

109TH CONGRESS
1ST SESSION

S. 4

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 27, 2005

Mr. FRIST (for himself, Mr. McCONNELL, Mr. GREGG, Mr. ENZI, Ms. MURKOWSKI, Mr. DEMINT, Mr. COBURN, and Mr. CORNYN) 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 value-based 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-medicare 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.**

2 Congress makes the following findings:

3 (1) Health care costs are growing rapidly, put-
4 ting health insurance and needed care out of reach
5 for too many Americans.

6 (2) Rapidly growing health care costs pose a
7 threat to the United States economy, as they make
8 American businesses less competitive and make it
9 more difficult to create new jobs.

10 (3) Growing health care costs are compromising
11 the stability of health care safety net and entitle-
12 ment programs.

13 (4) There are a series of steps Congress can
14 and should take to slow the growth of health care
15 costs, expand access to health coverage, and improve
16 access to quality health care for millions of Ameri-
17 cans.

1 **TITLE I—MAKING HEALTH CARE**
2 **MORE AFFORDABLE**
3 **Subtitle A—Medical Liability**
4 **Reform**

5 **SEC. 101. SHORT TITLE.**

6 This subtitle may be cited as the “Patients First Act
7 of 2005”.

8 **SEC. 102. FINDINGS AND PURPOSE.**

9 (a) FINDINGS.—

10 (1) EFFECT ON HEALTH CARE ACCESS AND
11 COSTS.—Congress finds that our current civil justice
12 system is adversely affecting patient access to health
13 care services, better patient care, and cost-efficient
14 health care, in that the current health care liability
15 system is a costly and ineffective mechanism for re-
16 solving claims of health care liability and compen-
17 sating injured patients, and is a deterrent to the
18 sharing of information among health care profes-
19 sionals which impedes efforts to improve patient
20 safety and quality of care.

21 (2) EFFECT ON INTERSTATE COMMERCE.—

22 Congress finds that the health care and insurance
23 industries are industries affecting interstate com-
24 merce and the health care liability litigation systems
25 existing throughout the United States are activities

1 that affect interstate commerce by contributing to
2 the high costs of health care and premiums for
3 health care liability insurance purchased by health
4 care system providers.

5 (3) EFFECT ON FEDERAL SPENDING.—Con-
6 gress finds that the health care liability litigation
7 systems existing throughout the United States have
8 a significant effect on the amount, distribution, and
9 use of Federal funds because of—

10 (A) the large number of individuals who
11 receive health care benefits under programs op-
12 erated or financed by the Federal Government;

13 (B) the large number of individuals who
14 benefit because of the exclusion from Federal
15 taxes of the amounts spent to provide them
16 with health insurance benefits; and

17 (C) the large number of health care pro-
18 viders who provide items or services for which
19 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

1 have been shown to be a factor in the decreased
2 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;

7 (3) ensure that persons with meritorious health
8 care injury claims receive fair and adequate com-
9 pensation, including reasonable noneconomic dam-
10 ages;

11 (4) improve the fairness and cost-effectiveness
12 of our current health care liability system to resolve
13 disputes over, and provide compensation for, health
14 care liability by reducing uncertainty in the amount
15 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.**

20 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

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; or

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
20 the claimant(s).

21 (2) $33\frac{1}{3}$ percent of the next \$50,000 recovered
22 by the claimant(s).

23 (3) 25 percent of the next \$500,000 recovered
24 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-

1 agnosis, and treatment of the disease or injury
2 which is the subject matter of the lawsuit
3 against the defendant, the individual was sub-
4 stantially familiar with applicable standards of
5 care and practice as they relate to the act or
6 omission which is the subject of the lawsuit on
7 the date of the incident.

8 (2) PHYSICIAN REVIEW.—In a health care law-
9 suit, if the claim of the plaintiff involved treatment
10 that is recommended or provided by a physician
11 (allopathic or osteopathic), an individual shall not be
12 qualified to be an expert witness under this sub-
13 section with respect to issues of negligence con-
14 cerning such treatment unless such individual is a
15 physician.

16 (3) SPECIALTIES AND SUBSPECIALTIES.—With
17 respect to a lawsuit described in paragraph (1), a
18 court shall not permit an expert in one medical spe-
19 cialty or subspecialty to testify against a defendant
20 in another medical specialty or subspecialty unless,
21 in addition to a showing of substantial familiarity in
22 accordance with paragraph (1)(B), there is a show-
23 ing that the standards of care and practice in the
24 two specialty or subspecialty fields are similar.

1 (4) LIMITATION.—The limitations in this sub-
2 section shall not apply to expert witnesses testifying
3 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-
19 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
4 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
9 prescribes a medical product approved or cleared by the
10 Food and Drug Administration shall not be named as a
11 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
19 award of future damages, without reduction to present
20 value, equaling or exceeding \$50,000 is made against a
21 party with sufficient insurance or other assets to fund a
22 periodic payment of such a judgment, the court shall, at
23 the request of any party, enter a judgment ordering that
24 the future damages be paid by periodic payments in ac-
25 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-
12 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, includ-
16 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 as-
20 serted or such an action is brought, whether de-
21 ceased, incompetent, or a minor.

22 (3) COLLATERAL SOURCE BENEFITS.—The
23 term “collateral source benefits” means any amount
24 paid or reasonably likely to be paid in the future to
25 or on behalf of the claimant, or any service, product

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
19 “compensatory damages” means objectively
20 verifiable monetary losses incurred as a result of the
21 provision of, use of, or payment for (or failure to
22 provide, use, or pay for) health care services or med-
23 ical products, such as past and future medical ex-
24 penses, loss of past and future earnings, cost of ob-
25 taining domestic services, loss of employment, and

1 loss of business or employment opportunities, dam-
2 ages for physical and emotional pain, suffering, in-
3 convenience, physical impairment, mental anguish,
4 disfigurement, loss of enjoyment of life, loss of soci-
5 ety and companionship, loss of consortium (other
6 than loss of domestic service), hedonic damages, in-
7 jury to reputation, and all other nonpecuniary losses
8 of any kind or nature. The term “compensatory
9 damages” includes economic damages and non-
10 economic damages, as such terms are defined in this
11 section.

12 (5) CONTINGENT FEE.—The term “contingent
13 fee” includes all compensation to any person or per-
14 sons which is payable only if a recovery is effected
15 on behalf of one or more claimants.

16 (6) ECONOMIC DAMAGES.—The term “economic
17 damages” means objectively verifiable monetary
18 losses incurred as a result of the provision of, use
19 of, or payment for (or failure to provide, use, or pay
20 for) health care services or medical products, such as
21 past and future medical expenses, loss of past and
22 future earnings, cost of obtaining domestic services,
23 loss of employment, and loss of business or employ-
24 ment opportunities.

1 (7) HEALTH CARE LAWSUIT.—The term
2 “health care lawsuit” means any health care liability
3 claim concerning the provision of health care goods
4 or services affecting interstate commerce, or any
5 health care liability action concerning the provision
6 of health care goods or services affecting interstate
7 commerce, brought in a State or Federal court or
8 pursuant to an alternative dispute resolution system,
9 against a health care provider, a health care organi-
10 zation, or the manufacturer, distributor, supplier,
11 marketer, promoter, or seller of a medical product,
12 regardless of the theory of liability on which the
13 claim is based, or the number of claimants, plain-
14 tiffs, defendants, or other parties, or the number of
15 claims or causes of action, in which the claimant al-
16 leges a health care liability claim.

17 (8) HEALTH CARE LIABILITY ACTION.—The
18 term “health care liability action” means a civil ac-
19 tion brought in a State or Federal Court or pursu-
20 ant to an alternative dispute resolution system,
21 against a health care provider, a health care organi-
22 zation, or the manufacturer, distributor, supplier,
23 marketer, promoter, or seller of a medical product,
24 regardless of the theory of liability on which the
25 claim is based, or the number of plaintiffs, defend-

1 ants, or other parties, or the number of causes of ac-
2 tion, in which the claimant alleges a health care li-
3 ability claim.

4 (9) HEALTH CARE LIABILITY CLAIM.—The
5 term “health care liability claim” means a demand
6 by any person, whether or not pursuant to ADR,
7 against a health care provider, health care organiza-
8 tion, or the manufacturer, distributor, supplier, mar-
9 keter, promoter, or seller of a medical product, in-
10 cluding, but not limited to, third-party claims, cross-
11 claims, counter-claims, or contribution claims, which
12 are based upon the provision of, use of, or payment
13 for (or the failure to provide, use, or pay for) health
14 care services or medical products, regardless of the
15 theory of liability on which the claim is based, or the
16 number of plaintiffs, defendants, or other parties, or
17 the number of causes of action.

18 (10) HEALTH CARE ORGANIZATION.—The term
19 “health care organization” means any person or en-
20 tity which is obligated to provide or pay for health
21 benefits under any health plan, including any person
22 or entity acting under a contract or arrangement
23 with a health care organization to provide or admin-
24 ister 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, reg-
6 istered, or certified, or exempted from such require-
7 ment by other statute or regulation.

8 (12) HEALTH CARE GOODS OR SERVICES.—The
9 term “health care goods or services” means any
10 goods or services provided by a health care organiza-
11 tion, provider, or by any individual working under
12 the supervision of a health care provider, that relates
13 to the diagnosis, prevention, or treatment of any
14 human disease or impairment, or the assessment of
15 the health of human beings.

16 (13) MALICIOUS INTENT TO INJURE.—The
17 term “malicious intent to injure” means inten-
18 tionally causing or attempting to cause physical in-
19 jury other than providing health care goods or serv-
20 ices.

21 (14) MEDICAL PRODUCT.—The term “medical
22 product” means a drug or device intended for hu-
23 mans, and the terms “drug” and “device” have the
24 meanings given such terms in sections 201(g)(1) and
25 201(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.

4 (15) NONECONOMIC DAMAGES.—The term
5 “noneconomic damages” means damages for phys-
6 ical and emotional pain, suffering, inconvenience,
7 physical impairment, mental anguish, disfigurement,
8 loss of enjoyment of life, loss of society and compan-
9 ionship, loss of consortium (other than loss of do-
10 mestic service), hedonic damages, injury to reputa-
11 tion, and all other nonpecuniary losses of any kind
12 or nature.

13 (16) PUNITIVE DAMAGES.—The term “punitive
14 damages” means damages awarded, for the purpose
15 of punishment or deterrence, and not solely for com-
16 pensatory purposes, against a health care provider,
17 health care organization, or a manufacturer, dis-
18 tributor, or supplier of a medical product. Punitive
19 damages are neither economic nor noneconomic
20 damages.

21 (17) RECOVERY.—The term “recovery” means
22 the net sum recovered after deducting any disburse-
23 ments or costs incurred in connection with prosecu-
24 tion or settlement of the claim, including all costs
25 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
25 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,
15 or after the date of the enactment of this subtitle)
16 that specifies a particular monetary amount of com-
17 pensatory or punitive damages (or the total amount
18 of damages) that may be awarded in a health care
19 lawsuit, regardless of whether such monetary
20 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
24 care lawsuit under any other provision of State or
25 Federal law.

1 **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 alter-
 4 native dispute resolution system, that is initiated on or
 5 after the date of the enactment of this Act, except that
 6 any health care lawsuit arising from an injury occurring
 7 prior to the date of the enactment of this Act shall be
 8 governed by the applicable statute of limitations provisions
 9 in effect at the time the injury occurred.

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

12 **CHAPTER 1—GENERAL PROVISIONS**

13 **SEC. 121. IMPROVING HEALTH CARE, QUALITY, SAFETY,**
 14 **AND EFFICIENCY.**

15 The Public Health Service Act (42 U.S.C. 201 et
 16 seq.) is amended by adding at the end the following:

17 **“TITLE XXIX—HEALTH**
 18 **INFORMATION TECHNOLOGY**

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 on
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 “(c) DUTIES OF THE NATIONAL COORDINATOR.—

11 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
24 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;

11 “(6) to the extent permitted by law, coordinate
12 outreach and consultation by the relevant executive
13 branch agencies (including Federal commissions)
14 with public and private parties of interest, including
15 consumers, payers, employers, hospitals and other
16 health care providers, physicians, community health
17 centers, laboratories, vendors and other stake-
18 holders;

19 “(7) advise the President regarding specific
20 Federal health information technology programs;
21 and

22 “(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-

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 lic—

14 “(i) consumer and patient organiza-
15 tions;

16 “(ii) experts in health information pri-
17 vacy and security;

18 “(iii) health care providers;

19 “(iv) health insurance plans or other
20 third party payors;

21 “(v) standards development organiza-
22 tions;

23 “(vi) information technology vendors;

24 “(vii) purchasers or employers; and

1 “(viii) State or local government agen-
2 cies or Indian tribe or tribal organizations.

3 “(2) CONSIDERATIONS.—In appointing mem-
4 bers under paragraph (1)(F), the Secretary shall se-
5 lect individuals with expertise in—

6 “(A) health information privacy;

7 “(B) health information security;

8 “(C) health care quality and patient safety,
9 including those individuals with experience in
10 utilizing health information technology to im-
11 prove health care quality and patient safety;

12 “(D) data exchange; and

13 “(E) developing health information tech-
14 nology standards and new health information
15 technology.

16 “(3) TERMS.—Members appointed under para-
17 graph (1)(G) shall serve for 2 year terms, except
18 that any member appointed to fill a vacancy for an
19 unexpired term shall be appointed for the remainder
20 of such term. A member may serve for not to exceed
21 180 days after the expiration of such member’s term
22 or until a successor has been appointed.

23 “(c) RECOMMENDATIONS AND POLICIES.—The Col-
24 laborative shall make recommendations to identify uni-
25 form national policies for adoption by the Federal Govern-

1 ment and voluntary adoption by private entities to support
2 the widespread adoption of health information technology,
3 including—

4 “(1) protection of individually identifiable
5 health information through privacy and security
6 practices;

7 “(2) measures to prevent unauthorized access
8 to health information;

9 “(3) methods to facilitate secure patient access
10 to health information;

11 “(4) the ongoing harmonization of industry-
12 wide health information technology standards;

13 “(5) recommendations for a nationwide inter-
14 operable health information technology infrastruc-
15 ture;

16 “(6) the identification and prioritization of spe-
17 cific use cases for which health information tech-
18 nology is valuable, beneficial, and feasible;

19 “(7) recommendations for the establishment of
20 an entity to ensure the continuation of the functions
21 of the Collaborative; and

22 “(8) other policies determined to be necessary
23 by the Collaborative.

24 “(d) STANDARDS.—

1 “(1) EXISTING STANDARDS.—The standards
2 adopted by the Consolidated Health Informatics Ini-
3 tiative shall be deemed to have been recommended
4 by the Collaborative under this section.

5 “(2) FIRST YEAR REVIEW.—Not later than 1
6 year after the date of enactment of this title, the
7 Collaborative shall—

8 “(A) review existing standards (including
9 content, communication, and security stand-
10 ards) for the electronic exchange of health in-
11 formation, including such standards adopted by
12 the Secretary under paragraph (2)(A);

13 “(B) identify deficiencies and omissions in
14 such existing standards; and

15 “(C) identify duplication and overlap in
16 such existing standards;

17 and recommend modifications to such standards as
18 necessary.

19 “(3) ONGOING REVIEW.—Beginning 1 year
20 after the date of enactment of this title, and annu-
21 ally thereafter, the Collaborative shall—

22 “(A) review existing standards (including
23 content, communication, and security stand-
24 ards) for the electronic exchange of health in-

1 formation, including such standards adopted by
2 the Secretary under paragraph (2)(A);

3 “(B) identify deficiencies and omissions in
4 such existing standards; and

5 “(C) identify duplication and overlap in
6 such existing standards;

7 and recommend modifications to such standards as
8 necessary.

9 “(4) LIMITATION.—The standards described in
10 this section shall be consistent with any standards
11 developed pursuant to the Health Insurance Port-
12 ability and Accountability Act of 1996.

13 “(e) FEDERAL ACTION.—Not later than 60 days
14 after the issuance of a recommendation from the Collabo-
15 rative under subsection (d)(2), the Secretary of Health
16 and Human Services, in consultation with the Secretary
17 of Veterans Affairs, the Secretary of Defense, and rep-
18 resentatives of other relevant Federal agencies, as deter-
19 mined appropriate by the Secretary, shall review such rec-
20 ommendations. The Secretary shall provide for the adop-
21 tion by the Federal Government of any standard or stand-
22 ards contained in such recommendation.

23 “(f) COORDINATION OF FEDERAL SPENDING.—Not
24 later than 1 year after the adoption by the Federal Gov-
25 ernment of a recommendation as provided for in sub-

1 section (e), and in compliance with chapter 113 of title
2 40, United States Code, no Federal agency shall expend
3 Federal funds for the purchase of any form of health in-
4 formation technology or health information technology
5 system for clinical care or for the electronic retrieval, stor-
6 age, or exchange of health information that is not con-
7 sistent with applicable standards adopted by the Federal
8 Government under subsection (e).

9 “(g) COORDINATION OF FEDERAL DATA COLLEC-
10 TION.—Not later than 3 years after the adoption by the
11 Federal Government of a recommendation as provided for
12 in subsection (e), all Federal agencies collecting health
13 data for the purposes of surveillance, epidemiology, ad-
14 verse event reporting, research, or for other purposes de-
15 termined appropriate by the Secretary shall comply with
16 standards adopted under subsection (e).

17 “(h) VOLUNTARY ADOPTION.—

18 “(1) IN GENERAL.—Any standards adopted by
19 the Federal Government under subsection (e) shall
20 be voluntary with respect to private entities.

21 “(2) RULE OF CONSTRUCTION.—Nothing in
22 this section shall be construed to require that a pri-
23 vate entity that enters into a contract with the Fed-
24 eral Government adopt the standards adopted by the

1 Federal Government under section 2903 with re-
2 spect to activities not related to the contract.

3 “(3) LIMITATION.—Private entities that enter
4 into a contract with the Federal Government shall
5 adopt the standards adopted under section 2903 for
6 the purpose of activities under such Federal con-
7 tract.

8 “(i) EFFECT ON OTHER PROVISIONS.—Nothing in
9 this title shall be construed to effect the scope or sub-
10 stance of—

11 “(1) section 264 of the Health Insurance Port-
12 ability and Accountability Act of 1996;

13 “(2) sections 1171 through 1179 of the Social
14 Security Act; and

15 “(3) any regulation issued pursuant to any such
16 section;

17 and such sections shall remain in effect and shall apply
18 to the implementation of standards, programs and activi-
19 ties under this title.

20 “(j) REPORTS.—The Secretary shall submit to the
21 Committee on Health, Education, Labor, and Pensions
22 and the Committee on Finance of the Senate and the
23 Committee on Energy and Commerce and the Committee
24 on Ways and Means of the House of Representatives, on
25 an annual basis, a report that—

1 “(1) describes the specific actions that have
2 been taken by the Federal Government and private
3 entities to facilitate the adoption of an interoperable
4 nationwide system for the electronic exchange of
5 health information;

6 “(2) describes barriers to the adoption of such
7 a nationwide system;

8 “(3) contains recommendations to achieve full
9 implementation of such a nationwide system; and

10 “(4) contains a plan and progress toward the
11 establishment of an entity to ensure the continuation
12 of the functions of the Collaborative.

13 “(k) APPLICATION OF FACCA.—The Federal Advisory
14 Committee Act (5 U.S.C. App.) shall apply to the Collabo-
15 rative, except that the term provided for under section
16 14(a)(2) shall be 5 years.

17 “(l) RULE OF CONSTRUCTION.—Nothing in this sec-
18 tion shall be construed to require the duplication of Fed-
19 eral efforts with respect to the establishment of the Col-
20 laborative, regardless of whether such efforts were carried
21 out prior to or after the enactment of this title.

22 **“SEC. 2904. IMPLEMENTATION AND CERTIFICATION OF**
23 **HEALTH INFORMATION STANDARDS.**

24 “(a) IMPLEMENTATION.—

1 “(1) IN GENERAL.—The Secretary, based upon
2 the recommendations of the Collaborative, shall de-
3 velop criteria to ensure uniform and consistent im-
4 plementation of any standards for the electronic ex-
5 change of health information voluntarily adopted by
6 private entities in technical conformance with such
7 standards adopted under this title.

8 “(2) IMPLEMENTATION ASSISTANCE.—The Sec-
9 retary may recognize a private entity or entities to
10 assist private entities in the implementation of the
11 standards adopted under this title using the criteria
12 developed by the Secretary under this section.

13 “(b) CERTIFICATION.—

14 “(1) IN GENERAL.—The Secretary, based upon
15 the recommendations of the Collaborative, shall de-
16 velop criteria to ensure and certify that hardware,
17 software, and support services that claim to be in
18 compliance with any standard for the electronic ex-
19 change of health information adopted under this title
20 have established and maintained such compliance in
21 technical conformance with such standards.

22 “(2) CERTIFICATION ASSISTANCE.—The Sec-
23 retary may recognize a private entity or entities to
24 assist in the certification described under paragraph

1 (1) using the criteria developed by the Secretary
2 under this section.

3 “(c) DELEGATION AUTHORITY.—The Secretary,
4 through consultation with the Collaborative, may delegate
5 the development of the criteria under subsections (a) and
6 (b) to a private entity.

7 **“SEC. 2905. STUDY OF STATE HEALTH INFORMATION LAWS**
8 **AND PRACTICES.**

9 “(a) IN GENERAL.—The Secretary shall carry out,
10 or contract with a private entity to carry out, a study that
11 examines—

12 “(1) the variation among State laws and prac-
13 tices that relate to the privacy, confidentiality, and
14 security of health information;

15 “(2) how such variation among State laws and
16 practices may impact the electronic exchange of
17 health information—

18 “(A) among the States;

19 “(B) between the States and the Federal
20 Government; and

21 “(C) among private entities; and

22 “(3) how such laws and practices may be har-
23 monized to permit the secure electronic exchange of
24 health information.

1 “(b) REPORT AND RECOMMENDATIONS.—Not later
2 than 1 year after the date of enactment of this title, the
3 Secretary shall submit to Congress a report that—

4 “(1) describes the results of the study carried
5 out under subsection (a); and

6 “(2) makes recommendations based on the re-
7 sults of such study.

8 **“SEC. 2906. SECURE EXCHANGE OF HEALTH INFORMATION;**
9 **INCENTIVE GRANTS.**

10 “(a) IN GENERAL.—The Secretary may make grants
11 to States to carry out programs under which such States
12 cooperate with other States to develop and implement
13 State policies that will facilitate the secure electronic ex-
14 change of health information utilizing the standards
15 adopted under section 2903—

16 “(1) among the States;

17 “(2) between the States and the Federal Gov-
18 ernment; and

19 “(3) among private entities.

20 “(b) PRIORITY.—In awarding grants under sub-
21 section (a), the Secretary shall give priority to States that
22 provide assurance that any funding awarded under such
23 a grant shall be used to harmonize privacy laws and prac-
24 tices between the States, the States and the Federal Gov-

1 ernment, and among private entities related to the privacy,
2 confidentiality, and security of health information.

3 “(c) DISSEMINATION OF INFORMATION.—The Sec-
4 retary shall disseminate information regarding the efficacy
5 of efforts of a recipient of a grant under this section.

6 “(d) TECHNICAL ASSISTANCE.—The Secretary may
7 provide technical assistance to recipients of a grant under
8 this section.

9 “(e) AUTHORIZATION OF APPROPRIATIONS.—For the
10 purpose of carrying out subsection (a), there are author-
11 ized to be appropriated such sums as may be necessary
12 for each of the fiscal years 2006 through 2010.

13 **“SEC. 2907. LICENSURE AND THE ELECTRONIC EXCHANGE**
14 **OF HEALTH INFORMATION.**

15 “(a) IN GENERAL.—The Secretary shall carry out,
16 or contract with a private entity to carry out, a study that
17 examines—

18 “(1) the variation among State laws that relate
19 to the licensure, registration, and certification of
20 medical professionals; and

21 “(2) how such variation among State laws im-
22 pacts the secure electronic exchange of health infor-
23 mation—

24 “(A) among the States; and

1 “(B) between the States and the Federal
2 Government.

3 “(b) REPORT AND RECOMMENDATIONS.—Not later
4 than 1 year after the date of enactment of this title, the
5 Secretary shall publish a report that—

6 “(1) describes the results of the study carried
7 out under subsection (a); and

8 “(2) makes recommendations to States regard-
9 ing the harmonization of State laws based on the re-
10 sults of such study.

11 **“SEC. 2908. AUTHORIZATION OF APPROPRIATIONS.**

12 “(a) IN GENERAL.—For the purpose of carrying out
13 this title, there is authorized to be appropriated
14 \$125,000,000 for fiscal year 2006, and such sums as may
15 be necessary for each of fiscal years 2007 through 2010.

16 “(b) AVAILABILITY.—Amounts appropriated under
17 subsection (a) shall remain available through fiscal year
18 2010.”.

19 **SEC. 122. HIPAA REPORT.**

20 (a) STUDY.—Not later than 2 years after the date
21 of enactment of this Act, the Secretary of Health and
22 Human Services shall carry out, or contract with a private
23 entity to carry out, a study that examines the integration
24 of the standards adopted under the amendments made by
25 this subtitle with the standards adopted under the Health

1 Insurance Portability and Accountability Act of 1996
2 (Public Law 104–191).

3 (b) PLAN; REPORT.—

4 (1) PLAN.—Not later than 3 years after the
5 date of enactment of this Act, the Secretary of
6 Health and Human Services shall, based on the re-
7 sults of the study carried out under subsection (a),
8 develop a plan for the integration of the standards
9 described under such subsection and submit a report
10 to Congress describing such plan.

11 (2) PERIODIC REPORTS.—The Secretary shall
12 submit periodic reports to Congress that describe the
13 progress of the integration described under para-
14 graph (1).

15 **SEC. 123. STUDY OF REIMBURSEMENT INCENTIVES.**

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

1 **SEC. 124. REAUTHORIZATION OF INCENTIVE GRANTS RE-**
2 **GARDING TELEMEDICINE.**

3 Section 330L(b) of the Public Health Service Act (42
4 U.S.C. 254c-18(b)) is amended by striking “2002 through
5 2006” and inserting “2006 through 2010”.

6 **SEC. 125. SENSE OF THE SENATE ON PHYSICIAN PAYMENT.**

7 It is the sense of the Senate that modifications to
8 the medicare fee schedule for physicians’ services under
9 section 1848 of the Social Security Act (42 U.S.C.
10 1394w-4) should include provisions based on the reporting
11 of quality measures pursuant to those adopted in section
12 2909 of the Public Health Service Act (as added by sec-
13 tion 121) and the overall improvement of healthcare qual-
14 ity through the use of the electronic exchange of health
15 information pursuant to the standards adopted under sec-
16 tion 2903 of such Act (as added by section 121).

17 **SEC. 126. ESTABLISHMENT OF QUALITY MEASUREMENT**
18 **SYSTEMS FOR MEDICARE VALUE-BASED PUR-**
19 **CHASING PROGRAMS.**

20 (a) IN GENERAL.—Title XVIII (42 U.S.C. 1395 et
21 seq.) is amended—

22 (1) by redesignating part E as part F; and

23 (2) by inserting after part D the following new
24 part:

1 “PART E—VALUE-BASED PURCHASING
2 “QUALITY MEASUREMENT SYSTEMS FOR VALUE-BASED
3 PURCHASING PROGRAMS

4 “SEC. 1860E–1. (a) ESTABLISHMENT.—

5 “ (1) IN GENERAL.—The Secretary shall develop
6 quality measurement systems for purposes of pro-
7 viding value-based payments to—

8 “ (A) hospitals pursuant to section 1860E–
9 2;

10 “ (B) physicians and practitioners pursuant
11 to section 1860E–3;

12 “ (C) plans pursuant to section 1860E–4;

13 “ (D) end stage renal disease providers and
14 facilities pursuant to section 1860E–5; and

15 “ (E) home health agencies pursuant to
16 section 1860E–6.

17 “ (2) QUALITY.—The systems developed under
18 paragraph (1) shall measure the quality of the care
19 furnished by the provider involved.

20 “ (3) HIGH QUALITY HEALTH CARE DEFINED.—

21 In this part, the term ‘high quality health care’
22 means health care that is safe, effective, patient-cen-
23 tered, timely, equitable, efficient, necessary, and ap-
24 propriate.

1 “(b) REQUIREMENTS FOR SYSTEMS.—Under each
2 quality measurement system described in subsection
3 (a)(1), the Secretary shall do the following:

4 “(1) MEASURES.—

5 “(A) IN GENERAL.—Subject to subpara-
6 graph (B), the Secretary shall select measures
7 of quality to be used by the Secretary under
8 each system.

9 “(B) REQUIREMENTS.—In selecting the
10 measures to be used under each system pursu-
11 ant to subparagraph (A), the Secretary shall, to
12 the extent feasible, ensure that—

13 “(i) such measures are evidence-
14 based, reliable and valid, and feasible to
15 collect and report;

16 “(ii) measures of process, structure,
17 outcomes, beneficiary experience, effi-
18 ciency, and equity are included;

19 “(iii) measures of overuse and
20 underuse of health care items and services
21 are included;

22 “(iv)(I) at least 1 measure of health
23 information technology infrastructure that
24 enables the provision of high quality health
25 care and facilitates the exchange of health

1 information, such as the use of one or
2 more elements of a qualified health infor-
3 mation system (as defined in subparagraph
4 (E)), is included during the first year each
5 system is implemented; and

6 “(II) additional measures of health in-
7 formation technology infrastructure are in-
8 cluded in subsequent years;

9 “(v) in the case of the system that is
10 used to provide value-based payments to
11 hospitals under section 1860E-2, by not
12 later than January 1, 2008, at least 5
13 measures that take into account the unique
14 characteristics of small hospitals located in
15 rural areas and frontier areas are included;
16 and

17 “(vi) measures that assess the quality
18 of care furnished to frail individuals over
19 the age of 75 and to individuals with mul-
20 tiple complex chronic conditions are in-
21 cluded.

22 “(C) REQUIREMENT FOR COLLECTION OF
23 DATA ON A MEASURE FOR 1 YEAR PRIOR TO
24 USE UNDER THE SYSTEMS.—Data on any
25 measure selected by the Secretary under sub-

1 paragraph (A) must be collected by the Sec-
2 retary for at least a 12-month period before
3 such measure may be used to determine wheth-
4 er a provider receives a value-based payment
5 under a program described in subsection (a)(1).

6 “(D) AUTHORITY TO VARY MEASURES.—

7 “(i) UNDER SYSTEM APPLICABLE TO
8 HOSPITALS.—In the case of the system ap-
9 plicable to hospitals under section 1860E-
10 2, the Secretary may vary the measures se-
11 lected under subparagraph (A) by hospital
12 depending on the size of, and the scope of
13 services provided by, the hospital.

14 “(ii) UNDER SYSTEM APPLICABLE TO
15 PHYSICIANS AND PRACTITIONERS.—In the
16 case of the system applicable to physicians
17 and practitioners under section 1860E-3,
18 the Secretary may vary the measures se-
19 lected under subparagraph (A) by physi-
20 cian or practitioner depending on the spe-
21 cialty of the physician, the type of practi-
22 tioner, or the volume of services furnished
23 to beneficiaries by the physician or practi-
24 tioner.

1 “(iii) UNDER SYSTEM APPLICABLE TO
2 ESRD PROVIDERS AND FACILITIES.—In the
3 case of the system applicable to providers
4 of services and renal dialysis facilities
5 under section 1860E–5, the Secretary may
6 vary the measures selected under subpara-
7 graph (A) by provider or facility depending
8 on the type of, the size of, and the scope
9 of services provided by, the provider or fa-
10 cility.

11 “(iv) UNDER SYSTEM APPLICABLE TO
12 HOME HEALTH AGENCIES.—In the case of
13 the system applicable to home health agen-
14 cies under section 1860E–6, the Secretary
15 may vary the measures selected under sub-
16 paragraph (A) by agency depending on the
17 size of, and the scope of services provided
18 by, the agency.

19 “(E) QUALIFIED HEALTH INFORMATION
20 SYSTEM DEFINED.—For purposes of subpara-
21 graph (B)(iv)(I), the term ‘qualified health in-
22 formation system’ means a computerized sys-
23 tem (including hardware, software, and train-
24 ing) that—

1 “(i) protects the privacy and security
2 of health information and properly
3 encrypts such health information;

4 “(ii) maintains and provides access to
5 patients’ health records in an electronic
6 format;

7 “(iii) incorporates decision support
8 software to reduce medical errors and en-
9 hance health care quality;

10 “(iv) is consistent with data standards
11 and certification processes recommended
12 by the Secretary;

13 “(v) allows for the reporting of quality
14 measures; and

15 “(vi) includes other features deter-
16 mined appropriate by the Secretary.

17 “(2) WEIGHTS OF MEASURES.—

18 “(A) IN GENERAL.—The Secretary shall
19 assign weights to the measures used by the Sec-
20 retary under each system.

21 “(B) CONSIDERATION.—If the Secretary
22 determines appropriate, in assigning the
23 weights under subparagraph (A)—

1 “(i) measures of clinical effectiveness
2 shall be weighted more heavily than meas-
3 ures of beneficiary experience; and

4 “(ii) measures of risk adjusted out-
5 comes shall be weighted more heavily than
6 measures of process; and

7 “(3) RISK ADJUSTMENT.—The Secretary shall
8 establish procedures, as appropriate, to control for
9 differences in beneficiary health status and bene-
10 ficiary characteristics. To the extent feasible, such
11 procedures may be based on existing models for con-
12 trolling for such differences.

13 “(4) MAINTENANCE.—

14 “(A) IN GENERAL.—The Secretary shall,
15 as determined appropriate, but not more often
16 than once each 12-month period, update each
17 system, including through—

18 “(i) the addition of more accurate and
19 precise measures under the systems and
20 the retirement of existing outdated meas-
21 ures under the system;

22 “(ii) the refinement of the weights as-
23 signed to measures under the system; and

1 “(iii) the refinement of the risk ad-
2 justment procedures established pursuant
3 to paragraph (3) under the system.

4 “(B) UPDATE SHALL ALLOW FOR COM-
5 PARISON OF DATA.—Each update under sub-
6 paragraph (A) of a quality measurement system
7 shall allow for the comparison of data from one
8 year to the next for purposes of providing
9 value-based payments under the programs de-
10 scribed in subsection (a)(1).

11 “(5) USE OF MOST RECENT QUALITY DATA.—

12 “(A) IN GENERAL.—Except as provided in
13 subparagraph (B), the Secretary shall use the
14 most recent quality data with respect to the
15 provider involved that is available to the Sec-
16 retary.

17 “(B) INSUFFICIENT DATA DUE TO LOW
18 VOLUME.—If the Secretary determines that
19 there is insufficient data with respect to a
20 measure or measures because of a low number
21 of services provided, the Secretary may aggre-
22 gate data across more than 1 fiscal or calendar
23 year, as the case may be.

24 “(c) REQUIREMENTS FOR DEVELOPING AND UPDAT-
25 ING THE SYSTEMS.—In developing and updating each

1 quality measurement system under this section, the Sec-
2 retary shall—

3 “(1) take into account the quality measures de-
4 veloped by nationally recognized quality measure-
5 ment organizations, researchers, health care provider
6 organizations, and other appropriate groups;

7 “(2) consult with, and take into account the
8 recommendations of, the entity that the Secretary
9 has an arrangement with under subsection (e);

10 “(3) consult with provider-based groups and
11 clinical specialty societies;

12 “(4) take into account existing quality measure-
13 ment systems that have been developed through a
14 rigorous process of validation and with the involve-
15 ment of entities and persons described in subsection
16 (e)(2)(B); and

17 “(5) take into account—

18 “(A) each of the reports by the Medicare
19 Payment Advisory Commission that are re-
20 quired under the Medicare Value Purchasing
21 Act of 2005;

22 “(B) the results of—

23 “(i) the demonstrations required
24 under such Act;

1 “(ii) the demonstration program
2 under section 1866A;

3 “(iii) the demonstration program
4 under section 1866C; and

5 “(iv) any other demonstration or pilot
6 program conducted by the Secretary relat-
7 ing to measuring and rewarding quality
8 and efficiency of care; and

9 “(C) the report by the Institute of Medi-
10 cine of the National Academy of Sciences under
11 section 238(b) of the Medicare Prescription
12 Drug, Improvement, and Modernization Act of
13 2003 (Public Law 108–173).

14 “(d) REQUIREMENTS FOR IMPLEMENTING THE SYS-
15 TEMS.—In implementing each quality measurement sys-
16 tem under this section, the Secretary shall consult with
17 entities—

18 “(1) that have joined together to develop strate-
19 gies for quality measurement and reporting, includ-
20 ing the feasibility of collecting and reporting mean-
21 ingful data on quality measures; and

22 “(2) that involve representatives of health care
23 providers, health plans, consumers, employers, pur-
24 chasers, quality experts, government agencies, and

1 other individuals and groups that are interested in
2 quality of care.

3 “(e) ARRANGEMENT WITH AN ENTITY TO PROVIDE
4 ADVICE AND RECOMMENDATIONS.—

5 “(1) ARRANGEMENT.—On and after July 1,
6 2006, the Secretary shall have in place an arrange-
7 ment with an entity that meets the requirements de-
8 scribed in paragraph (2) under which such entity
9 provides the Secretary with advice on, and rec-
10 ommendations with respect to, the development and
11 updating of the quality measurement systems under
12 this section, including the assigning of weights to
13 the measures under subsection (b)(2).

14 “(2) REQUIREMENTS DESCRIBED.—The re-
15 quirements described in this paragraph are the fol-
16 lowing:

17 “(A) The entity is a private nonprofit enti-
18 ty governed by an executive director and a
19 board.

20 “(B) The members of the entity include
21 representatives of—

22 “(i)(I) health plans and providers re-
23 ceiving reimbursement under this title for
24 the provision of items and services, includ-
25 ing health plans and providers with experi-

1 ence in the care of the frail elderly and in-
2 dividuals with multiple complex chronic
3 conditions; or

4 “ (II) groups representing such health
5 plans and providers;

6 “ (ii) groups representing individuals
7 receiving benefits under this title;

8 “ (iii) purchasers and employers or
9 groups representing purchasers or employ-
10 ers;

11 “ (iv) organizations that focus on qual-
12 ity improvement as well as the measure-
13 ment and reporting of quality measures;

14 “ (v) State government health pro-
15 grams;

16 “ (vi) persons skilled in the conduct
17 and interpretation of biomedical, health
18 services, and health economics research
19 and with expertise in outcomes and effec-
20 tiveness research and technology assess-
21 ment; and

22 “ (vii) persons or entities involved in
23 the development and establishment of
24 standards and certification for health in-

1 formation technology systems and clinical
2 data.

3 “(C) The membership of the entity is rep-
4 resentative of individuals with experience
5 with—

6 “(i) urban health care issues;

7 “(ii) safety net health care issues; and

8 “(iii) rural and frontier health care
9 issues.

10 “(D) The entity does not charge a fee for
11 membership for participation in the work of the
12 entity related to the arrangement with the Sec-
13 retary under paragraph (1). If the entity does
14 require a fee for membership for participation
15 in other functions of the entity, there shall be
16 no linkage between such fee and participation
17 in the work of the entity related to such ar-
18 rangement with the Secretary.

19 “(E) The entity—

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

24 “(ii) ensures that such members have
25 an equal vote on such matters .

1 “(F) With respect to matters related to the
2 arrangement with the Secretary under para-
3 graph (1), the entity conducts its business in an
4 open and transparent manner and provides the
5 opportunity for public comment.

6 “(G) The entity operates as a voluntary
7 consensus standards setting organization as de-
8 fined for purposes of section 12(d) of the Na-
9 tional Technology Transfer and Advancement
10 Act of 1995 (Public Law 104–113) and Office
11 of Management and Budget Revised Circular
12 A–119 (published in the Federal Register on
13 February 10, 1998).”.

14 (b) CONFORMING REFERENCES TO PREVIOUS PART
15 E.—Any reference in law (in effect before the date of the
16 enactment of this Act) to part E of title XVIII of the So-
17 cial Security Act is deemed a reference to part F of such
18 title (as in effect after such date).

19 **SEC. 127. EXCEPTION TO FEDERAL ANTI-KICKBACK AND**
20 **PHYSICIAN SELF REFERRAL LAWS FOR THE**
21 **PROVISION OF PERMITTED SUPPORT.**

22 (a) ANTI-KICKBACK.—Section 1128B(b) (42 U.S.C.
23 1320a–7b(b)(3)) is amended—

24 (1) in paragraph (3)—

1 (A) in subparagraph (G), by striking
2 “and” at the end;

3 (B) in subparagraph (H), as added by sec-
4 tion 237(d) of the Medicare Prescription Drug,
5 Improvement, and Modernization Act of 2003
6 (Public Law 108–173; 117 Stat. 2213)—

7 (i) by moving such subparagraph 2
8 ems to the left; and

9 (ii) by striking the period at the end
10 and inserting a semicolon;

11 (C) by redesignating subparagraph (H), as
12 added by section 431(a) of the Medicare Pre-
13 scription Drug, Improvement, and Moderniza-
14 tion Act of 2003 (Public Law 108–173; 117
15 Stat. 2287), as subparagraph (I);

16 (D) in subparagraph (I), as so redesis-
17 gnated—

18 (i) by moving such subparagraph 2
19 ems to the left; and

20 (ii) by striking the period at the end
21 and inserting “; and”; and

22 (E) by adding at the end the following
23 new:

24 “(J) during the 5-year period beginning on
25 the date the Secretary issues the interim final

1 rule under section 801(c)(1) of the Medicare
2 Value Purchasing Act of 2005, the provision,
3 with or without charge, of any permitted sup-
4 port (as defined in paragraph (4)).”;

5 (2) by adding at the end the following new
6 paragraph:

7 “(4) PERMITTED SUPPORT.—

8 “(A) DEFINITION OF PERMITTED SUP-
9 PORT.—Subject to subparagraph (B), in this
10 section, the term ‘permitted support’ means the
11 provision of any equipment, item, information,
12 right, license, intellectual property, software,
13 training, or service used for developing, imple-
14 menting, operating, or facilitating the use of
15 systems designed to improve the quality of
16 health care and to promote the electronic ex-
17 change of health information.

18 “(B) EXCEPTION.—The term ‘permitted
19 support’ shall not include the provision of—

20 “(i) any support that is determined in
21 a manner that is related to the volume or
22 value of any referrals or other business
23 generated between the parties for which
24 payment may be made in whole or in part
25 under a Federal health care program;

1 “(ii) any support that has more than
2 incidental utility or value to the recipient
3 beyond the exchange of health care infor-
4 mation; or

5 “(iii) any health information tech-
6 nology system, product, or service that is
7 not capable of exchanging health care in-
8 formation in compliance with data stand-
9 ards consistent with interoperability.

10 “(C) DETERMINATION.—In establishing
11 regulations with respect to the requirement
12 under subparagraph (B)(iii), the Secretary shall
13 take in account—

14 “(i) whether the health information
15 technology system, product, or service is
16 widely accepted within the industry and
17 whether there is sufficient industry experi-
18 ence to ensure successful implementation
19 of the system, product, or service; and

20 “(ii) whether the health information
21 technology system, product, or service im-
22 proves quality of care, enhances patient
23 safety, or provides greater administrative
24 efficiencies.”.

1 (b) PHYSICIAN SELF-REFERRAL.—Section 1877(e)
 2 (42 U.S.C. 1395nn(e)) is amended by adding at the end
 3 the following new paragraph:

4 “(9) PERMITTED SUPPORT.—During the 5-year
 5 period beginning on the date the Secretary issues
 6 the interim final rule under section 801(c)(1) of the
 7 Medicare Value Purchasing Act of 2005, the provi-
 8 sion, with or without charge, of any permitted sup-
 9 port (as defined in section 1128B(b)(4)).”.

10 (c) REGULATIONS.—In order to carry out the amend-
 11 ments made by this section—

12 (1) the Secretary shall issue an interim final
 13 rule with comment period by not later than the date
 14 that is 180 days after the date of enactment of this
 15 Act;

16 (2) the Secretary shall issue a final rule by not
 17 later than the date that is 180 days after the date
 18 that the interim final rule under paragraph (1) is
 19 issued.

20 **CHAPTER 2—VALUE BASED PURCHASING**

21 **SEC. 131. VALUE BASED PURCHASING PROGRAMS; SENSE**

22 **OF THE SENATE.**

23 (a) MEDICARE VALUE BASED PURCHASING PILOT
 24 PROGRAM.—

1 (1) IN GENERAL.—The Secretary of Health and
2 Human Services (referred to in this section as the
3 “Secretary”) shall establish under title XVIII of the
4 Social Security Act (42 U.S.C. 1395 et seq.) a value
5 based purchasing pilot program based on the report-
6 ing of quality measures pursuant to those adopted in
7 section 1860E–1 of the Social Security Act (as
8 added by section 126). Such pilot program should be
9 based on experience gained through previous dem-
10 onstration projects conducted by the Secretary, in-
11 cluding demonstration projects conducted under sec-
12 tions 1866A and 1866C of the Social Security Act
13 (42 U.S.C. 1395cc–1; 1395cc–3), section 649 of the
14 Medicare Prescription Drug, Improvement, and
15 Modernization Act of 2003 (Public Law 108–173;
16 117 Stat. 2322), and other relevant work conducted
17 by private entities.

18 (2) EXPANSION.—Not later than 2 years after
19 conducting the pilot program under paragraph (1),
20 the Secretary shall transition and implement such
21 program on a national basis.

22 (3) INFORMATION TECHNOLOGY.—Providers re-
23 porting quality measurement data electronically
24 under this section shall report such data pursuant to

1 the standards adopted under title XXIX of the Pub-
2 lic Health Service Act (as added by section 121).

3 (4) FUNDING.—The Secretary shall ensure that
4 the total amount of expenditures under this Act in
5 a year does not exceed the total amount of expendi-
6 tures that would have been expended in such year
7 under this Act if this subsection had not been en-
8 acted.

9 (b) MEDICAID VALUE BASED PURCHASING PRO-
10 GRAMS.—

11 (1) IN GENERAL.—The Secretary shall author-
12 ize waivers under section 1115 of the Social Security
13 Act (42 U.S.C. 1315) for States to establish value
14 based purchasing programs for State medicaid pro-
15 grams established under title XIX of such Act (42
16 U.S.C. 1396 et seq.). Such programs shall be based
17 on the reporting of quality measures pursuant to
18 those adopted in section 1860E-1 of the Social Secu-
19 rity Act (as added by section 126).

20 (2) INFORMATION TECHNOLOGY.—Providers re-
21 porting quality measurement data electronically
22 under this section shall report such data pursuant to
23 the standards adopted under title XXIX of the Pub-
24 lic Health Service Act (as added by section 121).

1 (3) WAIVER.—In authorizing such waivers, the
2 Secretary shall waive any provisions of title XI or
3 XIX of the Social Security Act that would otherwise
4 prevent a State from establishing a value based pur-
5 chasing program in accordance with paragraph (1).

6 **Subtitle C—Patient Safety and** 7 **Quality Improvement**

8 **SEC. 141. SHORT TITLE.**

9 This subtitle may be cited as the “Patient Safety and
10 Quality Improvement Act of 2005”.

11 **SEC. 142. FINDINGS AND PURPOSES.**

12 (a) FINDINGS.—Congress makes the following find-
13 ings:

14 (1) In 1999, the Institute of Medicine released
15 a report entitled *To Err is Human* that described
16 medical errors as the eighth leading cause of death
17 in the United States, with as many as 98,000 people
18 dying as a result of medical errors each year.

19 (2) To address these deaths and injuries due to
20 medical errors, the health care system must identify
21 and learn from such errors so that systems of care
22 can be improved.

23 (3) In their report, the Institute of Medicine
24 called on Congress to provide legal protections with

1 respect to information reported for the purposes of
2 quality improvement and patient safety.

3 (4) The Health, Education, Labor, and Pen-
4 sions Committee of the Senate held 4 hearings in
5 the 106th Congress and 1 hearing in the 107th Con-
6 gress on patient safety where experts in the field
7 supported the recommendation of the Institute of
8 Medicine for congressional action.

9 (5) Myriad public and private patient safety ini-
10 tiatives have begun. The Quality Interagency Coordi-
11 nation Taskforce has recommended steps to improve
12 patient safety that may be taken by each Federal
13 agency involved in health care and activities relating
14 to these steps are ongoing.

15 (6) The research on patient safety unequivocally
16 calls for a learning environment, rather than a
17 punitive environment, in order to improve patient
18 safety.

19 (7) Voluntary data gathering systems are more
20 supportive than mandatory systems in creating the
21 learning environment referred to in paragraph (6) as
22 stated in the Institute of Medicine's report.

23 (8) Promising patient safety reporting systems
24 have been established throughout the United States
25 and the best ways to structure and use these sys-

1 tems are currently being determined, largely through
2 projects funded by the Agency for Healthcare Re-
3 search and Quality.

4 (9) Many organizations currently collecting pa-
5 tient safety data have expressed a need for legal pro-
6 tections that will allow them to review protected in-
7 formation and collaborate in the development and
8 implementation of patient safety improvement strat-
9 egies. Currently, the State peer review protections
10 are inadequate to allow the sharing of information to
11 promote patient safety.

12 (b) PURPOSES.—It is the purpose of this subtitle
13 to—

14 (1) encourage a culture of safety and quality in
15 the United States health care system by providing
16 for legal protection of information reported volun-
17 tarily for the purposes of quality improvement and
18 patient safety; and

19 (2) ensure accountability by raising standards
20 and expectations for continuous quality improve-
21 ments in patient safety.

22 **SEC. 143. AMENDMENTS TO PUBLIC HEALTH SERVICE ACT.**

23 Title IX of the Public Health Service Act (42 U.S.C.
24 299 et seq.) is amended—

1 (1) in section 912(c), by inserting “, in accord-
2 ance with part C,” after “The Director shall”;

3 (2) by redesignating part C as part D;

4 (3) by redesignating sections 921 through 928,
5 as sections 931 through 938, respectively;

6 (4) in 934(d) (as so redesignated), by striking
7 the second sentence and inserting the following:
8 “Penalties provided for under this section shall be
9 imposed and collected by the Secretary using the ad-
10 ministrative and procedural processes used to impose
11 and collect civil money penalties under section
12 1128A of the Social Security Act (other than sub-
13 sections (a) and (b), the second sentence of sub-
14 section (f), and subsections (i), (m), and (n)), unless
15 the Secretary determines that a modification of pro-
16 cedures would be more suitable or reasonable to
17 carry out this subsection and provides for such
18 modification by regulation.”;

19 (5) in section 938(1) (as so redesignated), by
20 striking “921” and inserting “931”; and

21 (6) by inserting after part B the following:

22 **“PART C—PATIENT SAFETY IMPROVEMENT**

23 **“SEC. 921. DEFINITIONS.**

24 “In this part:

25 “(1) NON-IDENTIFIABLE INFORMATION.—

1 “(A) IN GENERAL.—The term ‘non-identi-
2 fiable information’ means, with respect to infor-
3 mation, that the information is presented in a
4 form and manner that prevents the identifica-
5 tion of a provider, a patient, or a reporter of
6 patient safety data.

7 “(B) IDENTIFIABILITY OF PATIENT.—For
8 purposes of subparagraph (A), the term ‘pre-
9 sented in a form and manner that prevents the
10 identification of a patient’ means, with respect
11 to information that has been subject to rules
12 promulgated pursuant to section 264(c) of the
13 Health Insurance Portability and Accountability
14 Act of 1996 (42 U.S.C. 1320d–2 note), that the
15 information has been de-identified so that it is
16 no longer individually identifiable health infor-
17 mation as defined in such rules.

18 “(2) PATIENT SAFETY DATA.—

19 “(A) IN GENERAL.—The term ‘patient
20 safety data’ means—

21 “(i) any data, reports, records, memo-
22 randa, analyses (such as root cause anal-
23 yses), or written or oral statements that
24 are—

1 “(I) collected or developed by a
2 provider for reporting to a patient
3 safety organization, provided that they
4 are reported to the patient safety or-
5 ganization within 60 days;

6 “(II) requested by a patient safe-
7 ty organization (including the con-
8 tents of such request), if they are re-
9 ported to the patient safety organiza-
10 tion within 60 days;

11 “(III) reported to a provider by a
12 patient safety organization; or

13 “(IV) collected by a patient safe-
14 ty organization from another patient
15 safety organization, or developed by a
16 patient safety organization;

17 that could result in improved patient safe-
18 ty, health care quality, or health care out-
19 comes; or

20 “(ii) any deliberative work or process
21 with respect to any patient safety data de-
22 scribed in clause (i).

23 “(B) LIMITATION.—

24 “(i) COLLECTION.—If the original
25 material from which any data, reports,

1 records, memoranda, analyses (such as
2 root case analyses), or written or oral
3 statements referred to in subclause (I) or
4 (IV) of subparagraph (A)(i) are collected
5 and is not patient safety data, the act of
6 such collection shall not make such original
7 material patient safety data for purposes
8 of this part.

9 “(ii) SEPARATE DATA.—The term ‘pa-
10 tient safety data’ shall not include infor-
11 mation (including a patient’s medical
12 record, billing and discharge information
13 or any other patient or provider record)
14 that is collected or developed separately
15 from and that exists separately from pa-
16 tient safety data. Such separate informa-
17 tion or a copy thereof submitted to a pa-
18 tient safety organization shall not itself be
19 considered as patient safety data. Nothing
20 in this part, except for section 922(f)(1),
21 shall be construed to limit—

22 “(I) the discovery of or admissi-
23 bility of information described in this
24 subparagraph in a criminal, civil, or
25 administrative proceeding;

1 “(II) the reporting of information
2 described in this subparagraph to a
3 Federal, State, or local governmental
4 agency for public health surveillance,
5 investigation, or other public health
6 purposes or health oversight purposes;
7 or

8 “(III) a provider’s recordkeeping
9 obligation with respect to information
10 described in this subparagraph under
11 Federal, State, or local law.

12 “(3) PATIENT SAFETY ORGANIZATION.—The
13 term ‘patient safety organization’ means a private or
14 public entity or component thereof that is currently
15 listed by the Secretary pursuant to section 924(e).

16 “(4) PATIENT SAFETY ORGANIZATION ACTIVI-
17 TIES.—The term ‘patient safety organization activi-
18 ties’ means the following activities, which are
19 deemed to be necessary for the proper management
20 and administration of a patient safety organization:

21 “(A) The conduct, as its primary activity,
22 of efforts to improve patient safety and the
23 quality of health care delivery.

1 “(B) The collection and analysis of patient
2 safety data that are submitted by more than
3 one provider.

4 “(C) The development and dissemination
5 of information to providers with respect to im-
6 proving patient safety, such as recommenda-
7 tions, protocols, or information regarding best
8 practices.

9 “(D) The utilization of patient safety data
10 for the purposes of encouraging a culture of
11 safety and of providing direct feedback and as-
12 sistance to providers to effectively minimize pa-
13 tient risk.

14 “(E) The maintenance of procedures to
15 preserve confidentiality with respect to patient
16 safety data.

17 “(F) The provision of appropriate security
18 measures with respect to patient safety data.

19 “(G) The utilization of qualified staff.

20 “(5) PERSON.—The term ‘person’ includes Fed-
21 eral, State, and local government agencies.

22 “(6) PROVIDER.—The term ‘provider’ means—

23 “(A) a person licensed or otherwise author-
24 ized under State law to provide health care
25 services, including—

1 “(i) a hospital, nursing facility, com-
2 prehensive outpatient rehabilitation facil-
3 ity, home health agency, hospice program,
4 renal dialysis facility, ambulatory surgical
5 center, pharmacy, physician or health care
6 practitioner’s office, long term care facility,
7 behavior health residential treatment facil-
8 ity, clinical laboratory, or health center; or

9 “(ii) a physician, physician assistant,
10 nurse practitioner, clinical nurse specialist,
11 certified registered nurse anesthetist, cer-
12 tified nurse midwife, psychologist, certified
13 social worker, registered dietitian or nutri-
14 tion professional, physical or occupational
15 therapist, pharmacist, or other individual
16 health care practitioner; or

17 “(B) any other person specified in regula-
18 tions promulgated by the Secretary.

19 **“SEC. 922. PRIVILEGE AND CONFIDENTIALITY PROTEC-**
20 **TIONS.**

21 “(a) PRIVILEGE.—Notwithstanding any other provi-
22 sion of Federal, State, or local law, patient safety data
23 shall be privileged and, subject to the provisions of sub-
24 section (c)(1), shall not be—

1 “(1) subject to a Federal, State, or local civil,
2 criminal, or administrative subpoena;

3 “(2) subject to discovery in connection with a
4 Federal, State, or local civil, criminal, or administra-
5 tive proceeding;

6 “(3) disclosed pursuant to section 552 of title
7 5, United States Code (commonly known as the
8 Freedom of Information Act) or any other similar
9 Federal, State, or local law;

10 “(4) admitted as evidence or otherwise disclosed
11 in any Federal, State, or local civil, criminal, or ad-
12 ministrative proceeding; or

13 “(5) utilized in a disciplinary proceeding
14 against a provider.

15 “(b) CONFIDENTIALITY.—Notwithstanding any other
16 provision of Federal, State, or local law, and subject to
17 the provisions of subsections (c) and (d), patient safety
18 data shall be confidential and shall not be disclosed.

19 “(c) EXCEPTIONS TO PRIVILEGE AND CONFIDEN-
20 TIALITY.—Nothing in this section shall be construed to
21 prohibit one or more of the following uses or disclosures:

22 “(1) Disclosure by a provider or patient safety
23 organization of relevant patient safety data for use
24 in a criminal proceeding only after a court makes an
25 in camera determination that such patient safety

1 data contains evidence of a wanton and criminal act
2 to directly harm the patient.

3 “(2) Voluntary disclosure of non-identifiable pa-
4 tient safety data by a provider or a patient safety
5 organization.

6 “(d) PROTECTED DISCLOSURE AND USE OF INFOR-
7 MATION.—Nothing in this section shall be construed to
8 prohibit one or more of the following uses or disclosures:

9 “(1) Disclosure of patient safety data by a per-
10 son that is a provider, a patient safety organization,
11 or a contractor of a provider or patient safety orga-
12 nization, to another such person, to carry out pa-
13 tient safety organization activities.

14 “(2) Disclosure of patient safety data by a pro-
15 vider or patient safety organization to grantees or
16 contractors carrying out patient safety research,
17 evaluation, or demonstration projects authorized by
18 the Director.

19 “(3) Disclosure of patient safety data by a pro-
20 vider to an accrediting body that accredits that pro-
21 vider.

22 “(4) Voluntary disclosure of patient safety data
23 by a patient safety organization to the Secretary for
24 public health surveillance if the consent of each pro-
25 vider identified in, or providing, such data is ob-

1 tained prior to such disclosure. Nothing in the pre-
2 ceding sentence shall be construed to prevent the re-
3 lease of patient safety data that is provided by, or
4 that relates solely to, a provider from which the con-
5 sent described in such sentence is obtained because
6 one or more other providers do not provide such con-
7 sent with respect to the disclosure of patient safety
8 date that relates to such nonconsenting providers.
9 Consent for the future release of patient safety data
10 for such purposes may be requested by the patient
11 safety organization at the time the data is sub-
12 mitted.

13 “(5) Voluntary disclosure of patient safety data
14 by a patient safety organization to State of local
15 government agencies for public health surveillance if
16 the consent of each provider identified in, or pro-
17 viding, such data is obtained prior to such disclo-
18 sure. Nothing in the preceding sentence shall be con-
19 strued to prevent the release of patient safety data
20 that is provided by, or that relates solely to, a pro-
21 vider from which the consent described in such sen-
22 tence is obtained because one or more other pro-
23 viders do not provide such consent with respect to
24 the disclosure of patient safety date that relates to
25 such nonconsenting providers. Consent for the fu-

1 ture release of patient safety data for such purposes
2 may be requested by the patient safety organization
3 at the time the data is submitted.

4 “(e) CONTINUED PROTECTION OF INFORMATION
5 AFTER DISCLOSURE.—

6 “(1) IN GENERAL.—Except as provided in para-
7 graph (2), patient safety data that is used or dis-
8 closed shall continue to be privileged and confiden-
9 tial as provided for in subsections (a) and (b), and
10 the provisions of such subsections shall apply to
11 such data in the possession or control of—

12 “(A) a provider or patient safety organiza-
13 tion that possessed such data before the use or
14 disclosure; or

15 “(B) a person to whom such data was dis-
16 closed.

17 “(2) EXCEPTION.—Notwithstanding paragraph
18 (1), and subject to paragraph (3)—

19 “(A) if patient safety data is used or dis-
20 closed as provided for in subsection (c)(1), and
21 such use or disclosure is in open court, the con-
22 fidentiality protections provided for in sub-
23 section (b) shall no longer apply to such data;
24 and

1 “(B) if patient safety data is used or dis-
2 closed as provided for in subsection (c)(2), the
3 privilege and confidentiality protections pro-
4 vided for in subsections (a) and (b) shall no
5 longer apply to such data.

6 “(3) CONSTRUCTION.—Paragraph (2) shall not
7 be construed as terminating or limiting the privilege
8 or confidentiality protections provided for in sub-
9 section (a) or (b) with respect to data other than the
10 specific data used or disclosed as provided for in
11 subsection (c).

12 “(f) LIMITATION ON ACTIONS.—

13 “(1) PATIENT SAFETY ORGANIZATIONS.—Ex-
14 cept to enforce disclosures pursuant to subsection
15 (c)(1), no action may be brought or process served
16 against a patient safety organization to compel dis-
17 closure of information collected or developed under
18 this part whether or not such information is patient
19 safety data unless such information is specifically
20 identified, is not patient safety data, and cannot oth-
21 erwise be obtained.

22 “(2) PROVIDERS.—An accrediting body shall
23 not take an accrediting action against a provider
24 based on the good faith participation of the provider
25 in the collection, development, reporting, or mainte-

1 nance of patient safety data in accordance with this
2 part. An accrediting body may not require a provider
3 to reveal its communications with any patient safety
4 organization established in accordance with this
5 part.

6 “(g) REPORTER PROTECTION.—

7 “(1) IN GENERAL.—A provider may not take an
8 adverse employment action, as described in para-
9 graph (2), against an individual based upon the fact
10 that the individual in good faith reported informa-
11 tion—

12 “(A) to the provider with the intention of
13 having the information reported to a patient
14 safety organization; or

15 “(B) directly to a patient safety organiza-
16 tion.

17 “(2) ADVERSE EMPLOYMENT ACTION.—For
18 purposes of this subsection, an ‘adverse employment
19 action’ includes—

20 “(A) loss of employment, the failure to
21 promote an individual, or the failure to provide
22 any other employment-related benefit for which
23 the individual would otherwise be eligible; or

1 “(B) an adverse evaluation or decision
2 made in relation to accreditation, certification,
3 credentialing, or licensing of the individual.

4 “(h) ENFORCEMENT.—

5 “(1) PROHIBITION.—Except as provided in sub-
6 sections (c) and (d) and as otherwise provided for in
7 this section, it shall be unlawful for any person to
8 negligently or intentionally disclose any patient safe-
9 ty data, and any such person shall, upon adjudica-
10 tion, be assessed in accordance with section 934(d).

11 “(2) RELATION TO HIPAA.—The penalty pro-
12 vided for under paragraph (1) shall not apply if the
13 defendant would otherwise be subject to a penalty
14 under the regulations promulgated under section
15 264(c) of the Health Insurance Portability and Ac-
16 countability Act of 1996 (42 U.S.C. 1320d–2 note)
17 or under section 1176 of the Social Security Act (42
18 U.S.C. 1320d–5) for the same disclosure.

19 “(3) EQUITABLE RELIEF.—

20 “(A) IN GENERAL.—Without limiting rem-
21 edies available to other parties, a civil action
22 may be brought by any aggrieved individual to
23 enjoin any act or practice that violates sub-
24 section (g) and to obtain other appropriate eq-
25 uitable relief (including reinstatement, back

1 pay, and restoration of benefits) to redress such
2 violation.

3 “(B) AGAINST STATE EMPLOYEES.—An
4 entity that is a State or an agency of a State
5 government may not assert the privilege de-
6 scribed in subsection (a) unless before the time
7 of the assertion, the entity or, in the case of
8 and with respect to an agency, the State has
9 consented to be subject to an action as de-
10 scribed by this paragraph, and that consent has
11 remained in effect.

12 “(i) RULE OF CONSTRUCTION.—Nothing in this sec-
13 tion shall be construed to—

14 “(1) limit other privileges that are available
15 under Federal, State, or local laws that provide
16 greater confidentiality protections or privileges than
17 the privilege and confidentiality protections provided
18 for in this section;

19 “(2) limit, alter, or affect the requirements of
20 Federal, State, or local law pertaining to informa-
21 tion that is not privileged or confidential under this
22 section;

23 “(3) alter or affect the implementation of any
24 provision of section 264(c) of the Health Insurance
25 Portability and Accountability Act of 1996 (Public

1 Law 104–191; 110 Stat. 2033), section 1176 of the
2 Social Security Act (42 U.S.C. 1320d–5), or any
3 regulation promulgated under such sections;

4 “(4) limit the authority of any provider, patient
5 safety organization, or other person to enter into a
6 contract requiring greater confidentiality or dele-
7 gating authority to make a disclosure or use in ac-
8 cordance with subsection (c) or (d); and

9 “(5) prohibit a provider from reporting a crime
10 to law enforcement authorities, regardless of whether
11 knowledge of the existence of, or the description of,
12 the crime is based on patient safety data, so long as
13 the provider does not disclose patient safety data in
14 making such report.

15 **“SEC. 923. PATIENT SAFETY NETWORK OF DATABASES.**

16 “(a) IN GENERAL.—The Secretary shall maintain a
17 patient safety network of databases that provides an inter-
18 active evidence-based management resource for providers,
19 patient safety organizations, and other persons. The net-
20 work of databases shall have the capacity to accept, aggre-
21 gate, and analyze nonidentifiable patient safety data vol-
22 untarily reported by patient safety organizations, pro-
23 viders, or other persons.

24 “(b) NETWORK OF DATABASE STANDARDS.—The
25 Secretary may determine common formats for the report-

1 ing to the patient safety network of databases maintained
 2 under subsection (a) of nonidentifiable patient safety data,
 3 including necessary data elements, common and consistent
 4 definitions, and a standardized computer interface for the
 5 processing of such data. To the extent practicable, such
 6 standards shall be consistent with the administrative sim-
 7 plification provisions of Part C of title XI of the Social
 8 Security Act.

9 **“SEC. 924. PATIENT SAFETY ORGANIZATION CERTIFI-**
 10 **CATION AND LISTING.**

11 “(a) CERTIFICATION.—

12 “(1) INITIAL CERTIFICATION.—Except as pro-
 13 vided in paragraph (2), an entity that seeks to be a
 14 patient safety organization shall submit an initial
 15 certification to the Secretary that the entity intends
 16 to perform the patient safety organization activities.

17 “(2) DELAYED CERTIFICATION OF COLLECTION
 18 FROM MORE THAN ONE PROVIDER.—An entity that
 19 seeks to be a patient safety organization may—

20 “(A) submit an initial certification that it
 21 intends to perform patient safety organization
 22 activities other than the activities described in
 23 subparagraph (B) of section 921(4); and

24 “(B) within 2 years of submitting the ini-
 25 tial certification under subparagraph (A), sub-

1 mit a supplemental certification that it per-
2 forms the patient safety organization activities
3 described in subparagraphs (A) through (F) of
4 section 921(4).

5 “(3) EXPIRATION AND RENEWAL.—

6 “(A) EXPIRATION.—An initial certification
7 under paragraph (1) or (2)(A) shall expire on
8 the date that is 3 years after it is submitted.

9 “(B) RENEWAL.—

10 “(i) IN GENERAL.—An entity that
11 seeks to remain a patient safety organiza-
12 tion after the expiration of an initial cer-
13 tification under paragraph (1) or (2)(A)
14 shall, within the 3-year period described in
15 subparagraph (A), submit a renewal cer-
16 tification to the Secretary that the entity
17 performs the patient safety organization
18 activities described in section 921(4).

19 “(ii) TERM OF RENEWAL.—A renewal
20 certification under clause (i) shall expire
21 on the date that is 3 years after the date
22 on which it is submitted, and may be re-
23 newed in the same manner as an initial
24 certification.

1 “(b) ACCEPTANCE OF CERTIFICATION.—Upon the
2 submission by an organization of an initial certification
3 pursuant to subsection (a)(1) or (a)(2)(A), a supplemental
4 certification pursuant to subsection (a)(2)(B), or a re-
5 newal certification pursuant to subsection (a)(3)(B), the
6 Secretary shall review such certification and—

7 “(1) if such certification meets the require-
8 ments of subsection (a)(1), (a)(2)(A), (a)(2)(B), or
9 (a)(3)(B), as applicable, the Secretary shall notify
10 the organization that such certification is accepted;
11 or

12 “(2) if such certification does not meet such re-
13 quirements, as applicable, the Secretary shall notify
14 the organization that such certification is not accept-
15 ed and the reasons therefor.

16 “(c) LISTING.—

17 “(1) IN GENERAL.—Except as otherwise pro-
18 vided in this subsection, the Secretary shall compile
19 and maintain a current listing of patient safety or-
20 ganizations with respect to which the Secretary has
21 accepted a certification pursuant to subsection (b).

22 “(2) REMOVAL FROM LISTING.—The Secretary
23 shall remove from the listing under paragraph (1)—

24 “(A) an entity with respect to which the
25 Secretary has accepted an initial certification

1 pursuant to subsection (a)(2)(A) and which
2 does not submit a supplemental certification
3 pursuant to subsection (a)(2)(B) that is accept-
4 ed by the Secretary;

5 “(B) an entity whose certification expires
6 and which does not submit a renewal applica-
7 tion that is accepted by the Secretary; and

8 “(C) an entity with respect to which the
9 Secretary revokes the Secretary’s acceptance of
10 the entity’s certification, pursuant to subsection
11 (d).

12 “(d) REVOCATION OF ACCEPTANCE.—

13 “(1) IN GENERAL.—Except as provided in para-
14 graph (2), if the Secretary determines (through a re-
15 view of patient safety organization activities) that a
16 patient safety organization does not perform one of
17 the patient safety organization activities described in
18 subparagraph (A) through (F) of section 921(4), the
19 Secretary may, after notice and an opportunity for
20 a hearing, revoke the Secretary’s acceptance of the
21 certification of such organization.

22 “(2) DELAYED CERTIFICATION OF COLLECTION
23 FROM MORE THAN ONE PROVIDER.—A revocation
24 under paragraph (1) may not be based on a deter-

1 mination that the organization does not perform the
2 activity described in section 921(4)(B) if—

3 “(A) the listing of the organization is
4 based on its submittal of an initial certification
5 under subsection (a)(2)(A);

6 “(B) the organization has not submitted a
7 supplemental certification under subsection
8 (a)(2)(B); and

9 “(C) the 2-year period described in sub-
10 section (a)(2)(B) has not expired.

11 “(e) NOTIFICATION OF REVOCATION OR REMOVAL
12 FROM LISTING.—

13 “(1) SUPPLYING CONFIRMATION OF NOTIFICA-
14 TION TO PROVIDERS.—Within 15 days of a revoca-
15 tion under subsection (d)(1), a patient safety organi-
16 zation shall submit to the Secretary a confirmation
17 that the organization has taken all reasonable ac-
18 tions to notify each provider whose patient safety
19 data is collected or analyzed by the organization of
20 such revocation.

21 “(2) PUBLICATION.—Upon the revocation of an
22 acceptance of an organization’s certification under
23 subsection (d)(1), or upon the removal of an organi-
24 zation from the listing under subsection (c)(2), the

1 Secretary shall publish notice of the revocation or
2 removal in the Federal Register.

3 “(f) STATUS OF DATA AFTER REMOVAL FROM LIST-
4 ING.—

5 “(1) NEW DATA.—With respect to the privilege
6 and confidentiality protections described in section
7 922, data submitted to an organization within 30
8 days after the organization is removed from the list-
9 ing under subsection (c)(2) shall have the same sta-
10 tus as data submitted while the organization was
11 still listed.

12 “(2) PROTECTION TO CONTINUE TO APPLY.—If
13 the privilege and confidentiality protections de-
14 scribed in section 922 applied to data while an orga-
15 nization was listed, or during the 30-day period de-
16 scribed in paragraph (1), such protections shall con-
17 tinue to apply to such data after the organization is
18 removed from the listing under subsection (c)(2).

19 “(g) DISPOSITION OF DATA.—If the Secretary re-
20 moves an organization from the listing as provided for in
21 subsection (c)(2), with respect to the patient safety data
22 that the organization received from providers, the organi-
23 zation shall—

1 “(1) with the approval of the provider and an-
2 other patient safety organization, transfer such data
3 to such other organization;

4 “(2) return such data to the person that sub-
5 mitted the data; or

6 “(3) if returning such data to such person is
7 not practicable, destroy such data.

8 **“SEC. 925. TECHNICAL ASSISTANCE.**

9 “The Secretary, acting through the Director, may
10 provide technical assistance to patient safety organiza-
11 tions, including convening annual meetings for patient
12 safety organizations to discuss methodology, communica-
13 tion, data collection, or privacy concerns.

14 **“SEC. 926. PROMOTING THE INTEROPERABILITY OF**
15 **HEALTH CARE INFORMATION TECHNOLOGY**
16 **SYSTEMS.**

17 “(a) DEVELOPMENT.—Not later than 36 months
18 after the date of enactment of the Patient Safety and
19 Quality Improvement Act of 2005, the Secretary shall de-
20 velop or adopt voluntary standards that promote the elec-
21 tronic exchange of health care information.

22 “(b) UPDATES.—The Secretary shall provide for the
23 ongoing review and periodic updating of the standards de-
24 veloped under subsection (a).

1 “(c) DISSEMINATION.—The Secretary shall provide
2 for the dissemination of the standards developed and up-
3 dated under this section.

4 **“SEC. 927. AUTHORIZATION OF APPROPRIATIONS.**

5 “‘There is authorized to be appropriated such sums
6 as may be necessary to carry out this part.’”.

7 **SEC. 144. STUDIES AND REPORTS.**

8 (a) IN GENERAL.—The Secretary of Health and
9 Human Services shall enter into a contract (based upon
10 a competitive contracting process) with an appropriate re-
11 search organization for the conduct of a study to assess
12 the impact of medical technologies and therapies on pa-
13 tient safety, patient benefit, health care quality, and the
14 costs of care as well as productivity growth. Such study
15 shall examine—

16 (1) the extent to which factors, such as the use
17 of labor and technological advances, have contrib-
18 uted to increases in the share of the gross domestic
19 product that is devoted to health care and the im-
20 pact of medical technologies and therapies on such
21 increases;

22 (2) the extent to which early and appropriate
23 introduction and integration of innovative medical
24 technologies and therapies may affect the overall

1 productivity and quality of the health care delivery
2 systems of the United States; and

3 (3) the relationship of such medical technologies
4 and therapies to patient safety, patient benefit,
5 health care quality, and cost of care.

6 (b) REPORT.—Not later than 18 months after the
7 date of enactment of this Act, the Secretary of Health and
8 Human Services shall prepare and submit to the appro-
9 priate committees of Congress a report containing the re-
10 sults of the study conducted under subsection (a).

11 **Subtitle D—Fraud and Abuse**

12 **SEC. 151. NATIONAL EXPANSION OF THE MEDICARE-MED- 13 ICAID DATA MATCH PILOT PROGRAM.**

14 (a) REQUIREMENT OF THE MEDICARE INTEGRITY
15 PROGRAM.—Section 1893 of the Social Security Act (42
16 U.S.C. 1395ddd) is amended—

17 (1) in subsection (b), by adding at the end the
18 following:

19 “(6) The Medicare-Medicaid data match pro-
20 gram in accordance with subsection (g).”; and

21 (2) by adding at the end the following:

22 “(g) MEDICARE-MEDICAID DATA MATCH PRO-
23 GRAM.—

24 “(1) EXPANSION OF PROGRAM.—

1 “(A) IN GENERAL.—The Secretary shall
2 enter into contracts with eligible entities for the
3 purpose of ensuring that, beginning with 2006,
4 the Medicare-Medicaid data match program
5 (commonly referred to as the ‘Medi-Medi Pro-
6 gram’) is conducted with respect to the pro-
7 gram established under this title and the appli-
8 cable number of State Medicaid programs
9 under title XIX for the purpose of—

10 “(i) identifying vulnerabilities in both
11 such programs;

12 “(ii) assisting States, as appropriate,
13 to take action to protect the Federal share
14 of expenditures under the Medicaid pro-
15 gram; and

16 “(iii) increasing the effectiveness and
17 efficiency of both such programs through
18 cost avoidance, savings, and recoupments
19 of fraudulent, wasteful, or abusive expendi-
20 tures.

21 “(B) APPLICABLE NUMBER.—For pur-
22 poses of subparagraph (A), the term ‘applicable
23 number’ means—

24 “(i) in the case of fiscal year 2006, 10
25 State Medicaid programs;

1 “(ii) in the case of fiscal year 2007,
2 12 State Medicaid programs; and

3 “(iii) in the case of fiscal year 2008,
4 15 State Medicaid programs.

5 “(2) LIMITED WAIVER AUTHORITY.—The Sec-
6 retary shall waive only such requirements of this sec-
7 tion and of titles XI and XIX as are necessary to
8 carry out paragraph (1).”.

9 (b) FUNDING.—Section 1817(k)(4) of the Social Se-
10 curity Act (42 U.S.C. 1395i(k)(4)) is amended—

11 (1) in subparagraph (A), by striking “subpara-
12 graph (B)” and inserting “subparagraphs (B) and
13 (C)”;

14 (2) by adding at the end the following:

15 “(C) EXPANSION OF THE MEDICARE-MED-
16 ICAID DATA MATCH PROGRAM.—Of the amount
17 appropriated under subparagraph (A) for a fis-
18 cal year, the following amounts shall be used to
19 carry out section 1893(b)(6) for that year:

20 “(i) \$10,000,000 of the amount ap-
21 propriated for fiscal year 2006.

22 “(ii) \$12,200,000 of the amount ap-
23 propriated for fiscal year 2007.

24 “(iii) \$15,800,000 of the amount ap-
25 propriated for fiscal year 2008.”.

1 **Subtitle E—Miscellaneous**
2 **Provisions**

3 **SEC. 161. SENSE OF THE SENATE ON ESTABLISHING A MAN-**
4 **DATED BENEFITS COMMISSION.**

5 It is the Sense of the Senate that—

6 (1) there should be established an independent
7 Federal entity to study and provide advice to Con-
8 gress on existing and proposed federally mandated
9 health insurance benefits offered by employer-spon-
10 sored health plans and insurance issuers; and

11 (2) advice provided under paragraph (1) should
12 be evidence- and actuarially-based, and take into
13 consideration the population costs and benefits, in-
14 cluding the health, financial, and social impact on
15 affected populations, safety and medical efficacy, the
16 impact on costs and access to insurance generally,
17 and to different types of insurance products, the im-
18 pact on labor costs and jobs, and any other relevant
19 factors.

20 **SEC. 162. ENFORCEMENT OF REIMBURSEMENT PROVI-**
21 **SIONS BY FIDUCIARIES.**

22 Section 502(a)(3) of the Employee Retirement In-
23 come Security Act of 1974 (29 U.S.C. 1132(a)(3)) is
24 amended by inserting before the semicolon the following:
25 “(which may include the recovery of amounts on behalf

1 of the plan by a fiduciary enforcing the terms of the plan
 2 that provide a right of recovery by reimbursement or sub-
 3 rogation with respect to benefits provided to a participant
 4 or beneficiary)”.
 5

6 **TITLE II—EXPANDING ACCESS**
 7 **TO AFFORDABLE HEALTH**
 8 **COVERAGE THROUGH TAX IN-**
 9 **CENTIVES AND OTHER INI-**
 10 **TIATIVES**

11 **Subtitle A—Refundable Health**
 12 **Insurance Credit**

13 **SEC. 201. REFUNDABLE HEALTH INSURANCE COSTS CRED-**
 14 **IT.**

15 (a) ALLOWANCE OF CREDIT.—

16 (1) IN GENERAL.—Subpart C of part IV of sub-
 17 chapter A of chapter 1 of the Internal Revenue Code
 18 of 1986 (relating to refundable personal credits) is
 19 amended by redesignating section 36 as section 37
 20 and by inserting after section 35 the following new
 21 section:

22 **“SEC. 36. HEALTH INSURANCE COSTS FOR UNINSURED IN-**
 23 **DIVIDUALS.**

24 “(a) ALLOWANCE OF CREDIT.—In the case of an in-
 25 dividual, there shall be allowed as a credit against the tax
 imposed by this subtitle for the taxable year an amount

1 equal to the amount paid by the taxpayer during such tax-
2 able year for qualified health insurance for the taxpayer
3 and the taxpayer's spouse and dependents.

4 “(b) LIMITATIONS.—

5 “(1) IN GENERAL.—Except as provided in para-
6 graphs (2) and (3), the amount allowed as a credit
7 under subsection (a) to the taxpayer for the taxable
8 year shall not exceed the lesser of—

9 “(A) 90 percent of the sum of the amounts
10 paid by the taxpayer for qualified health insur-
11 ance for each individual referred to in sub-
12 section (a) for coverage months of the indi-
13 vidual during the taxable year, or

14 “(B) \$3,000.

15 “(2) MONTHLY LIMITATION.—

16 “(A) IN GENERAL.—For purposes of para-
17 graph (1), amounts paid by the taxpayer for
18 qualified health insurance for an individual for
19 any coverage month of such individual during
20 the taxable year shall not be taken into account
21 to the extent such amounts exceed the amount
22 equal to $\frac{1}{12}$ of—

23 “(i) \$1,111 if such individual is the
24 taxpayer,

25 “(ii) \$1,111 if—

1 “(I) such individual is the spouse
2 of the taxpayer,

3 “(II) the taxpayer and such
4 spouse are married as of the first day
5 of such month, and

6 “(III) the taxpayer files a joint
7 return for the taxable year,

8 “(iii) \$1,111 if such individual has at-
9 tained the age of 24 as of the close of the
10 taxable year and is a dependent of the tax-
11 payer for such taxable year, and

12 “(iv) one-half of the amount described
13 in clause (i) if such individual has not at-
14 tained the age of 24 as of the close of the
15 taxable year and is a dependent of the tax-
16 payer for such taxable year.

17 “(B) LIMITATION TO 2 YOUNG DEPEND-
18 ENTS.—If there are more than 2 individuals de-
19 scribed in subparagraph (A)(iv) with respect to
20 the taxpayer for any coverage month, the aggre-
21 gate amounts paid by the taxpayer for qualified
22 health insurance for such individuals which may
23 be taken into account under paragraph (1) shall
24 not exceed $\frac{1}{12}$ of the dollar amount in effect

1 under subparagraph (A)(i) for the coverage
2 month.

3 “(C) SPECIAL RULE FOR MARRIED INDI-
4 VIDUALS.—In the case of a taxpayer—

5 “(i) who is married (within the mean-
6 ing of section 7703) as of the close of the
7 taxable year but does not file a joint return
8 for such year, and

9 “(ii) who does not live apart from
10 such taxpayer’s spouse at all times during
11 the taxable year,

12 any dollar limitation imposed under this para-
13 graph on amounts paid for qualified health in-
14 surance for individuals described in subpara-
15 graph (A)(iv) shall be divided equally between
16 the taxpayer and the taxpayer’s spouse unless
17 they agree on a different division.

18 “(3) INCOME PHASEOUT OF CREDIT PERCENT-
19 AGE FOR ONE-PERSON COVERAGE.—

20 “(A) PHASEOUT FOR UNMARRIED INDIVID-
21 UALS (OTHER THAN SURVIVING SPOUSES AND
22 HEADS OF HOUSEHOLDS).—In the case of an
23 individual (other than a surviving spouse, the
24 head of a household, or a married individual)

1 with one-person coverage, if such individual has
2 modified adjusted gross income—

3 “(i) in excess of \$15,000 for a taxable
4 year but not in excess of \$20,000, the 90
5 percent under paragraph (1)(B) shall be
6 reduced by the number of percentage
7 points which bears the same ratio to 40
8 percentage points as—

9 “(I) the excess of modified ad-
10 justed gross income in excess of
11 \$15,000, bears to

12 “(II) \$5,000, or

13 “(ii) in excess of \$20,000 for a tax-
14 able year, the 90 percent under paragraph
15 (1)(B) shall be reduced by the sum of 40
16 percentage points plus the number of per-
17 centage points which bears the same ratio
18 to 50 percentage points as—

19 “(I) the excess of modified ad-
20 justed gross income in excess of
21 \$20,000, bears to

22 “(II) \$10,000.

23 “(B) PHASEOUT FOR OTHER INDIVID-
24 UALS.—In the case of a taxpayer (other than
25 an individual described in subparagraph (A) or

1 (C)) with one-person coverage, if the taxpayer
2 has modified adjusted gross income in excess of
3 \$25,000 for a taxable year, the 90 percent
4 under paragraph (1)(B) shall be reduced by the
5 number of percentage points which bears the
6 same ratio to 90 percentage points as—

7 “(i) the excess of modified adjusted
8 gross income in excess of \$25,000, bears to

9 “(ii) \$15,000.

10 “(C) MARRIED FILING SEPARATE RE-
11 TURN.—In the case of a taxpayer who is mar-
12 ried filing a separate return for the taxable year
13 and who has one-person coverage, if the tax-
14 payer has modified adjusted gross income in ex-
15 cess of \$12,500 for the taxable year, the 90
16 percent under paragraph (1)(B) shall be re-
17 duced by the number of percentage points
18 which bears the same ratio to 90 percentage
19 points as—

20 “(i) the excess of modified adjusted
21 gross income in excess of \$12,500, bears to

22 “(ii) \$7,500.

23 “(4) INCOME PHASEOUT OF CREDIT PERCENT-
24 AGE FOR COVERAGE OF MORE THAN ONE PERSON.—

1 “(A) IN GENERAL.—Except as provided in
2 subparagraph (B), in the case of a taxpayer
3 with coverage of more than one person, if the
4 taxpayer has modified adjusted gross income in
5 excess of \$25,000 for a taxable year, the 90
6 percent under paragraph (1)(B) shall be re-
7 duced by the number of percentage points
8 which bears the same ratio to 90 percentage
9 points as—

10 “(i) the excess of modified adjusted
11 gross income in excess of \$25,000, bears to

12 “(ii) \$35,000.

13 “(B) MARRIED FILING SEPARATE RE-
14 TURN.—In the case of a taxpayer who is mar-
15 ried filing a separate return for the taxable year
16 and who has coverage of more than one person,
17 if the taxpayer has modified adjusted gross in-
18 come in excess of \$12,500 for the taxable year,
19 the 90 percent under paragraph (1)(B) shall be
20 reduced by the number of percentage points
21 which bears the same ratio to 90 percentage
22 points as—

23 “(i) the excess of modified adjusted
24 gross income in excess of \$12,500, bears to

25 “(ii) \$17,500.

1 “(5) ROUNDING.—Any percentage resulting
2 from a reduction under paragraphs (3) and (4) shall
3 be rounded to the nearest one-tenth of a percent.

4 “(6) MODIFIED ADJUSTED GROSS INCOME.—
5 The term ‘modified adjusted gross income’ means
6 adjusted gross income determined—

7 “(A) without regard to this section and
8 sections 911, 931, and 933, and

9 “(B) after application of sections 86, 135,
10 137, 219, 221, and 469.

11 “(c) COVERAGE MONTH.—For purposes of this sec-
12 tion—

13 “(1) IN GENERAL.—The term ‘coverage month’
14 means, with respect to an individual, any month if—

15 “(A) as of the first day of such month
16 such individual is covered by qualified health in-
17 surance, and

18 “(B) the premium for coverage under such
19 insurance for such month is paid by the tax-
20 payer.

21 “(2) GROUP HEALTH PLAN COVERAGE.—

22 “(A) IN GENERAL.—The term ‘coverage
23 month’ shall not include any month for which
24 if, as of the first day of the month, the indi-
25 vidual participates in any group health plan

1 (within the meaning of section 5000 without re-
2 gard to section 5000(d)).

3 “(B) EXCEPTION FOR CERTAIN PER-
4 MITTED COVERAGE.—Subparagraph (A) shall
5 not apply to an individual if the individual’s
6 only coverage for a month is coverage described
7 in clause (i) or (ii) of section 223(c)(1)(B).

8 “(3) EMPLOYER-PROVIDED COVERAGE.—The
9 term ‘coverage month’ shall not include any month
10 during a taxable year if any amount is not includible
11 in the gross income of the taxpayer for such year
12 under section 106 (other than coverage described in
13 clause (i) or (ii) of section 223(c)(1)(B)).

14 “(4) MEDICARE, MEDICAID, AND SCHIP.—The
15 term ‘coverage month’ shall not include any month
16 with respect to an individual if, as of the first day
17 of such month, such individual—

18 “(A) is entitled to any benefits under part
19 A of title XVIII of the Social Security Act or
20 is enrolled under part B of such title, or

21 “(B) is enrolled in the program under title
22 XIX or XXI of such Act (other than under sec-
23 tion 1928 of such Act).

24 “(5) CERTAIN OTHER COVERAGE.—The term
25 ‘coverage month’ shall not include any month during

1 a taxable year with respect to an individual if, as of
2 the first day of such month at any time during such
3 month, such individual is enrolled in a program
4 under—

5 “(A) chapter 89 of title 5, United States
6 Code, or

7 “(B) chapter 55 of title 10, United States
8 Code.

9 “(6) PRISONERS.—The term ‘coverage month’
10 shall not include any month with respect to an indi-
11 vidual if, as of the first day of such month, such in-
12 dividual is imprisoned under Federal, State, or local
13 authority.

14 “(7) INSUFFICIENT PRESENCE IN UNITED
15 STATES.—The term ‘coverage month’ shall not in-
16 clude any month during a taxable year with respect
17 to an individual if such individual is present in the
18 United States on fewer than 183 days during such
19 year (determined in accordance with section
20 7701(b)(7)).

21 “(d) QUALIFIED HEALTH INSURANCE.—For pur-
22 poses of this section—

23 “(1) IN GENERAL.—The term ‘qualified health
24 insurance’ means health insurance coverage (as de-
25 fined in section 9832(b)(1)) which—

1 “(A) is coverage described in paragraph
2 (2), and

3 “(B) meets the requirements of paragraph
4 (3).

5 “(2) ELIGIBLE COVERAGE.—Coverage described
6 in this paragraph is the following:

7 “(A) Coverage under individual health in-
8 surance.

9 “(B) Coverage through a private sector
10 health care coverage purchasing pool.

11 “(C) Coverage through a State care cov-
12 erage purchasing pool.

13 “(D) Coverage under a State high-risk
14 pool described in subparagraph (C) of section
15 35(e)(1).

16 “(E) Coverage after December 31, 2006,
17 under an eligible State buy in program.

18 “(3) REQUIREMENTS.—The requirements of
19 this paragraph are as follows:

20 “(A) COST LIMITS.—The coverage meets
21 the requirements of section 223(c)(2)(A)(ii).

22 “(B) MAXIMUM BENEFITS.—Under the
23 coverage, the annual and lifetime maximum
24 benefits are not less than \$700,000.

1 “(C) BROAD COVERAGE.—The coverage in-
2 cludes inpatient and outpatient care, emergency
3 benefits, and physician care.

4 “(D) GUARANTEED RENEWABILITY.—Such
5 coverage is guaranteed renewable by the pro-
6 vider.

7 “(4) ELIGIBLE STATE BUY IN PROGRAM.—For
8 purposes of paragraph (2)(E)—

9 “(A) IN GENERAL.—The term ‘eligible
10 State buy in program’ means a State program
11 under which an individual who—

12 “(i) is not eligible for assistance under
13 the State medicaid program under title
14 XIX of the Social Security Act,

15 “(ii) is not eligible for assistance
16 under the State children’s health insurance
17 program under title XXI of such Act, or

18 “(iii) is not a State employee,
19 is able to buy health insurance coverage
20 through a purchasing arrangement entered into
21 between the State and a private sector health
22 care purchasing group or health plan.

23 “(B) REQUIREMENTS.—Subparagraph (A)
24 shall only apply to a State program if—

1 “(i) the program uses private sector
2 health care purchasing groups or health
3 plans, and

4 “(ii) the State maintains separate risk
5 pools for participants under the State buy
6 in program and other participants.

7 “(C) SUBSIDIES.—

8 “(i) IN GENERAL.—A State program
9 shall not fail to be treated as an eligible
10 State buy in program merely because the
11 State subsidizes the costs of an individual
12 in buying health insurance coverage under
13 the program.

14 “(ii) EXCEPTION.—Clause (i) shall
15 not apply if the State subsidy under the
16 program for any adult for any consecutive
17 12-month period exceeds the applicable
18 dollar amount.

19 “(iii) APPLICABLE DOLLAR
20 AMOUNT.—

21 “(I) IN GENERAL.—For purposes
22 of clause (ii), the applicable dollar
23 amount is \$2,000.

24 “(II) REDUCTION.—In the case
25 of a family with annual income in ex-

1 cess of 133 percent of the applicable
2 poverty line (as determined in accord-
3 ance with criteria established by the
4 Director of the Office of Management
5 and Budget) but not in excess of 200
6 percent of such line, the dollar
7 amount under clause (i) shall be rat-
8 ably reduced (but not below zero) for
9 each dollar of such excess. In the case
10 of a family with annual income in ex-
11 cess of 200 percent of such line, the
12 applicable dollar amount shall be zero.

13 “(e) ARRANGEMENTS UNDER WHICH INSURERS
14 CONTRIBUTE TO HSA.—

15 “(1) IN GENERAL.—For purposes of this sec-
16 tion, health insurance shall not be treated as quali-
17 fied health insurance if the insurer makes contribu-
18 tions to a health savings account of the taxpayer un-
19 less such insurance is provided under an arrange-
20 ment described in paragraph (2).

21 “(2) ARRANGEMENTS DESCRIBED.—

22 “(A) AMOUNTS PAID FOR COVERAGE EX-
23 CEED MONTHLY LIMITATION.—In the case of
24 amounts paid under an arrangement for health
25 insurance for a coverage month in excess of the

1 amount in effect under subsection (b)(2)(A) for
2 such month, an arrangement is described in
3 this subparagraph if under the arrangement—

4 “(i) the aggregate amount contributed
5 by the insurer to any health savings ac-
6 count of the taxpayer does not exceed 90
7 percent of the excess of—

8 “(I) the amount paid by the tax-
9 payer for qualified health insurance
10 under such arrangement for such
11 month, over

12 “(II) the amount in effect under
13 subsection (b)(2)(A) for such month,
14 and

15 “(ii) the amount contributed by the
16 insurer to a qualified health savings ac-
17 count of the taxpayer, reduced by the
18 amount of the excess under clause (i), does
19 not exceed 27 percent of the amount in ef-
20 fect under subsection (b)(2)(A) for such
21 month.

22 “(B) AMOUNTS PAID FOR COVERAGE LESS
23 THAN MONTHLY LIMITATION.—In the case of
24 an arrangement under which the amount paid
25 for qualified health insurance for a coverage

1 month does not exceed the amount in effect
2 under subsection (b)(2)(A) for such month, an
3 arrangement is described in this subparagraph
4 if—

5 “(i) under the arrangement the value
6 of the insured benefits (excluding over-
7 head) exceeds 65 percent of the amount
8 paid for qualified health insurance for such
9 month, and

10 “(ii) the amount contributed by the
11 insurer to a qualified health savings ac-
12 count of the taxpayer does not exceed 27
13 percent of the amount in effect under sub-
14 section (b)(2)(A) for such month.

15 “(3) QUALIFIED HEALTH SAVINGS ACCOUNT.—

16 “(A) IN GENERAL.—The term ‘qualified
17 health savings account’ means a health savings
18 account (as defined in section 223(d))—

19 “(i) which is designated (in such form
20 as the Secretary may prescribe) as a quali-
21 fied account for purposes of this section,

22 “(ii) which may not include any
23 amount other than contributions described
24 in this subsection and earnings on such
25 contributions, and

1 “(iii) with respect to which section
2 223(f)(4)(A) is applied by substituting
3 ‘100 percent’ for ‘10 percent’.

4 “(B) SUBACCOUNTS AND SEPARATE AC-
5 COUNTING.—The Secretary may prescribe rules
6 under which a subaccount within a health sav-
7 ings account, or separate accounting with re-
8 spect to contributions and earnings described in
9 subparagraph (A)(ii), may be treated in the
10 same manner as a qualified health savings ac-
11 count.

12 “(C) ROLLOVERS.—A contribution of a
13 distribution from a qualified health savings ac-
14 count to another health savings account shall be
15 treated as a rollover contribution for purposes
16 of section 223(f)(5) only if the other account is
17 a qualified health savings account.

18 “(f) DEPENDENTS.—For purposes of this section—

19 “(1) DEPENDENT DEFINED.—The term ‘de-
20 pendent’ has the meaning given such term by section
21 152 (determined without regard to subsections
22 (b)(1), (b)(2), and (d)(1)(B) thereof).

23 “(2) SPECIAL RULE FOR DEPENDENT CHILD OF
24 DIVORCED PARENTS.—An individual who is a child
25 to whom section 152(e) applies shall be treated as

1 a dependent of the custodial parent for a coverage
2 month unless the custodial and noncustodial parent
3 provide otherwise.

4 “(3) DENIAL OF CREDIT TO DEPENDENTS.—No
5 credit shall be allowed under this section to any indi-
6 vidual with respect to whom a deduction under sec-
7 tion 151(c) is allowable to another taxpayer for a
8 taxable year beginning in the calendar year in which
9 such individual’s taxable year begins.

10 “(g) INFLATION ADJUSTMENTS.—

11 “(1) CREDIT AND HEALTH INSURANCE
12 AMOUNTS.—In the case of any taxable year begin-
13 ning after 2006, each dollar amount referred to in
14 subsections (b)(1)(B), (b)(2)(A), (d)(3)(B), and
15 (d)(4)(C)(iii)(I) shall be increased by an amount
16 equal to—

17 “(A) such dollar amount, multiplied by

18 “(B) the cost-of-living adjustment deter-
19 mined under section 213(d)(10)(B)(ii) for the
20 calendar year in which the taxable year begins,
21 determined by substituting ‘2005’ for ‘1996’ in
22 subclause (II) thereof.

23 If any amount as adjusted under the preceding sen-
24 tence is not a multiple of \$10, such amount shall be
25 rounded to the nearest multiple of \$10.

1 “(2) INCOME PHASEOUT AMOUNTS.—In the
2 case of any taxable year beginning after 2006, each
3 dollar amount referred to in paragraph (3) and (4)
4 of subsection (b) shall be increased by an amount
5 equal to—

6 “(A) such dollar amount, multiplied by

7 “(B) the cost-of-living adjustment deter-
8 mined under section 1(f)(3) for the calendar
9 year in which the taxable year begins, deter-
10 mined by substituting ‘calendar year 2005’ for
11 ‘calendar year 1992’ in subparagraph (B)
12 thereof.

13 If any amount as adjusted under the preceding sen-
14 tence is not a multiple of \$50, such amount shall be
15 rounded to the next lowest multiple of \$50.

16 “(h) ARCHER MSA CONTRIBUTIONS; HSA CON-
17 TRIBUTIONS.—If a deduction would be allowed under sec-
18 tion 220 to the taxpayer for a payment for the taxable
19 year to the Archer MSA of an individual or under section
20 223 to the taxpayer for a payment for the taxable year
21 to the Health Savings Account of such individual, sub-
22 section (a) shall not apply to the taxpayer for any month
23 during such taxable year for which the taxpayer, spouse,
24 or dependent is an eligible individual for purposes of either
25 such section.

1 “(i) OTHER RULES.—For purposes of this section—

2 “(1) COORDINATION WITH MEDICAL EXPENSE
3 AND PREMIUM DEDUCTIONS FOR HIGH DEDUCTIBLE
4 HEALTH PLANS.—The amount which would (but for
5 this paragraph) be taken into account by the tax-
6 payer under section 213 or 224 for the taxable year
7 shall be reduced by the credit (if any) allowed by
8 this section to the taxpayer for such year.

9 “(2) COORDINATION WITH DEDUCTION FOR
10 HEALTH INSURANCE COSTS OF SELF-EMPLOYED IN-
11 DIVIDUALS.—No credit shall be allowable under this
12 section for a taxable year if a deduction is allowed
13 under section 162(1) for the taxable year.

14 “(3) COORDINATION WITH ADVANCE PAY-
15 MENT.—Rules similar to the rules of section
16 35(g)(1) shall apply to any credit to which this sec-
17 tion applies.

18 “(4) COORDINATION WITH SECTION 35.—If a
19 taxpayer is eligible for the credit allowed under this
20 section and section 35 for any taxable year, the tax-
21 payer shall elect which credit is to be allowed.

22 “(j) EXPENSES MUST BE SUBSTANTIATED.—A pay-
23 ment for insurance to which subsection (a) applies may
24 be taken into account under this section only if the tax-

1 payer substantiates such payment in such form as the Sec-
 2 retary may prescribe.

3 “(k) REGULATIONS.—The Secretary shall prescribe
 4 such regulations as may be necessary to carry out the pur-
 5 poses of this section.”.

6 (b) INFORMATION REPORTING.—

7 (1) IN GENERAL.—Subpart B of part III of
 8 subchapter A of chapter 61 of the Internal Revenue
 9 Code of 1986 (relating to information concerning
 10 transactions with other persons) is amended by in-
 11 serting after section 6050T the following:

12 **“SEC. 6050U. RETURNS RELATING TO PAYMENTS FOR**
 13 **QUALIFIED HEALTH INSURANCE.**

14 “(a) IN GENERAL.—Any person who, in connection
 15 with a trade or business conducted by such person, re-
 16 ceives payments during any calendar year from any indi-
 17 vidual for coverage of such individual or any other indi-
 18 vidual under creditable health insurance, shall make the
 19 return described in subsection (b) (at such time as the
 20 Secretary may by regulations prescribe) with respect to
 21 each individual from whom such payments were received.

22 “(b) FORM AND MANNER OF RETURNS.—A return
 23 is described in this subsection if such return—

24 “(1) is in such form as the Secretary may pre-
 25 scribe, and

1 “(2) contains—

2 “(A) the name, address, and TIN of the
3 individual from whom payments described in
4 subsection (a) were received,

5 “(B) the name, address, and TIN of each
6 individual who was provided by such person
7 with coverage under creditable health insurance
8 by reason of such payments and the period of
9 such coverage,

10 “(C) the aggregate amount of payments
11 described in subsection (a), and

12 “(D) such other information as the Sec-
13 retary may reasonably prescribe.

14 “(c) CREDITABLE HEALTH INSURANCE.—For pur-
15 poses of this section, the term ‘creditable health insurance’
16 means qualified health insurance (as defined in section
17 36(d)).

18 “(d) STATEMENTS TO BE FURNISHED TO INDIVID-
19 UALS WITH RESPECT TO WHOM INFORMATION IS RE-
20 QUIRED.—Every person required to make a return under
21 subsection (a) shall furnish to each individual whose name
22 is required under subsection (b)(2)(A) to be set forth in
23 such return a written statement showing—

1 “(1) the name and address of the person re-
2 quired to make such return and the phone number
3 of the information contact for such person,

4 “(2) the aggregate amount of payments de-
5 scribed in subsection (a) received by the person re-
6 quired to make such return from the individual to
7 whom the statement is required to be furnished, and

8 “(3) the information required under subsection
9 (b)(2)(B) with respect to such payments.

10 The written statement required under the preceding sen-
11 tence shall be furnished on or before January 31 of the
12 year following the calendar year for which the return
13 under subsection (a) is required to be made.

14 “(e) RETURNS WHICH WOULD BE REQUIRED TO BE
15 MADE BY 2 OR MORE PERSONS.—Except to the extent
16 provided in regulations prescribed by the Secretary, in the
17 case of any amount received by any person on behalf of
18 another person, only the person first receiving such
19 amount shall be required to make the return under sub-
20 section (a).”.

21 (2) ASSESSABLE PENALTIES.—

22 (A) Subparagraph (B) of section
23 6724(d)(1) of such Code (relating to defini-
24 tions) is amended by redesignating clauses (xiii)
25 through (xviii) as clauses (xiv) through (xix),

1 respectively, and by inserting after clause (xii)
2 the following:

3 “(xiii) section 6050U (relating to re-
4 turns relating to payments for qualified
5 health insurance),”.

6 (B) Paragraph (2) of section 6724(d) of
7 such Code is amended by striking “or” at the
8 end of subparagraph (AA), by striking the pe-
9 riod at the end of the subparagraph (BB) and
10 inserting “, or”, and by adding at the end the
11 following:

12 “(CC) section 6050U(d) (relating to re-
13 turns relating to payments for qualified health
14 insurance).”.

15 (3) CLERICAL AMENDMENT.—The table of sec-
16 tions for subpart B of part III of subchapter A of
17 chapter 61 of such Code is amended by inserting
18 after the item relating to section 6050T the fol-
19 lowing:

 “Sec. 6050U. Returns relating to payments for qualified health insurance.”.

20 (c) CRIMINAL PENALTY FOR FRAUD.—Subchapter B
21 of chapter 75 of the Internal Revenue Code of 1986 (relat-
22 ing to other offenses) is amended by adding at the end
23 the following:

1 **“SEC. 7276. PENALTIES FOR OFFENSES RELATING TO**
2 **HEALTH INSURANCE TAX CREDIT.**

3 “Any person who knowingly misuses Department of
4 the Treasury names, symbols, titles, or initials to convey
5 the false impression of association with, or approval or en-
6 dorsement by, the Department of the Treasury of any in-
7 surance products or group health coverage in connection
8 with the credit for health insurance costs under section
9 36 shall on conviction thereof be fined not more than
10 \$10,000, or imprisoned not more than 1 year, or both.”.

11 (d) CONFORMING AMENDMENTS.—

12 (1) Section 162(l) of the Internal Revenue Code
13 of 1986 is amended by adding at the end the fol-
14 lowing:

15 “(6) ELECTION TO HAVE SUBSECTION
16 APPLY.—No deduction shall be allowed under para-
17 graph (1) for a taxable year unless the taxpayer
18 elects to have this subsection apply for such year.”.

19 (2) Paragraph (2) of section 1324(b) of title
20 31, United States Code, is amended by inserting be-
21 fore the period “, or from section 36 of such Code”.

22 (3) The table of sections for subpart C of part
23 IV of subchapter A of chapter 1 of the Internal Rev-
24 enue Code of 1986 is amended by striking “35” and

1 inserting “36” and by inserting after the item relat-
 2 ing to section 35 the following:

“Sec. 36. Health insurance costs for uninsured individuals.”.

3 (4) The table of sections for subchapter B of
 4 chapter 75 of such Code is amended by adding at
 5 the end the following:

“Sec. 7276. Penalties for offenses relating to health insurance tax credit.”.

6 (e) EFFECTIVE DATES.—

7 (1) IN GENERAL.—Except as provided in para-
 8 graph (2), the amendments made by this section
 9 shall apply to taxable years beginning after Decem-
 10 ber 31, 2005.

11 (2) PENALTIES.—The amendments made by
 12 subsections (c) and (d)(4) shall take effect on the
 13 date of the enactment of this Act.

14 **SEC. 202. ADVANCE PAYMENT OF CREDIT TO ISSUERS OF**
 15 **QUALIFIED HEALTH INSURANCE.**

16 (a) IN GENERAL.—Chapter 77 of the Internal Rev-
 17 enue Code of 1986 (relating to miscellaneous provisions)
 18 is amended by adding at the end the following:

19 **“SEC. 7529. ADVANCE PAYMENT OF CREDIT FOR HEALTH**
 20 **INSURANCE COSTS OF ELIGIBLE INDIVID-**
 21 **UALS.**

22 “Not later than July 1, 2007, the Secretary shall es-
 23 tablish a program for making payments to providers of
 24 qualified health insurance (as defined in section 36(d)) on

1 behalf of individuals eligible for the credit under section
 2 36. Such payments shall be made on the basis of modified
 3 adjusted gross income of eligible individuals for the pre-
 4 ceding taxable year.”.

5 (b) CLERICAL AMENDMENT.—The table of sections
 6 for chapter 77 of the Internal Revenue Code of 1986 is
 7 amended by adding at the end the following:

“Sec. 7529. Advance payment of health insurance credit for purchasers of
 qualified health insurance.”.

8 **Subtitle B—High Deductible Health**
 9 **Plans and Health Savings Accounts**

10 **SEC. 211. DEDUCTION OF PREMIUMS FOR HIGH DEDUCT-**
 11 **IBLE HEALTH PLANS.**

12 (a) IN GENERAL.—Part VII of subchapter B of chap-
 13 ter 1 of the Internal Revenue Code of 1986 (relating to
 14 additional itemized deductions for individuals) is amended
 15 by redesignating section 224 as section 225 and by insert-
 16 ing after section 223 the following new section:

17 **“SEC. 224. PREMIUMS FOR HIGH DEDUCTIBLE HEALTH**
 18 **PLANS.**

19 “(a) DEDUCTION ALLOWED.—In the case of an indi-
 20 vidual, there shall be allowed as a deduction for the tax-
 21 able year the aggregate amount paid by or on behalf of
 22 such individual as premiums under a high deductible
 23 health plan with respect to months during such year for

1 which such individual is an eligible individual with respect
2 to such health plan.

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

4 “(1) ELIGIBLE INDIVIDUAL.—The term ‘eligible
5 individual’ has the meaning given such term by sec-
6 tion 223(c)(1).

7 “(2) HIGH DEDUCTIBLE HEALTH PLAN.—The
8 term ‘high deductible health plan’ has the meaning
9 given such term by section 223(c)(2).

10 “(c) SPECIAL RULES.—

11 “(1) DEDUCTION ALLOWABLE FOR ONLY 1
12 PLAN.—For purposes of this section, in the case of
13 an individual covered by more than 1 high deductible
14 health plan for any month, the individual may only
15 take into account amounts paid for 1 of such plans
16 for such month.

17 “(2) GROUP HEALTH PLAN COVERAGE.—

18 “(A) IN GENERAL.—No deduction shall be
19 allowed to an individual under subsection (a)
20 for any amount paid for coverage under a high
21 deductible health plan for a month if, as of the
22 first day of that month, that individual partici-
23 pates in any coverage under a group health
24 plan (within the meaning of section 5000 with-
25 out regard to section 5000(d)).

1 “(B) EXCEPTION FOR CERTAIN PER-
2 MITTED COVERAGE.—Subparagraph (A) shall
3 not apply to an individual if the individual’s
4 only coverage under a group health plan for a
5 month is coverage described in clause (i) or (ii)
6 of section 223(c)(1)(B).

7 “(3) MEDICARE ELIGIBLE INDIVIDUALS.—No
8 deduction shall be allowed under subsection (a) with
9 respect to any individual for any month if the indi-
10 vidual is entitled to benefits under title XVIII of the
11 Social Security Act for the month.

12 “(4) HEALTH SAVINGS ACCOUNT REQUIRED.—
13 A deduction shall not be allowed under subsection
14 (a) for a taxable year with respect to an individual
15 unless the individual is an account beneficiary of a
16 health savings account during a portion of the tax-
17 able year.

18 “(5) MEDICAL AND HEALTH SAVINGS AC-
19 COUNTS.—Subsection (a) shall not apply with re-
20 spect to any amount which is paid or distributed out
21 of an Archer MSA or a health savings account which
22 is not included in gross income under section 220(f)
23 or 223(f), as the case may be.

24 “(6) COORDINATION WITH DEDUCTION FOR
25 HEALTH INSURANCE OF SELF-EMPLOYED INDIVID-

1 UALS.—The amount taken into account by the tax-
 2 payer in computing the deduction under section
 3 162(l) shall not be taken into account under this
 4 section.

5 “(7) COORDINATION WITH MEDICAL EXPENSE
 6 DEDUCTION.—The amount taken into account by
 7 the taxpayer in computing the deduction under this
 8 section shall not be taken into account under section
 9 213.”.

10 (b) DEDUCTION ALLOWED WHETHER OR NOT INDI-
 11 VIDUAL ITEMIZES OTHER DEDUCTIONS.—Subsection (a)
 12 of section 62 of the Internal Revenue Code of 1986 (defin-
 13 ing adjusted gross income) is amended by inserting before
 14 the last sentence at the end the following new paragraph:

15 “(21) PREMIUMS FOR HIGH DEDUCTIBLE
 16 HEALTH PLANS.—The deduction allowed by section
 17 224.”.

18 (c) COORDINATION WITH HEALTH INSURANCE
 19 COSTS CREDIT.—Section 35(g)(2) of the Internal Rev-
 20 enue Code of 1986 is amended by striking “or 213” and
 21 inserting “,213, or 224”.

22 (d) CLERICAL AMENDMENT.—The table of sections
 23 for part VII of subchapter B of chapter 1 of the Internal
 24 Revenue Code of 1986 is amended by redesignating sec-

1 tion 224 as section 225 and by inserting before such item
2 the following new item:

“Sec. 224. Premiums for high deductible health plans.”.

3 (e) **EFFECTIVE DATE.**—The amendments made by
4 this section shall apply to taxable years beginning after
5 December 31, 2005.

6 **SEC. 212. REFUNDABLE CREDIT FOR CONTRIBUTIONS TO**
7 **HEALTH SAVINGS ACCOUNTS OF SMALL BUSI-**
8 **NESS EMPLOYEES.**

9 (a) **IN GENERAL.**—Subpart C of part IV of sub-
10 chapter A of chapter 1 of the Internal Revenue Code of
11 1986, as amended by subtitle A, is amended by inserting
12 after section 36 the following new section:

13 **“SEC. 36A. SMALL EMPLOYER CONTRIBUTIONS TO HEALTH**
14 **SAVINGS ACCOUNTS.**

15 “(a) **GENERAL RULE.**—In the case of an eligible em-
16 ployer, there shall be allowed as a credit against the tax
17 imposed by this subtitle an amount equal to the lesser of—

18 “(1) the amount contributed by such employer
19 to any qualified health savings account of any em-
20 ployee who is an eligible individual (as defined in
21 section 223(c)(1)) during the taxable year, or

22 “(2) an amount equal to the product of—

23 “(A) \$200 (\$500 if coverage for all months
24 described in subparagraph (B)(i) is family cov-
25 erage), and

1 “(B) a fraction—

2 “(i) the numerator of which is the
3 number of months that the employee was
4 covered under a high deductible health
5 plan maintained by the employer, and

6 “(ii) the denominator of which is the
7 number of months in the taxable year.

8 “(b) ELIGIBLE EMPLOYER.—For purposes of this
9 section—

10 “(1) IN GENERAL.—The term ‘eligible em-
11 ployer’ means, with respect to any taxable year, an
12 employer which—

13 “(A) is a small employer, and

14 “(B) maintains a high deductible health
15 plan under which all employees of the employer
16 reasonably expected to receive at least \$5,000
17 of compensation during the taxable year are eli-
18 gible to participate.

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

24 “(2) EXCEPTION FOR GOVERNMENTAL AND
25 TAX-EXEMPT EMPLOYERS.—The term ‘eligible em-

1 employer’ shall not include the Federal Government or
2 any employer described in section 457(e)(1).

3 “(3) SMALL EMPLOYER.—

4 “(A) IN GENERAL.—The term ‘small em-
5 ployer’ means, with respect to any calendar
6 year, any employer if such employer employed
7 an average of 100 or fewer employees on busi-
8 ness days during either of the 2 preceding cal-
9 endar years. For purposes of the preceding sen-
10 tence, a preceding calendar year may be taken
11 into account only if the employer was in exist-
12 ence throughout such year.

13 “(B) EMPLOYERS NOT IN EXISTENCE IN
14 PRECEDING YEAR.—In the case of an employer
15 which was not in existence throughout the 1st
16 preceding calendar year, the determination
17 under subparagraph (A) shall be based on the
18 average number of employees that it is reason-
19 ably expected such employer will employ on
20 business days in the current calendar year.

21 “(C) SPECIAL RULE.—Any reference in
22 this paragraph to an employer shall include a
23 reference to any predecessor of such employer.

24 “(c) DEFINITIONS.—For purposes of this section—

1 “(1) HIGH DEDUCTIBLE HEALTH PLAN.—The
2 term ‘high deductible health plan’ has the meaning
3 given such term by section 223(c)(2).

4 “(2) QUALIFIED HEALTH SAVINGS ACCOUNT.—

5 “(A) IN GENERAL.—The term ‘qualified
6 health savings account’ means a health savings
7 account (as defined in section 223(d))—

8 “(i) which is designated (in such form
9 as the Secretary may prescribe) as a quali-
10 fied account for purposes of this section,

11 “(ii) which may not include any
12 amount other than contributions described
13 in subsection (a) and earnings on such
14 contributions, and

15 “(iii) with respect to which section
16 223(f)(4)(A) is applied by substituting
17 ‘100 percent’ for ‘10 percent’.

18 “(B) SUBACCOUNTS AND SEPARATE AC-
19 COUNTING.—The Secretary may prescribe rules
20 under which a subaccount within a health sav-
21 ings account, or separate accounting with re-
22 spect to contributions and earnings described in
23 subparagraph (A)(ii), may be treated in the
24 same manner as a qualified health savings ac-
25 count.

1 “(C) ROLLOVERS.—A contribution of a
2 distribution from a qualified health savings ac-
3 count to another health savings account shall be
4 treated as a rollover contribution for purposes
5 of section 223(f)(5) only if the other account is
6 a qualified health savings account.

7 “(d) SPECIAL RULES.—For purposes of this sec-
8 tion—

9 “(1) AGGREGATION RULES.—All persons treat-
10 ed as a single employer under subsection (a) or (b)
11 of section 52, or subsection (n) or (o) of section 414,
12 shall be treated as one person.

13 “(2) DISALLOWANCE OF DEDUCTION.—No de-
14 duction shall be allowed for that portion of contribu-
15 tions to any health savings accounts for the taxable
16 year which is equal to the credit determined under
17 subsection (a).

18 “(3) ELECTION NOT TO CLAIM CREDIT.—This
19 section shall not apply to a taxpayer for any taxable
20 year if such taxpayer elects to have this section not
21 apply for such taxable year.”.

22 (b) CONFORMING AMENDMENTS.—

23 (1) Paragraph (2) of section 1324(b) of title
24 31, United States Code, is amended by inserting be-

1 fore the period “, or from section 36A of such
2 Code”.

3 (2) The table of sections for subpart C of part
4 IV of chapter 1 of the Internal Revenue Code of
5 1986, as amended by subtitle A, is amended by in-
6 serting after the item relating to section 36 the fol-
7 lowing new item:

“Sec. 36A. Small employer contributions to health savings accounts.”.

8 (c) EFFECTIVE DATE.—The amendments made by
9 this section shall apply to contributions made in taxable
10 years beginning after December 31, 2005.

11 **Subtitle C—Improvement of the** 12 **Health Coverage Tax Credit**

13 **SEC. 221. CHANGE IN STATE-BASED COVERAGE RULES RE-** 14 **LATED TO PREEXISTING CONDITIONS.**

15 (a) IN GENERAL.—Section 35(e)(2) of the Internal
16 Revenue Code of 1986 (relating to requirements for State-
17 based coverage) is amended by adding at the end the fol-
18 lowing:

19 “(C) LIMITATION ON PREEXISTING CONDI-
20 TION EXCLUSION PERIOD.—The term ‘qualified
21 health insurance’ does not include any coverage
22 described in subparagraphs (C) through (H) of
23 paragraph (1) that imposes a pre-existing con-
24 dition exclusion with respect to any individual
25 unless—

1 “(i) such exclusion relates to a phys-
 2 ical or mental condition, regardless of the
 3 cause of the condition, for which medical
 4 advice, diagnosis, care, or treatment was
 5 recommended or received within the 6-
 6 month period ending on the date the indi-
 7 vidual seeks to enroll in the coverage,

8 “(ii) such exclusion extends for a pe-
 9 riod of not more than 12 months after the
 10 individual seeks to enroll in the coverage,

11 “(iii) the period of any such pre-
 12 existing condition exclusion is reduced by
 13 the length of the aggregate of the periods
 14 of creditable coverage (as defined in sec-
 15 tion 9801(c)) applicable to the individual
 16 as of the enrollment date, and

17 “(iv) such exclusion is not an exclu-
 18 sion described in section 9801(d).”.

19 (b) CONFORMING AMENDMENTS.—

20 (1) INTERNAL REVENUE CODE OF 1986.—Sub-
 21 paragraph (A) of section 35(e)(2) of such Code is
 22 amended—

23 (A) by striking clause (ii); and

24 (B) by redesignating clauses (iii) and (iv)
 25 as clauses (ii) and (iii), respectively.

1 (2) WORKFORCE INVESTMENT ACT OF 1998
2 AMENDMENTS.—Section 173(f)(2)(B) of the Work-
3 force Investment Act of 1998 (29 U.S.C.
4 2918(f)(2)(B)) is amended—

5 (A) in clause (i)—

6 (i) by striking subclause (II); and

7 (ii) by redesignating subclauses (III)
8 and (IV) as subclauses (II) and (III), re-
9 spectively; and

10 (B) by adding at the end the following:

11 “(iii) LIMITATION ON PREEXISTING
12 CONDITION EXCLUSION PERIOD.—The
13 term ‘qualified health insurance’ does not
14 include any coverage described in clauses
15 (iii) through (ix) of subparagraph (A) that
16 imposes a pre-existing condition exclusion
17 with respect to any individual unless—

18 “(I) such exclusion relates to a
19 physical or mental condition, regard-
20 less of the cause of the condition, for
21 which medical advice, diagnosis, care,
22 or treatment was recommended or re-
23 ceived within the 6-month period end-
24 ing on the date the individual seeks to
25 enroll in the coverage;

1 “(II) such exclusion extends for a
 2 period of not more than 12 months
 3 after the individual seeks to enroll in
 4 the coverage;

5 “(III) the period of any such pre-
 6 existing condition exclusion is reduced
 7 by the length of the aggregate of the
 8 periods of creditable coverage (as de-
 9 fined in section 9801(c) of the Inter-
 10 nal Revenue Code of 1986) applicable
 11 to the individual as of the enrollment
 12 date; and

13 “(IV) such exclusion is not an ex-
 14 clusion described in section 9801(d) of
 15 such Code.”.

16 (c) EFFECTIVE DATE.—The amendments made by
 17 this section apply to taxable years beginning after Decem-
 18 ber 31, 2005.

19 **SEC. 222. ELIGIBILITY OF SPOUSE OF CERTAIN INDIVID-**
 20 **UALS ENTITLED TO MEDICARE.**

21 (a) IN GENERAL.—Subsection (b) of section 35 of
 22 such Code (defining eligible coverage month) is amended
 23 by adding at the end the following:

24 “(3) SPECIAL RULE FOR SPOUSE OF INDI-
 25 VIDUAL ENTITLED TO MEDICARE.—Any month

1 which would be an eligible coverage month with re-
2 spect to a taxpayer (determined without regard to
3 subsection (f)(2)(A)) shall be an eligible coverage
4 month for any spouse of such taxpayer, provided the
5 spouse has attained age 55 and meets the require-
6 ments of clauses (ii), (iii), and (iv) of paragraph
7 (1)(A).”.

8 (b) EFFECTIVE DATE.—The amendment made by
9 subsection (a) applies to taxable years beginning after De-
10 cember 31, 2005.

11 **SEC. 223. ELIGIBLE PBGC PENSION RECIPIENT.**

12 (a) IN GENERAL.—Subparagraph (B) of section
13 35(c)(4) of such Code (relating to eligible PBGC pension
14 recipients) is amended by inserting before the period the
15 following “, or, after August 6, 2002, received from such
16 Corporation a one-time single-sum pension payment in
17 lieu of an annuity”.

18 (b) EFFECTIVE DATE.—The amendment made by
19 subsection (a) shall take effect as if included in the enact-
20 ment of section 201 of the Trade Act of 2002 (Public Law
21 107–210, 116 Stat. 954).

1 **SEC. 224. APPLICATION OF OPTION TO OFFER STATE-**
 2 **BASED COVERAGE TO PUERTO RICO, NORTH-**
 3 **ERN MARIANA ISLANDS, AMERICAN SAMOA,**
 4 **GUAM, AND THE UNITED STATES VIRGIN IS-**
 5 **LANDS.**

6 (a) IN GENERAL.—Section 35(e) of such Code (relat-
 7 ing to requirements for qualified health insurance) is
 8 amended by adding at the end the following:

9 “(4) APPLICATION TO PUERTO RICO, NORTH-
 10 ERN MARIANA ISLANDS, AMERICAN SAMOA, GUAM,
 11 AND THE UNITED STATES VIRGIN ISLANDS.—For
 12 purposes of this section, Puerto Rico, Northern Mar-
 13 iana Islands, American Samoa, Guam, and the
 14 United States Virgin Islands shall be considered
 15 States.”.

16 (b) CONFORMING AMENDMENT.—Section 173(f)(2)
 17 of the Workforce Investment Act of 1998 (29 U.S.C.
 18 2918(f)(2)) is amended by adding at the end the following:

19 “(D) APPLICATION TO NORTHERN MAR-
 20 IANA ISLANDS, AMERICAN SAMOA, GUAM, AND
 21 THE UNITED STATES VIRGIN ISLANDS.—For
 22 purposes of subsection (a)(4)(A) and this sub-
 23 section, the term ‘State’ shall include the
 24 Northern Mariana Islands, American Samoa,
 25 Guam, and the United States Virgin Islands.”.

1 (c) EFFECTIVE DATE.—The amendments made by
2 this section apply to taxable years beginning after Decem-
3 ber 31, 2005.

4 **SEC. 225. CLARIFICATION OF DISCLOSURE RULES.**

5 (a) IN GENERAL.—Subsection (k) of section 6103 of
6 such Code (relating to disclosure of certain returns and
7 return information for tax administration purposes) is
8 amended by adding at the end the following:

9 “(10) DISCLOSURE OF CERTAIN RETURN IN-
10 FORMATION FOR PURPOSES OF CARRYING OUT A
11 PROGRAM FOR ADVANCE PAYMENT OF CREDIT FOR
12 HEALTH INSURANCE COSTS OF ELIGIBLE INDIVID-
13 UALS.—The Secretary may disclose to providers of
14 health insurance, administrators of health plans, or
15 contractors of such providers or administrators, for
16 any certified individual (as defined in section
17 7527(e)) the taxpayer identity and health insurance
18 member and group numbers of the certified indi-
19 vidual (and any qualifying family member as defined
20 in section 35(d), if applicable) and the amount and
21 period of the payment, to the extent the Secretary
22 deems necessary for the administration of the pro-
23 gram established by section 7527 (relating to ad-
24 vance payment of credit for health insurance costs of
25 eligible individuals).”.

1 (b) CONFORMING AMENDMENTS.—

2 (1) Section 6103 of such Code (relating to con-
3 fidentiality and disclosure of returns and return in-
4 formation) is amended—

5 (A) in subsection (a)(3), by inserting
6 “(k)(10),” after “(e)(1)(D)(iii),”;

7 (B) in subsection (l), by striking para-
8 graph (18); and

9 (C) in subsection (p)—

10 (i) in paragraph (3)(A)—

11 (I) by striking “or (9)” and in-
12 serting “(9), or (10)”;

13 (II) by striking “(17), or (18)”
14 and inserting “or (17)”;

15 (ii) in paragraph (4), by striking
16 “(18)” after “(l)(16)” each place it ap-
17 pears.

18 (2) Section 7213(a)(2) of such Code (relating
19 to unauthorized disclosure of information) is amend-
20 ed by inserting “(k)(10)” before “(l)(6)”.

21 (3) Section 7213A(a)(1)(B) of such Code (re-
22 lating to unauthorized inspection of returns or re-
23 turn information) is amended by striking “sub-
24 section (l)(18) or (n) of section 6103” and inserting
25 “section 6103(n)”.

1 (c) EFFECTIVE DATE.—The amendments made by
2 this section apply to taxable years beginning after Decem-
3 ber 31, 2005.

4 **SEC. 226. CLARIFICATION THAT STATE-BASED COBRA CON-**
5 **TINUATION COVERAGE IS SUBJECT TO SAME**
6 **RULES AS FEDERAL COBRA.**

7 (a) IN GENERAL.—Section 35(e)(2) of such Code (re-
8 lating to state-based coverage requirements) is amended—

9 (1) in subparagraph (A), in the matter pre-
10 ceding clause (i), by striking “(B)” and inserting
11 “(C)”; and

12 (2) in subparagraph(B)(i), by striking “(B)”
13 and inserting “(C)”.

14 (b) CONFORMING AMENDMENTS.—Section
15 173(f)(2)(B) of the Workforce Investment Act of 1998 (29
16 U.S.C. 2918(f)(2)(B)) is amended—

17 (1) in clause (i), in the matter preceding sub-
18 clause (I), by striking “(ii)” and inserting “(iii)”;
19 and

20 (2) in clause (ii)(I), by striking “(ii)” and in-
21 serting “(iii)”.

22 (c) EFFECTIVE DATE.—The amendments made by
23 this section shall take effect as if included in the enact-
24 ment of sections 201 and 203, respectively, of the Trade
25 Act of 2002 (Public Law 107–210, 116 Stat. 954).

1 **SEC. 227. APPLICATION OF RULES FOR OTHER SPECIFIED**
 2 **COVERAGE TO ELIGIBLE ALTERNATIVE TAA**
 3 **RECIPIENTS CONSISTENT WITH RULES FOR**
 4 **OTHER ELIGIBLE INDIVIDUALS.**

5 (a) **IN GENERAL.**—Section 35(f)(1) of such Code (re-
 6 lating to subsidized coverage) is amended by striking sub-
 7 paragraph (B) and redesignating subparagraph (C) as
 8 subparagraph (B).

9 (b) **CONFORMING AMENDMENTS.**—Section
 10 173(f)(7)(A) of the Workforce Investment Act of 1998 (29
 11 U.S.C. 2918(f)(7)(A)) is amended by striking clause (ii)
 12 and redesignating clause (iii) as clause (ii).

13 **Subtitle D—Long-Term Care**
 14 **Insurance**

15 **SEC. 231. SENSE OF THE SENATE CONCERNING LONG-TERM**
 16 **CARE.**

17 It is the sense of the Senate that Congress should
 18 take steps to make long-term care more affordable by pro-
 19 viding tax incentives for the purchase of long-term care
 20 insurance, support for family caregivers, and making nec-
 21 essary public program reforms.

1 **Subtitle E—Other Provisions**

2 **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 Rev-
6 enue 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

21 “(B) to the extent permitted by section
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
5 without compromising program integrity as a
6 means of encouraging institutions of higher
7 education to provide uninsured students with
8 access to health care coverage;

9 (C) other incentives or disincentives that
10 would increase the level of institutional partici-
11 pation in health care coverage programs; and

12 (D) an analysis of the costs and effective-
13 ness (to reduce the number of uninsured stu-
14 dents) of including the cost of health insurance
15 as an allowable cost of attendance under the
16 Higher Education Act of 1965, and the impact
17 of such inclusion on the student's financial aid
18 package.

19 (d) 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

1 Pensions of the Senate, and the Committee on Education
2 and the Workforce of the House of Representatives.

3 (e) 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**
13 **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.

3 “(B) An amount equal to 25 percent of the
4 appropriated amount for the fiscal year shall be
5 allocated among the States so that the amount
6 provided to a State bears the same ratio to
7 such available amount as the number of unin-
8 insured individuals in the State bears to the total
9 number of uninsured individuals in all States
10 (as determined by the Secretary).

11 “(C) An amount equal to 25 percent of the
12 appropriated amount for the fiscal year shall be
13 allocated among the States so that the amount
14 provided to a State bears the same ratio to
15 such available amount as the number of individ-
16 uals enrolled in health care coverage through
17 the qualified high risk pool of the State bears
18 to the total number of individuals so enrolled
19 through qualified high risk pools in all States
20 (as determined by the Secretary).

21 “(c) BONUS GRANTS FOR SUPPLEMENTAL CON-
22 SUMER BENEFITS.—

23 “(1) IN GENERAL.—In the case of a State that
24 has established a qualified high risk pool, the Sec-
25 retary 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 (c)(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 lowing:

20 **“SEC. 2111. EXPANDED OUTREACH ACTIVITIES.**

21 **“(a) GRANTS TO CONDUCT INNOVATIVE OUTREACH**
 22 **AND ENROLLMENT EFFORTS.—**

23 **“(1) IN GENERAL.—**The Secretary shall award
 24 grants to eligible entities to—

25 **“(A) conduct innovative outreach and en-**
 26 **rollment efforts that are designed to increase**

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 disproportio-
2 nate 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 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
3 21 years of age) by using a determination made
4 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—

18 “(i) the agency has fiscal liabilities or re-
19 sponsibilities affected or potentially affected by
20 such determination; and

21 “(ii) any information furnished by the
22 agency pursuant to this subparagraph is used
23 solely for purposes of determining financial eli-
24 gibility for medical assistance under this title or
25 for child health assistance under title XXI.

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.—

1 “(A) IN GENERAL.—In this subsection, the
2 term ‘high need area’ means a county or a re-
3 gional area identified by the Secretary pursuant
4 to the regulations promulgated under subpara-
5 graph (B).

6 “(B) REGULATIONS.—The Secretary shall
7 promulgate regulations that define the term
8 ‘high need area’ for purposes of this subsection.
9 Such regulations shall specify procedures that
10 the Department shall follow in determining esti-
11 mates on a periodic basis in the United States
12 of the number of medically uninsured persons
13 and the national percentage of medically unin-
14 sured persons served by health centers (referred
15 to in this subsection as the ‘ENP’) and for the
16 designation of an area as a ‘high need area’ if
17 the estimated percentage of medically uninsured
18 individuals in the area is higher than the na-
19 tional average and the estimated percentage of
20 medically uninsured individuals in the area
21 served by health centers in the area is below the
22 ENP.

23 “(C) MEDICALLY UNDERSERVED AREA.—
24 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 subsection (k)(3)” and inserting “subsection (l)(3)”;

11 (4) in subsection (l)(3)(H)(iii) (as so redesign-
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 subsection (l)(3)”;

16 (6) in subsection (q) (as so redesignated), by
17 striking “subsection (k)(3)(G)” and inserting “sub-
18 subsection (l)(3)(G)”;

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:

1 “(5) ECONOMIC VIABILITY OF APPLICANTS.—

2 “(A) IN GENERAL.—In considering appli-
3 cations under this section, the Secretary shall
4 ensure that an application that demonstrates
5 economic viability, consistent with funding
6 guidelines established by the Secretary for pur-
7 poses of this section, is not disadvantaged in
8 the evaluation process on the basis that it relies
9 solely on Federal funding.

10 “(B) QUALIFICATION OF INDIVIDUALS RE-
11 VIEWING APPLICATIONS.—The Secretary shall
12 require verification that all individuals who are
13 evaluating community health center grant appli-
14 cations have completed within the 3-year period
15 ending on the date on which the application is
16 being evaluated a training course on the com-
17 munity health center program which addresses
18 the purposes served by community health cen-
19 ters, the critical role of community health cen-
20 ters in the safety net, expectations for the eval-
21 uation of applications, and the criteria for
22 awarding grant funding.

23 “(C) MEDICALLY UNDERSERVED DESIGNA-
24 TIONS.—Not later than 6 months after the date
25 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.”.

16 **Subtitle B—Qualified Integrated**
 17 **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:

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 (c)(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
23 Secretary shall prescribe.

24 “(2) DESCRIPTION OF NEED.—

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
24 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.

3 “(2) FUNDING REPORT.—The Secretary shall
4 annually prepare and submit to the appropriate com-
5 mittees of Congress a report concerning the distribu-
6 tion of funds under this section that are provided to
7 meet the health care needs of medically underserved
8 populations, and the appropriateness of the delivery
9 systems involved in responding to the needs of the
10 particular populations. Such report shall include an
11 assessment of the relative health care access needs
12 of the targeted populations and the rationale for any
13 substantial changes in the distribution of funds.

14 “(e) RECORDS.—

15 “(1) IN GENERAL.—Each entity which receives
16 a grant under subsection (b)(1) shall establish and
17 maintain such records as the Secretary shall require.

18 “(2) AVAILABILITY.—Each entity which is re-
19 quired to establish and maintain records under this
20 subsection shall make such books, documents, pa-
21 pers, and records available to the Secretary or the
22 Comptroller General of the United States, or any of
23 their duly authorized representatives, for examina-
24 tion, copying, or mechanical reproduction on or off
25 the premises of such entity upon a reasonable re-

1 quest therefore. The Secretary and the Comptroller
2 General of the United States, or any of their duly
3 authorized representatives, shall have the authority
4 to conduct such examination, copying, and reproduc-
5 tion.

6 “(f) AUDITS.—

7 “(1) IN GENERAL.—Each entity which receives
8 a grant under this section shall provide for an inde-
9 pendent annual financial audit of any books, ac-
10 counts, financial records, files, and other papers and
11 property which relate to the disposition or use of the
12 funds received under such grant and such other
13 funds received by or allocated to the project for
14 which such grant was made. For purposes of assur-
15 ing accurate, current, and complete disclosure of the
16 disposition or use of the funds received, each such
17 audit shall be conducted in accordance with gen-
18 erally accepted accounting principles. Each audit
19 shall evaluate—

20 “(A) the entity’s implementation of the
21 guidelines established by the Secretary respect-
22 ing cost accounting;

23 “(B) the processes used by the entity to
24 meet the financial and program reporting re-
25 quirements 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.

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

10 “(2) RECORDS.—Each entity which receives a
11 grant under this section shall establish and maintain
12 such records as the Secretary shall by regulation re-
13 quire to facilitate the audit required by paragraph
14 (1). The Secretary may specify by regulation the
15 form and manner in which such records shall be es-
16 tablished and maintained.

17 “(3) AVAILABILITY OF RECORDS.—Each entity
18 which is required to establish and maintain records
19 or to provide for an audit under this subsection shall
20 make such books, documents, papers, and records
21 available to the Secretary or the Comptroller Gen-
22 eral of the United States, or any of their duly au-
23 thorized representatives, for examination, copying, or
24 mechanical reproduction on or off the premises of
25 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-
20 ters additional health services (as defined in sub-
21 section (b)(2)) necessary for the adequate support of
22 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-

1 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)”;

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.

3 “(2) FISCAL YEAR 2006.—Subject to paragraph
4 (4), for services furnished on and after January 1,
5 2006, during fiscal year 2006, the State plan shall
6 provide for payment for such services in an amount
7 (calculated on a per visit basis) that is equal to 100
8 percent of the average of the costs of the center of
9 furnishing such services during fiscal years 2004
10 and 2005 which are reasonable and related to the
11 cost of furnishing such services, or based on such
12 other tests of reasonableness as the Secretary pre-
13 scribes in regulations under section 1833(a)(3), or,
14 in the case of services to which such regulations do
15 not apply, the same methodology used under section
16 1833(a)(3), adjusted to take into account any in-
17 crease or decrease in the scope of such services fur-
18 nished by the center during fiscal years 2004 and
19 2005.

20 “(3) FISCAL YEAR 2007 AND SUCCEEDING FIS-
21 CAL YEARS.—Subject to paragraph (4), for services
22 furnished during fiscal year 2007 or a succeeding
23 fiscal year, the State plan shall provide for payment
24 for such services in an amount (calculated on a per
25 visit basis) that is equal to the amount calculated for

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

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

5 “(5) ADMINISTRATION IN THE CASE OF MAN-
6 AGED CARE.—

7 “(A) IN GENERAL.—In the case of services
8 furnished by an integrated health center pursu-
9 ant to a contract between the center and a
10 managed care entity (as defined in section
11 1932(a)(1)(B)), the State plan shall provide for
12 payment to the center by the State of a supple-
13 mental payment equal to the amount (if any) by
14 which the amount determined under paragraphs
15 (2), (3), and (4) exceeds the amount of the pay-
16 ments provided under the contract.

17 “(B) PAYMENT SCHEDULE.—The supple-
18 mental payment required under subparagraph
19 (A) shall be made pursuant to a payment
20 schedule agreed to by the State and the inte-
21 grated health center, but in no case less fre-
22 quently than every 4 months.

23 “(6) ALTERNATIVE PAYMENT METHODOLO-
24 GIES.—Notwithstanding any other provision of this
25 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 TION.—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

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
22 within defined time periods in response to ques-
23 tions from manufacturers or covered entities re-
24 garding the application of the requirements of
25 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 (o)(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 clinic.”; 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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