
21	tion 1861 (aa) $(5)(B)$ " after "section
22	1861(aa)(3)(B)".
23	(D) WAIVER OF ANTI-KICKBACK RESTRIC-
24	TION.—Section 1128B(b)(3)(D) of the Social
25	Security Act (42 U.S.C. 1320a-7b(b)(3)(D)) is

1	amended by inserting "or by an integrated
2	health center" after "Federally qualified health
3	center".
4	(4) Conforming amendments.—(A) Clauses
5	(ii) and (iv) of section 1834(a)(1)(E) of the Social
6	Security Act (42 U.S.C. 1395m(a)(1)(E)) are each
7	amended by striking "section 1861(aa)(5)" and in-
8	serting "section 1861(aa)(7)".
9	(B) Section 1842(b)(18)(C)(i) of the Social Se-
10	curity Act (42 U.S.C. 1395u(b)(18)(C)(i)) is amend-
11	ed by striking "section 1861(aa)(5)" and inserting
12	"section 1861(aa)(7)".
13	(C) Section 1861(s)(2) of the Social Security
14	Act (42 U.S.C. 1395x(s)(2)) is amended—
15	(i) in subparagraph (H)(i), by striking
16	"subsection (aa)(5)" and inserting "subsection
17	(aa)(7)"; and
18	(ii) in subparagraph (K)—
19	(I) by striking "subsection (aa)(5)"
20	each place it appears and inserting "sub-
21	section (aa)(7)"; and
22	(II) by striking "subsection (aa)(6)"
23	and inserting "subsection (aa)(8)".
24	(D) Section 1861(dd)(3)(B) of the Social Secu-
25	rity Act (42 U.S.C. 1395x(dd)(3)(B)) is amended by

1	striking "subsection (aa)(5)" and inserting "sub-
2	section (aa)(7)".
3	(c) RECOGNITION UNDER MEDICAID.—
4	(1) Coverage.—Section 1905(a)(2) of the So-
5	cial Security Act (42 U.S.C. 1396d(a)(2)) is amend-
6	ed —
7	(A) by striking "and (C)" and inserting ",
8	(C)"; and
9	(B) by inserting ", and
10	"(D) integrated health center services (as
11	defined in subsection (1)(3)(A)) and any other
12	ambulatory services offered by the integrated
13	health center and which are otherwise included
14	in the plan." after "included in the plan" the
15	second place it appears.
16	(2) Definitions.—Section 1905(l) of such Act
17	(42 U.S.C. 1396d(l)) is amended by adding at the
18	end the following:
19	"(3)(A) The term 'integrated health center services'
20	means services of the type described in subparagraphs (A)
21	through (C) of section 1861(aa) when furnished to an in-
22	dividual as a patient of an integrated health center and,
23	for this purpose, any reference to a rural health clinic or
24	a physician described in section 1861(aa)(2)(B) is deemed

1	a reference to an integrated health center or a physician
2	at the center, respectively.
3	"(B) The term 'integrated health center' means a
4	center that is operated by a qualified integrated health
5	care system that—
6	"(i) is receiving a grant under section 340H of
7	the Public Health Service Act; or
8	"(ii) is determined by the Secretary, based on
9	the recommendations of the Administrator of the
10	Centers for Medicare & Medicaid Services, to meet
11	the requirements for receiving such a grant.".
12	(3) Payment.—Section 1902(a) of such Act
13	(42 U.S.C. 1396a(a)) is amended—
14	(A) in paragraph (15), by inserting "and
15	for services described in clause (D) of section
16	1905(a)(2) in accordance with the provisions of
17	subsection (cc)" after "subsection (bb)"; and
18	(B) by adding at the end the following:
19	"(cc) Payment for Services Provided by Inte-
20	GRATED HEALTH CENTERS.—
21	"(1) In general.—Beginning with fiscal year
22	2006 with respect to services furnished on or after
23	January 1, 2006, and each succeeding fiscal year,
24	the State plan shall provide for payment for services
25	described in section 1905(a)(2)(D) furnished by an

1 integrated health center in accordance with the pro-2 visions of this subsection.

> "(2) FISCAL YEAR 2006.—Subject to paragraph (4), for services furnished on and after January 1, 2006, during fiscal year 2006, the State plan shall provide for payment for such services in an amount (calculated on a per visit basis) that is equal to 100 percent of the average of the costs of the center of furnishing such services during fiscal years 2004 and 2005 which are reasonable and related to the cost of furnishing such services, or based on such other tests of reasonableness as the Secretary prescribes in regulations under section 1833(a)(3), or, in the case of services to which such regulations do not apply, the same methodology used under section 1833(a)(3), adjusted to take into account any increase or decrease in the scope of such services furnished by the center during fiscal years 2004 and 2005.

> "(3) FISCAL YEAR 2007 AND SUCCEEDING FISCAL YEARS.—Subject to paragraph (4), for services furnished during fiscal year 2007 or a succeeding fiscal year, the State plan shall provide for payment for such services in an amount (calculated on a per visit basis) that is equal to the amount calculated for

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1	such services under this subsection for the preceding
2	fiscal year—
3	"(A) increased by the percentage increase
4	in the MEI (as defined in section 1842(i)(3))
5	for that fiscal year; and
6	"(B) adjusted to take into account any in-
7	crease or decrease in the scope of such services
8	furnished by the center during that fiscal year.
9	"(4) Establishment of initial year pay-
10	MENT AMOUNT FOR NEW CENTERS.—In any case in
11	which an entity first qualifies as an integrated
12	health center after fiscal year 2006, the State plan
13	shall provide for payment for services described in
14	section 1905(a)(2)(D) furnished by the center in the
15	first fiscal year in which the center so qualifies in
16	an amount (calculated on a per visit basis) that is
17	equal to 100 percent of the costs of furnishing such
18	services during such fiscal year based on the rates
19	established under this subsection for the fiscal year
20	for other such centers located in the same or adja-
21	cent area with a similar case load or, in the absence
22	of such a center, in accordance with the regulations
23	and methodology referred to in paragraph (2) or
24	based on such other tests of reasonableness as the
25	Secretary may specify. For each fiscal year following

the fiscal year in which the entity first qualifies as
an integrated health center, the State plan shall pro-
vide for the payment amount to be calculated in ac-
cordance with paragraph (3).

- "(5) Administration in the case of managed care.—
 - "(A) IN GENERAL.—In the case of services furnished by an integrated health center pursuant to a contract between the center and a managed care entity (as defined in section 1932(a)(1)(B)), the State plan shall provide for payment to the center by the State of a supplemental payment equal to the amount (if any) by which the amount determined under paragraphs (2), (3), and (4) exceeds the amount of the payments provided under the contract.
 - "(B) Payment schedule.—The supplemental payment required under subparagraph (A) shall be made pursuant to a payment schedule agreed to by the State and the integrated health center, but in no case less frequently than every 4 months.
- "(6) ALTERNATIVE PAYMENT METHODOLO-GIES.—Notwithstanding any other provision of this section, the State plan may provide for payment in

1	any fiscal year to an integrated health center for
2	services described in section $1905(a)(2)(D)$ in an
3	amount which is determined under an alternative
4	payment methodology that—
5	"(A) is agreed to by the State and the cen-
6	ter; and
7	"(B) results in payment to the center of an
8	amount which is at least equal to the amount
9	otherwise required to be paid to the center
10	under this section.".
11	(4) Waiver prohibited.—Section 1915(b) of
12	the Social Security Act (42 U.S.C.1396n(b)) is
13	amended in the matter preceding paragraph (1), by
14	inserting "1902(cc)," after "1902(bb),".
15	(d) Protection Against Liability.—Section
16	224(g) of the Public Health Service Act (42 U.S.C.
17	233(g)) is amended—
18	(1) In paragraph (4), by striking "An entity"
19	and inserting "Subject to paragraph (6), an entity";
20	and
21	(2) by adding at the end the following:
22	"(6) For purposes of this section—
23	"(A) a qualified integrated health care system
24	receiving a grant under section 340H and any inte-
25	grated health center operated by such system shall

1	be considered to be an entity described in paragraph
2	(4); and
3	"(B) the provisions of this section shall apply to
4	such system and centers in the same manner as such
5	provisions apply to an entity described in such para-
6	graph (4), except that—
7	"(i) notwithstanding paragraph (1)(B), the
8	deeming of any system or center, or of an offi-
9	cer, governing board member, employee, or con-
10	tractor of such system or center, to be an em-
11	ployee of the Public Health Service for purposes
12	of this section shall apply only with respect to
13	items and services that are furnished to a mem-
14	ber of the underserved population served by the
15	entity;
16	"(ii) notwithstanding paragraph (3), this
17	paragraph shall apply only with respect to
18	causes of action arising from acts or omissions
19	that occur on or after January 1, 2006; and
20	"(iii) the Secretary shall make separate es-
21	timates under subsection $(k)(1)$ with respect to
22	such systems and centers and entities described
23	in paragraph (4) (other than such systems and
24	centers), establish separate funds under sub-
25	section (k)(2) with respect to such groups of

1	entities, and any appropriations under this sub-
2	section for such systems and centers shall be
3	separate from the amounts authorized by sub-
4	section $(k)(2)$.".
5	(e) Effective Date.—The amendments made sub-
6	sections (b) and (c) shall apply to items and services fur-
7	nished on or after October 1, 2005.
8	Subtitle C—Miscellaneous
9	Provisions
10	SEC. 331. COMMUNITY HEALTH CENTER COLLABORATIVE
11	ACCESS EXPANSION.
12	Section 330 of the Public Health Service Act (42
13	U.S.C. 254b) is amended by adding at the end the fol-
14	lowing:
15	"(s) Miscellaneous Provisions.—
16	"(1) Rule of construction with respect
17	TO RURAL HEALTH CLINICS.—
18	"(A) In general.—Nothing in this sec-
19	tion shall be construed to prevent a community
20	health center from contracting with a federally
21	certified rural health clinic (as defined by sec-
22	tion 1861(aa)(2) of the Social Security Act) for
23	the delivery of primary health care services that
24	are available at the rural health clinic to indi-
25	viduals who would otherwise be eligible for free

1	or reduced cost care if that individual were able
2	to obtain that care at the community health
3	center. Such services may be limited in scope to
4	those primary health care services available in
5	that rural health clinic.
6	"(B) Assurances.—In order for a rural
7	health clinic to receive funds under this section
8	through a contract with a community health
9	center under paragraph (1), such rural health
10	clinic shall establish policies to ensure—
11	"(i) nondiscrimination based upon the
12	ability of a patient to pay; and
13	"(ii) the establishment of a sliding fee
14	scale for low-income patients.".
15	SEC. 332. IMPROVEMENTS TO SECTION 340B PROGRAM.
16	(a) Elimination of Group Purchasing Prohibi-
17	TION FOR CERTAIN HOSPITALS.—Section 340B(a)(4)(L)
18	of the Public Health Service Act (42 U.S.C.
19	256b(a)(4)(L)) is amended—
20	(1) in clause (i), by adding "and" at the end;
21	(2) in clause (ii), by striking "; and and in-
22	serting a period; and
23	(3) by striking clause (iii).
24	(b) Permitting Use of Multiple Contract
25	Pharmacies.—Section 340B f the Public Health Service

1	Act (42 U.S.C. 256b) is amended by adding at the end
2	the following:
3	"(e) Permitting Use of Multiple Contract
4	Pharmacies.—Nothing in this section shall be construed
5	as prohibiting a covered entity from entering into con-
6	tracts with more than one pharmacy for the provision of
7	covered drugs, including a contract that—
8	"(1) supplements the use of an in-house phar-
9	macy arrangement; or
10	"(2) requires the approval of the Secretary.".
11	(c) Improvements in Program Administra-
12	${\tt TION.}{\tt}{\tt Section}$ 340B of the Public Health Service Act (42
13	U.S.C. 256b), as amended by subsection (b), is further
14	amended by adding at the end the following:
15	"(f) Improvements in Program Administra-
16	TION.—
17	"(1) In General.—The Secretary shall pro-
18	vide, from funds appropriated under paragraph (2),
19	for improvements in the integrity and administration
20	of the program under this section in order to pre-
21	vent abuse and misuse of discounted prices made
22	available under this section. Such improvements
23	shall include the following:
24	"(A) The development of a system to verify
25	the accuracy of information regarding covered

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1	entities that is listed on the Internet website of
2	the Department of Health and Human Services
3	relating to this section.
4	"(B) The establishment of a third-party
5	auditing system by which covered entities and
6	manufacturers are regularly audited to ensure
7	compliance with the requirements of this sec-
8	tion.
9	"(C) The conduct of such audits under
10	subsection (a)(5)(C) that supplement the audits
11	conducted under subparagraph (B) as the Sec-
12	retary determines appropriate and the imple-
13	mentation of dispute resolution guidelines and
14	other compliance programs.
15	"(D) The development of more detailed
16	guidance regarding the definition of section
17	340B patients and describing options for billing
18	under the medicaid program under title XIX of
19	the Social Security Act in order to avoid dupli-
20	cative discounts.
21	"(E) The issuance of advisory opinions

"(E) The issuance of advisory opinions within defined time periods in response to questions from manufacturers or covered entities regarding the application of the requirements of this section in specific factual circumstances.

1	"(F) Insofar as the Secretary determines
2	feasible, providing access through the Internet
3	website of the Department of Health and
4	Human Services on the prices for covered drugs
5	made available under this section, but only in a
6	manner (such as through the use of password
7	protection) that limits such access to covered
8	entities.
9	"(G) The improved dissemination of edu-
10	cational materials regarding the program under
11	this section to covered entities that are not cur-
12	rently participating in such programs including
13	regional educational sessions.
14	"(2) Authorization of appropriations.—
15	There are authorized to be appropriated to carry out
16	this subsection, such sums as may be necessary for
17	fiscal year 2006 and each succeeding fiscal year.".
18	SEC. 333. FORBEARANCE FOR STUDENT LOANS FOR PHYSI-
19	CIANS PROVIDING SERVICES IN FREE CLIN-
20	ICS.
21	(a) In General.—Section 428(c)(3)(A) of the High-
22	er Education Act of 1965 (20 U.S.C. 1078(c)(3)(A)) is
23	amended—
24	(1) in clause (i)—

1	(A) in subclause (III), by striking "or" at
2	the end;
3	(B) in subclause (V), by adding "or" at
4	the end; and
5	(C) by adding at the end the following:
6	"(V) is volunteering without pay
7	for at least 80 hours per month at a
8	free clinic as defined under section
9	224 of the Public Health Service
10	Act;"; and
11	(2) in clause (ii)(III), by inserting "or (i)(V)"
12	after "clause (i)(III)".
13	(b) Perkins Program.—Section 464(e) of the High-
14	er Education Act of 1965 (20 U.S.C. $1087dd(e)$) is
15	amended—
16	(1) in paragraph (1), by striking "or" at the
17	end;
18	(2) in paragraph (2), by striking the period and
19	inserting "; or"; and
20	(3) by adding at the end the following:
21	"(3) the borrower is volunteering without pay
22	for at least 80 hours per month at a free clinic as
23	defined under section 224 of the Public Health Serv-
24	ice Act.".

1	SEC. 334. AMENDMENTS TO THE PUBLIC HEALTH SERVICE
2	ACT RELATING TO LIABILITY.
3	Section 224 of the Public Health Service Act (42
4	U.S.C. 233) is amended—
5	(1) in subsection $(g)(1)$ —
6	(A) in subparagraph (A)—
7	(i) in the first sentence, by striking
8	"or employee" and inserting "employee, or
9	(subject to subsection $(k)(4)$) volunteer
10	practitioner"; and
11	(ii) in the second sentence, by insert-
12	ing "and subsection $(k)(4)$ " after "subject
13	to paragraph (5)"; and
14	(B) by adding at the end the following:
15	"(I) For purposes of this subsection, the term 'em-
16	ployee' shall include a health professional who volunteers
17	to provide health-related services for an entity described
18	in paragraph (4).";
19	(2) in subsection (k), by adding at the end the
20	following:
21	"(4)(A) Subsections (g) through (m) apply with re-
22	spect to volunteer practitioners beginning with the first
23	fiscal year for which an appropriations Act provides that
24	amounts in the fund under paragraph (2) are available
25	with respect to such practitioners.

1	"(B) For purposes of subsections (g) through (m),
2	the term 'volunteer practitioner' means a practitioner who,
3	with respect to an entity described in subsection $(g)(4)$,
4	meets the following conditions:
5	"(i) The practitioner is a licensed physician or
6	a licensed clinical psychologist.
7	"(ii) At the request of such entity, the practi-
8	tioner provides services to patients of the entity, at
9	a site at which the entity operates or at a site des-
10	ignated by the entity. The weekly number of hours
11	of services provided to the patients by the practi-
12	tioner is not a factor with respect to meeting condi-
13	tions under this subparagraph.
14	"(iii) The practitioner does not for the provision
15	of such services receive any compensation from such
16	patients, from the entity, or from third-party payors
17	(including reimbursement under any insurance pol-
18	icy or health plan, or under any Federal or State
19	health benefits program).";
20	(3) in subsection $(0)(2)$ —
21	(A) in subparagraph (D), by striking
22	clause (i) and inserting the following:
23	"(i) The health care practitioner may pro-
24	vide the services involved as an employee of the
25	free clinic, or may receive repayment from the

1	free clinic only for reasonable expenses incurred
2	by the health care practitioner in the provision
3	of the services to the individual."; and
4	(B) by adding at the end the following:
5	"(G) The health care practitioner is providing
6	the services involved as a paid employee of the free
7	elinie."; and
8	(4) in each of subsections (g), (i), (j), (k), (l),
9	and (m), by striking "employee, or contractor" each
10	place such term appears and inserting "employee,
11	volunteer practitioner, or contractor".
12	SEC. 335. SENSE OF THE SENATE CONCERNING HEALTH
13	DISPARITIES.
14	It is the sense of the Senate that additional measures
15	are needed to reduce or eliminate disparities in health care
16	related to race, ethnicity, socioeconomic status, and geog-
17	raphy that affect access to quality health care.

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