

111TH CONGRESS
1ST SESSION

H. R. 3970

To protect the doctor-patient relationship, improve the quality of health care services, lower the costs of health care services, expand access to health care services, and for other purposes.

IN THE HOUSE OF REPRESENTATIVES

OCTOBER 29, 2009

Mr. KIRK (for himself, Mr. BURGESS, Mrs. BIGGERT, Mr. LEE of New York, Mr. LANCE, Mr. SCHOCK, Mr. MICA, Mrs. CAPITO, Mr. FRELINGHUYSEN, and Mr. MACK) introduced the following bill; which was referred to the Committee on Energy and Commerce, and in addition to the Committees on the Judiciary, Ways and Means, Education and Labor, Appropriations, and Financial Services, for a period to be subsequently determined by the Speaker, in each case for consideration of such provisions as fall within the jurisdiction of the committee concerned

A BILL

To protect the doctor-patient relationship, improve the quality of health care services, lower the costs of health care services, expand access to health care services, 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.**

4 This Act may be cited as the “Medical Rights and
5 Reform Act of 2009”.

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1 **TITLE I—PROTECTING THE DOC-**
 2 **TOR-PATIENT RELATIONSHIP**

3 **SEC. 101. PROHIBITION ON RESTRICTIONS ON THE PRAC-**
 4 **TICE OF MEDICINE AND OTHER HEALTH**
 5 **CARE PROFESSIONS.**

6 (a) IN GENERAL.—Subject to subsection (b), no Fed-
 7 eral funds shall be used to permit any Federal officer or
 8 employee to exercise any supervision or control over—

9 (1) the practice of medicine, the practice of
 10 other health care professions, or the manner in
 11 which health care services are provided;

12 (2) the provision, by a physician or a health
 13 care practitioner, of advice to a patient about the

1 patient's health status or recommended treatment
2 for a condition or disease;

3 (3) the selection, tenure, or compensation of
4 any officer, employee, or contractor of any institu-
5 tion, business, non-Federal agency, or individual
6 providing health care services; or

7 (4) the administration or operation of any such
8 institution, business, non-Federal agency, or indi-
9 vidual, with respect to the provision of health care
10 services to a patient.

11 (b) PRESERVING CERTAIN CURRENT PROGRAMS.—

12 Subsection (a) shall not prohibit the Federal Government
13 from operating, managing, supervising employees of, or
14 defining the scope of services provided by Federal entities
15 when directly providing health care services and products,
16 only with respect to the following:

17 (1) The Veterans Health Administration—

18 (A) in the case of directly providing health
19 care services through its own facilities and by
20 its own employees; or

21 (B) in the case of coordinating health care
22 services not described in subparagraph (A) and
23 paid for with Federal funds under programs op-
24 erated by the Veterans Health Administration.

25 (2) The Department of Defense—

1 (A) in the case of directly providing health
2 care services through military treatment facili-
3 ties;

4 (B) in the case of paying for health care
5 services for active-duty members of the Armed
6 Forces or members of the Reserve component
7 when called to active duty;

8 (C) in the case of directly providing health
9 care services to the public in the event of emer-
10 gency or under other lawful circumstances; or

11 (D) when necessary to determine whether
12 health care services provided to those who are
13 not active-duty members of the Armed Forces
14 are eligible for payment with Federal funds or
15 to coordinate health care services for patients
16 who are served by both non-Federal entities and
17 military treatment facilities.

18 (3) The United States Public Health Service—

19 (A) in the case of providing health care
20 services through its own facilities or by its offi-
21 cers or civilian Federal employees;

22 (B) in the case of providing or paying for
23 health care services to active-duty members of
24 uniformed services or to Reserve members of
25 such services when called to active duty; or

1 (C) when necessary to determine whether
2 health care services provided to those who are
3 not active-duty members of uniformed services
4 are eligible for payment with Federal funds or
5 to coordinate health care services for patients
6 who are served by both non-Federal entities and
7 Public Health Service treatment facilities.

8 (4) The Indian Health Service—

9 (A) in the case of directly providing health
10 care services through its own facilities or Fed-
11 eral employees; or

12 (B) in the case of providing care by non-
13 Federal entities, to the extent necessary to ad-
14 minister contracts and grants pursuant to the
15 Indian Health Care Improvement Act.

16 (5) The National Institutes of Health—

17 (A) in the case of providing direct patient
18 care incident to medical research; or

19 (B) in the case of administering grants for
20 medical research, but in no case shall a non-
21 Federal entity be required or requested to waive
22 the protections of subsection (a) for health care
23 services not incident to medical research funded
24 by the National Institutes of Health as a condi-

1 tion of receiving research grant funding from
2 the National Institutes of Health.

3 (6) The Health Resources and Services Admin-
4 istration—

5 (A) in the case of certifying federally quali-
6 fied health centers, as defined by section
7 1905(l)(2)(B) of the Social Security Act (42
8 U.S.C. 1396d(l)(2)(B)), certifying FQHC look-
9 alike status, as defined in section 413.65(n) of
10 title 45 of the Code of Federal Regulations, or
11 providing grants under section 330 of the Pub-
12 lic Health Service Act (42 U.S.C. 254b), but
13 only to the extent necessary to determine eligi-
14 bility for such certification and grant funding
15 and the appropriate amounts of such funding;
16 or

17 (B) in the case of operating the nation’s
18 human organ, bone marrow, and umbilical cord
19 blood donation and transplantation systems, as
20 and to the extent authorized by law and nec-
21 essary for the operation of those programs.

22 **SEC. 102. RIGHT TO CONTRACT FOR HEALTH CARE SERV-**
23 **ICES AND HEALTH INSURANCE.**

24 (a) RECEIPT OF HEALTH SERVICES.—No Federal
25 funds shall be used by any Federal officer or employee

1 to prohibit any individual from receiving health care serv-
2 ices from any provider of health care services—

3 (1) under terms and conditions mutually ac-
4 ceptable to the patient and the provider; or

5 (2) under terms and conditions mutually ac-
6 ceptable to the patient, the provider, and any group
7 health plan or health insurance issuer that is obli-
8 gated to provide health insurance coverage to the pa-
9 tient or any other entity indemnifying the patient's
10 consumption of health care services;

11 provided that any such agreement shall be subject to the
12 requirements of section 1802(b) of the Social Security Act
13 (42 U.S.C. 1395a(b)), as amended by section 105.

14 (b) HEALTH INSURANCE COVERAGE.—No Federal
15 funds shall be used by any Federal officer or employee
16 to prohibit any person from entering into a contract with
17 any group health plan, health insurance issuer, or other
18 business, for the provision of, or payment to other parties
19 for, health care services to be determined and provided
20 subsequent to the effective date of the contract, according
21 to terms, conditions, and procedures specified in such con-
22 tract.

23 (c) ELIGIBILITY FOR FEDERAL BENEFITS.—No per-
24 son's eligibility for benefits under any program operated
25 by or funded wholly or partly by the Federal Government

1 shall be adversely affected as a result of having received
2 services in a manner described by subsection (a) or having
3 entered into a contract described in subsection (b).

4 (d) FEDERAL PROGRAM PARTICIPATION.—No pro-
5 vider of health care services—

6 (1) shall be denied participation in a Federal
7 program for which it would otherwise be eligible as
8 a result of having provided services in a manner de-
9 scribed in subsection (a); or

10 (2) shall be denied payment for services other-
11 wise eligible for payment under a Federal program
12 as a result of having provided services in a manner
13 described in subsection (a), except to the extent re-
14 quired by subsection (a)(1).

15 **SEC. 103. PROHIBITION ON MANDATING STATE RESTRIC-**
16 **TIONS.**

17 (a) IN GENERAL.—No Federal funds shall be used
18 by any Federal officer or employee to induce or encourage
19 any State or other jurisdiction of the United States to
20 enact any restriction or prohibition prohibited to the Fed-
21 eral Government by this title.

22 (b) PROTECTING STATE ELIGIBILITY FOR FEDERAL
23 FUNDS.—No State's eligibility for participation in any
24 program operated by or funded wholly or partly by the
25 Federal Government, or for receiving funds from the Fed-

1 eral Government shall be conditioned on that State enact-
2 ing any restriction or prohibition prohibited to the Federal
3 Government by this title, nor adversely affected by that
4 State’s failure to enact any restriction or prohibition pro-
5 hibited to the Federal Government by this title.

6 **SEC. 104. CLARIFICATION.**

7 Nothing in this subtitle shall be construed to permit
8 the expenditure of funds otherwise prohibited by law.

9 **SEC. 105. CONFORMING AMENDMENT.**

10 Section 1802(b)(3) of the Social Security Act (42
11 U.S.C. 1395a(b)(3)) is hereby repealed.

12 **SEC. 106. DEFINITIONS.**

13 For purposes of this title:

14 (1) **HEALTH CARE SERVICES.**—The term
15 “health care services” means any lawful service in-
16 tended to diagnose, cure, prevent, or mitigate the
17 adverse effects of any disease, injury, infirmity, or
18 physical or mental disability, including the provision
19 of any lawful product the use of which is so in-
20 tended.

21 (2) **PHYSICIAN.**—The term “physician”
22 means—

23 (A) a doctor of medicine or osteopathy le-
24 gally authorized to practice medicine and sur-

1 gery by the State in which he performs such
2 practice and surgery;

3 (B) a doctor of dental surgery or of dental
4 medicine who is legally authorized to practice
5 dentistry by the State in which he performs
6 such function and who is acting within the
7 scope of his license when he performs such
8 functions;

9 (C) a doctor of podiatric medicine but only
10 with respect to functions which he is legally au-
11 thorized to perform as such by the State in
12 which he performs them;

13 (D) a doctor of optometry with respect to
14 the provision of items or services which he is le-
15 gally authorized to perform as a doctor of op-
16 tometry by the State in which he performs
17 them; or

18 (E) a chiropractor who is licensed as such
19 by the State (or in a State which does not li-
20 cense chiropractors as such, is legally author-
21 ized to perform the services of a chiropractor in
22 the jurisdiction in which he performs such serv-
23 ices), but only with respect to treatment which
24 he is legally authorized to perform by the State

1 or jurisdiction in which such treatment is pro-
2 vided.

3 (3) PRACTICE OF MEDICINE.—The term “prac-
4 tice of medicine” means—

5 (A) health care services that are performed
6 by physicians; and

7 (B) services and supplies furnished as an
8 incident to a physician’s professional service.

9 (4) HEALTH CARE PRACTITIONER.—The term
10 “health care practitioner” means a physician assist-
11 ant, registered nurse, nurse practitioner, psycholo-
12 gist, clinical social worker, midwife, or other indi-
13 vidual (other than a physician) licensed or legally
14 authorized to perform health care services in the
15 State in which the individual performs such services.

16 (5) PRACTICE OF OTHER HEALTH CARE PRO-
17 FESSIONS.—The term “practice of other health care
18 professions” means—

19 (A) health care services performed by a
20 health care practitioner; and

21 (B) services and supplies furnished as an
22 incident to a health care practitioner’s profes-
23 sional service.

24 (6) GROUP HEALTH PLAN.—The term “group
25 health plan” has the meaning given such term in

1 section 733(a)(1) of the Employee Retirement In-
2 come Security Act of 1974 (29 U.S.C. 1191b(a)(1)).

3 (7) HEALTH INSURANCE ISSUER.—The term
4 “health insurance issuer” has the meaning given
5 such term in section 733(b)(2) of the Employee Re-
6 tirement Income Security Act of 1974 (29 U.S.C.
7 1191b(b)(2)).

8 (8) BUSINESS.—The term “business” means
9 any sole proprietorship, partnership, for-profit cor-
10 poration, or not-for-profit corporation.

11 (9) STATE.—The term “State” means any of
12 the United States, the Commonwealth of Puerto
13 Rico, the Commonwealth of the Northern Mariana
14 Islands, the United States Virgin Islands, Guam,
15 American Samoa, or the District of Columbia.

16 **SEC. 107. EFFECTIVE DATE.**

17 The provisions of this title shall apply to Federal enti-
18 ties, including employees and officials of such entities, be-
19 ginning on January 1, 2009.

1 **TITLE II—IMPROVING QUALITY**
2 **AND LOWERING THE COST OF**
3 **HEALTH CARE**

4 **Subtitle A—Equity for Our Nation’s**
5 **Self-Employed**

6 **SEC. 201. SECA TAX DEDUCTION FOR HEALTH INSURANCE**
7 **COSTS.**

8 (a) IN GENERAL.—Subsection (l) of section 162 of
9 the Internal Revenue Code of 1986 (relating to special
10 rules for health insurance costs of self-employed individ-
11 uals) is amended by striking paragraph (4) and by redес-
12 ignating paragraph (5) as paragraph (4).

13 (b) EFFECTIVE DATE.—The amendment made by
14 this section shall apply to taxable years beginning after
15 the date of the enactment of this subtitle.

16 **Subtitle B—Help Efficient, Acces-**
17 **sible, Low-cost, Timely**
18 **Healthcare**

19 **SEC. 211. FINDINGS AND PURPOSE.**

20 (a) FINDINGS.—

21 (1) EFFECT ON HEALTH CARE ACCESS AND
22 COSTS.—Congress finds that our current civil justice
23 system is adversely affecting patient access to health
24 care services, better patient care, and cost-efficient
25 health care, in that the health care liability system

1 is a costly and ineffective mechanism for resolving
2 claims of health care liability and compensating in-
3 jured patients, and is a deterrent to the sharing of
4 information among health care professionals which
5 impedes efforts to improve patient safety and quality
6 of care.

7 (2) EFFECT ON INTERSTATE COMMERCE.—
8 Congress finds that the health care and insurance
9 industries are industries affecting interstate com-
10 merce and the health care liability litigation systems
11 existing throughout the United States are activities
12 that affect interstate commerce by contributing to
13 the high costs of health care and premiums for
14 health care liability insurance purchased by health
15 care system providers.

16 (3) EFFECT ON FEDERAL SPENDING.—Con-
17 gress finds that the health care liability litigation
18 systems existing throughout the United States have
19 a significant effect on the amount, distribution, and
20 use of Federal funds because of—

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

24 (B) the large number of individuals who
25 benefit because of the exclusion from Federal

1 taxes of the amounts spent to provide them
2 with health insurance benefits; and

3 (C) the large number of health care pro-
4 viders who provide items or services for which
5 the Federal Government makes payments.

6 (b) PURPOSE.—It is the purpose of this subtitle to
7 implement reasonable, comprehensive, and effective health
8 care liability reforms designed to—

9 (1) improve the availability of health care serv-
10 ices in cases in which health care liability actions
11 have been shown to be a factor in the decreased
12 availability of services;

13 (2) reduce the incidence of “defensive medi-
14 cine” and lower the cost of health care liability in-
15 surance, all of which contribute to the escalation of
16 health care costs;

17 (3) ensure that persons with meritorious health
18 care injury claims receive fair and adequate com-
19 pensation, including reasonable noneconomic dam-
20 ages;

21 (4) improve the fairness and cost-effectiveness
22 of our current health care liability system to resolve
23 disputes over, and provide compensation for, health
24 care liability by reducing uncertainty in the amount
25 of compensation provided to injured individuals; and

1 (5) provide an increased sharing of information
2 in the health care system which will reduce unin-
3 tended injury and improve patient care.

4 **SEC. 212. ENCOURAGING SPEEDY RESOLUTION OF CLAIMS.**

5 The time for the commencement of a health care law-
6 suit shall be 3 years after the date of manifestation of
7 injury or 1 year after the claimant discovers, or through
8 the use of reasonable diligence should have discovered, the
9 injury, whichever occurs first. In no event shall the time
10 for commencement of a health care lawsuit exceed 3 years
11 after the date of manifestation of injury unless tolled for
12 any of the following—

13 (1) upon proof of fraud;

14 (2) intentional concealment; or

15 (3) the presence of a foreign body, which has no
16 therapeutic or diagnostic purpose or effect, in the
17 person of the injured person.

18 Actions by a minor shall be commenced within 3 years
19 from the date of the alleged manifestation of injury except
20 that actions by a minor under the full age of 6 years shall
21 be commenced within 3 years of manifestation of injury
22 or prior to the minor's 8th birthday, whichever provides
23 a longer period. Such time limitation shall be tolled for
24 minors for any period during which a parent or guardian
25 and a health care provider or health care organization

1 have committed fraud or collusion in the failure to bring
2 an action on behalf of the injured minor.

3 **SEC. 213. COMPENSATING PATIENT INJURY.**

4 (a) UNLIMITED AMOUNT OF DAMAGES FOR ACTUAL
5 ECONOMIC LOSSES IN HEALTH CARE LAWSUITS.—In any
6 health care lawsuit, nothing in this subtitle shall limit a
7 claimant’s recovery of the full amount of the available eco-
8 nomic damages, notwithstanding the limitation in sub-
9 section (b).

10 (b) ADDITIONAL NONECONOMIC DAMAGES.—In any
11 health care lawsuit, the amount of noneconomic damages,
12 if available, may be as much as \$250,000, regardless of
13 the number of parties against whom the action is brought
14 or the number of separate claims or actions brought with
15 respect to the same injury.

16 (c) NO DISCOUNT OF AWARD FOR NONECONOMIC
17 DAMAGES.—For purposes of applying the limitation in
18 subsection (b), future noneconomic damages shall not be
19 discounted to present value. The jury shall not be in-
20 formed about the maximum award for noneconomic dam-
21 ages. An award for noneconomic damages in excess of
22 \$250,000 shall be reduced either before the entry of judg-
23 ment, or by amendment of the judgment after entry of
24 judgment, and such reduction shall be made before ac-
25 counting for any other reduction in damages required by

1 law. If separate awards are rendered for past and future
2 noneconomic damages and the combined awards exceed
3 \$250,000, the future noneconomic damages shall be re-
4 duced first.

5 (d) FAIR SHARE RULE.—In any health care lawsuit,
6 each party shall be liable for that party’s several share
7 of any damages only and not for the share of any other
8 person. Each party shall be liable only for the amount of
9 damages allocated to such party in direct proportion to
10 such party’s percentage of responsibility. Whenever a
11 judgment of liability is rendered as to any party, a sepa-
12 rate judgment shall be rendered against each such party
13 for the amount allocated to such party. For purposes of
14 this section, the trier of fact shall determine the propor-
15 tion of responsibility of each party for the claimant’s
16 harm.

17 **SEC. 214. MAXIMIZING PATIENT RECOVERY.**

18 (a) COURT SUPERVISION OF SHARE OF DAMAGES
19 ACTUALLY PAID TO CLAIMANTS.—In any health care law-
20 suit, the court shall supervise the arrangements for pay-
21 ment of damages to protect against conflicts of interest
22 that may have the effect of reducing the amount of dam-
23 ages awarded that are actually paid to claimants. In par-
24 ticular, in any health care lawsuit in which the attorney
25 for a party claims a financial stake in the outcome by vir-

1 tue of a contingent fee, the court shall have the power
2 to restrict the payment of a claimant's damage recovery
3 to such attorney, and to redirect such damages to the
4 claimant based upon the interests of justice and principles
5 of equity. In no event shall the total of all contingent fees
6 for representing all claimants in a health care lawsuit ex-
7 ceed the following limits:

8 (1) 40 percent of the first \$50,000 recovered by
9 the claimant(s).

10 (2) $33\frac{1}{3}$ percent of the next \$50,000 recovered
11 by the claimant(s).

12 (3) 25 percent of the next \$500,000 recovered
13 by the claimant(s).

14 (4) 15 percent of any amount by which the re-
15 covery by the claimant(s) is in excess of \$600,000.

16 (b) APPLICABILITY.—The limitations in this section
17 shall apply whether the recovery is by judgment, settle-
18 ment, mediation, arbitration, or any other form of alter-
19 native dispute resolution. In a health care lawsuit involv-
20 ing a minor or incompetent person, a court retains the
21 authority to authorize or approve a fee that is less than
22 the maximum permitted under this section. The require-
23 ment for court supervision in the first two sentences of
24 subsection (a) applies only in civil actions.

1 **SEC. 215. ADDITIONAL HEALTH BENEFITS.**

2 In any health care lawsuit involving injury or wrong-
3 ful death, any party may introduce evidence of collateral
4 source benefits. If a party elects to introduce such evi-
5 dence, any opposing party may introduce evidence of any
6 amount paid or contributed or reasonably likely to be paid
7 or contributed in the future by or on behalf of the oppos-
8 ing party to secure the right to such collateral source bene-
9 fits. No provider of collateral source benefits shall recover
10 any amount against the claimant or receive any lien or
11 credit against the claimant's recovery or be equitably or
12 legally subrogated to the right of the claimant in a health
13 care lawsuit involving injury or wrongful death. This sec-
14 tion shall apply to any health care lawsuit that is settled
15 as well as a health care lawsuit that is resolved by a fact
16 finder. This section shall not apply to section 1862(b) (42
17 U.S.C. 1395y(b)) or section 1902(a)(25) (42 U.S.C.
18 1396a(a)(25)) of the Social Security Act.

19 **SEC. 216. PUNITIVE DAMAGES.**

20 (a) IN GENERAL.—Punitive damages may, if other-
21 wise permitted by applicable State or Federal law, be
22 awarded against any person in a health care lawsuit only
23 if it is proven by clear and convincing evidence that such
24 person acted with malicious intent to injure the claimant,
25 or that such person deliberately failed to avoid unneces-
26 sary injury that such person knew the claimant was sub-

1 stantially certain to suffer. In any health care lawsuit
2 where no judgment for compensatory damages is rendered
3 against such person, no punitive damages may be awarded
4 with respect to the claim in such lawsuit. No demand for
5 punitive damages shall be included in a health care lawsuit
6 as initially filed. A court may allow a claimant to file an
7 amended pleading for punitive damages only upon a mo-
8 tion by the claimant and after a finding by the court, upon
9 review of supporting and opposing affidavits or after a
10 hearing, after weighing the evidence, that the claimant has
11 established by a substantial probability that the claimant
12 will prevail on the claim for punitive damages. At the re-
13 quest of any party in a health care lawsuit, the trier of
14 fact shall consider in a separate proceeding—

15 (1) whether punitive damages are to be award-
16 ed and the amount of such award; and

17 (2) the amount of punitive damages following a
18 determination of punitive liability.

19 If a separate proceeding is requested, evidence relevant
20 only to the claim for punitive damages, as determined by
21 applicable State law, shall be inadmissible in any pro-
22 ceeding to determine whether compensatory damages are
23 to be awarded.

24 (b) DETERMINING AMOUNT OF PUNITIVE DAM-
25 AGES.—

1 (1) FACTORS CONSIDERED.—In determining
2 the amount of punitive damages, if awarded, in a
3 health care lawsuit, the trier of fact shall consider
4 only the following—

5 (A) the severity of the harm caused by the
6 conduct of such party;

7 (B) the duration of the conduct or any
8 concealment of it by such party;

9 (C) the profitability of the conduct to such
10 party;

11 (D) the number of products sold or med-
12 ical procedures rendered for compensation, as
13 the case may be, by such party, of the kind
14 causing the harm complained of by the claim-
15 ant;

16 (E) any criminal penalties imposed on such
17 party, as a result of the conduct complained of
18 by the claimant; and

19 (F) the amount of any civil fines assessed
20 against such party as a result of the conduct
21 complained of by the claimant.

22 (2) MAXIMUM AWARD.—The amount of punitive
23 damages, if awarded, in a health care lawsuit may
24 be as much as \$250,000 or as much as two times
25 the amount of economic damages awarded, which-

1 ever is greater. The jury shall not be informed of
2 this limitation.

3 (c) NO PUNITIVE DAMAGES FOR PRODUCTS THAT
4 COMPLY WITH FDA STANDARDS.—

5 (1) IN GENERAL.—

6 (A) No punitive damages may be awarded
7 against the manufacturer or distributor of a
8 medical product, or a supplier of any compo-
9 nent or raw material of such medical product,
10 based on a claim that such product caused the
11 claimant's harm where—

12 (i)(I) such medical product was sub-
13 ject to premarket approval, clearance, or li-
14 censure by the Food and Drug Administra-
15 tion with respect to the safety of the for-
16 mulation or performance of the aspect of
17 such medical product which caused the
18 claimant's harm or the adequacy of the
19 packaging or labeling of such medical
20 product; and

21 (II) such medical product was so ap-
22 proved, cleared, or licensed; or

23 (ii) such medical product is generally
24 recognized among qualified experts as safe
25 and effective pursuant to conditions estab-

1 lished by the Food and Drug Administra-
2 tion and applicable Food and Drug Admin-
3 istration regulations, including without
4 limitation those related to packaging and
5 labeling, unless the Food and Drug Admin-
6 istration has determined that such medical
7 product was not manufactured or distrib-
8 uted in substantial compliance with appli-
9 cable Food and Drug Administration stat-
10 utes and regulations.

11 (B) RULE OF CONSTRUCTION.—Subpara-
12 graph (A) may not be construed as establishing
13 the obligation of the Food and Drug Adminis-
14 tration to demonstrate affirmatively that a
15 manufacturer, distributor, or supplier referred
16 to in such subparagraph meets any of the con-
17 ditions described in such subparagraph.

18 (2) LIABILITY OF HEALTH CARE PROVIDERS.—
19 A health care provider who prescribes, or who dis-
20 penses pursuant to a prescription, a medical product
21 approved, licensed, or cleared by the Food and Drug
22 Administration shall not be named as a party to a
23 product liability lawsuit involving such product and
24 shall not be liable to a claimant in a class action
25 lawsuit against the manufacturer, distributor, or

1 seller of such product. Nothing in this paragraph
2 prevents a court from consolidating cases involving
3 health care providers and cases involving products li-
4 ability claims against the manufacturer, distributor,
5 or product seller of such medical product.

6 (3) PACKAGING.—In a health care lawsuit for
7 harm which is alleged to relate to the adequacy of
8 the packaging or labeling of a drug which is required
9 to have tamper-resistant packaging under regula-
10 tions of the Secretary of Health and Human Serv-
11 ices (including labeling regulations related to such
12 packaging), the manufacturer or product seller of
13 the drug shall not be held liable for punitive dam-
14 ages unless such packaging or labeling is found by
15 the trier of fact by clear and convincing evidence to
16 be substantially out of compliance with such regula-
17 tions.

18 (4) EXCEPTION.—Paragraph (1) shall not
19 apply in any health care lawsuit in which—

20 (A) a person, before or after premarket ap-
21 proval, clearance, or licensure of such medical
22 product, knowingly misrepresented to or with-
23 held from the Food and Drug Administration
24 information that is required to be submitted
25 under the Federal Food, Drug, and Cosmetic

1 Act (21 U.S.C. 301 et seq.) or section 351 of
2 the Public Health Service Act (42 U.S.C. 262)
3 that is material and is causally related to the
4 harm which the claimant allegedly suffered; or

5 (B) a person made an illegal payment to
6 an official of the Food and Drug Administra-
7 tion for the purpose of either securing or main-
8 taining approval, clearance, or licensure of such
9 medical product.

10 **SEC. 217. AUTHORIZATION OF PAYMENT OF FUTURE DAM-**
11 **AGES TO CLAIMANTS IN HEALTH CARE LAW-**
12 **SUITS.**

13 (a) IN GENERAL.—In any health care lawsuit, if an
14 award of future damages, without reduction to present
15 value, equaling or exceeding \$50,000 is made against a
16 party with sufficient insurance or other assets to fund a
17 periodic payment of such a judgment, the court shall, at
18 the request of any party, enter a judgment ordering that
19 the future damages be paid by periodic payments. In any
20 health care lawsuit, the court may be guided by the Uni-
21 form Periodic Payment of Judgments Act promulgated by
22 the National Conference of Commissioners on Uniform
23 State Laws.

1 (b) APPLICABILITY.—This section applies to all ac-
2 tions which have not been first set for trial or retrial be-
3 fore the effective date of this subtitle.

4 **SEC. 218. DEFINITIONS.**

5 In this subtitle:

6 (1) ALTERNATIVE DISPUTE RESOLUTION SYS-
7 TEM; ADR.—The term “alternative dispute resolution
8 system” or “ADR” means a system that provides
9 for the resolution of health care lawsuits in a man-
10 ner other than through a civil action brought in a
11 State or Federal court.

12 (2) CLAIMANT.—The term “claimant” means
13 any person who brings a health care lawsuit, includ-
14 ing a person who asserts or claims a right to legal
15 or equitable contribution, indemnity, or subrogation,
16 arising out of a health care liability claim or action,
17 and any person on whose behalf such a claim is as-
18 serted or such an action is brought, whether de-
19 ceased, incompetent, or a minor.

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

1 ant, as a result of the injury or wrongful death, pur-
2 suant to—

3 (A) any State or Federal health, sickness,
4 income-disability, accident, or workers' com-
5 pensation law;

6 (B) any health, sickness, income-disability,
7 or accident insurance that provides health bene-
8 fits or income-disability coverage;

9 (C) any contract or agreement of any
10 group, organization, partnership, or corporation
11 to provide, pay for, or reimburse the cost of
12 medical, hospital, dental, or income-disability
13 benefits; and

14 (D) any other publicly or privately funded
15 program.

16 (4) COMPENSATORY DAMAGES.—The term
17 “compensatory damages” means objectively
18 verifiable monetary losses incurred as a result of the
19 provision of, use of, or payment for (or failure to
20 provide, use, or pay for) health care services or med-
21 ical products, such as past and future medical ex-
22 penses, loss of past and future earnings, cost of ob-
23 taining domestic services, loss of employment, and
24 loss of business or employment opportunities, dam-
25 ages for physical and emotional pain, suffering, in-

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

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

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

23 (7) HEALTH CARE LAWSUIT.—The term
24 “health care lawsuit” means any health care liability
25 claim concerning the provision of health care goods

1 or services or any medical product affecting inter-
2 state commerce, or any health care liability action
3 concerning the provision of health care goods or
4 services or any medical product affecting interstate
5 commerce, brought in a State or Federal court or
6 pursuant to an alternative dispute resolution system,
7 against a health care provider, a health care organi-
8 zation, or the manufacturer, distributor, supplier,
9 marketer, promoter, or seller of a medical product,
10 regardless of the theory of liability on which the
11 claim is based, or the number of claimants, plain-
12 tiffs, defendants, or other parties, or the number of
13 claims or causes of action, in which the claimant al-
14 leges a health care liability claim. Such term does
15 not include a claim or action which is based on
16 criminal liability; which seeks civil fines or penalties
17 paid to Federal, State, or local government; or which
18 is grounded in antitrust.

19 (8) HEALTH CARE LIABILITY ACTION.—The
20 term “health care liability action” means a civil ac-
21 tion brought in a State or Federal court or pursuant
22 to an alternative dispute resolution system, against
23 a health care provider, a health care organization, or
24 the manufacturer, distributor, supplier, marketer,
25 promoter, or seller of a medical product, regardless

1 of the theory of liability on which the claim is based,
2 or the number of plaintiffs, defendants, or other par-
3 ties, or the number of causes of action, in which the
4 claimant alleges a health care liability claim.

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

19 (10) HEALTH CARE ORGANIZATION.—The term
20 “health care organization” means any person or en-
21 tity which is obligated to provide or pay for health
22 benefits under any health plan, including any person
23 or entity acting under a contract or arrangement
24 with a health care organization to provide or admin-
25 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 or
15 care of 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, device, or biological product
23 intended for humans, and the terms “drug”, “de-
24 vice”, and “biological product” have the meanings
25 given such terms in sections 201(g)(1) and 201(h)

1 of the Federal Food, Drug and Cosmetic Act (21
2 U.S.C. 321(g)(1) and (h)) and section 351(a) of the
3 Public Health Service Act (42 U.S.C. 262(a)), re-
4 spectively, including any component or raw material
5 used therein, but excluding health care services.

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

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

23 (17) RECOVERY.—The term “recovery” means
24 the net sum recovered after deducting any disburse-
25 ments or costs incurred in connection with prosecu-

1 tion or settlement of the claim, including all costs
2 paid or advanced by any person. Costs of health care
3 incurred by the plaintiff and the attorneys' office
4 overhead costs or charges for legal services are not
5 deductible disbursements or costs for such purpose.

6 (18) STATE.—The term “State” means each of
7 the several States, the District of Columbia, the
8 Commonwealth of Puerto Rico, the Virgin Islands,
9 Guam, American Samoa, the Northern Mariana Is-
10 lands, the Trust Territory of the Pacific Islands, and
11 any other territory or possession of the United
12 States, or any political subdivision thereof.

13 **SEC. 219. EFFECT ON OTHER LAWS.**

14 (a) VACCINE INJURY.—

15 (1) To the extent that title XXI of the Public
16 Health Service Act establishes a Federal rule of law
17 applicable to a civil action brought for a vaccine-re-
18 lated injury or death—

19 (A) this subtitle does not affect the appli-
20 cation of the rule of law to such an action; and

21 (B) any rule of law prescribed by this sub-
22 title in conflict with a rule of law of such title
23 XXI shall not apply to such action.

24 (2) If there is an aspect of a civil action
25 brought for a vaccine-related injury or death to

1 which a Federal rule of law under title XXI of the
2 Public Health Service Act does not apply, then this
3 subtitle or otherwise applicable law (as determined
4 under this subtitle) will apply to such aspect of such
5 action.

6 (b) OTHER FEDERAL LAW.—Except as provided in
7 this section, nothing in this subtitle shall be deemed to
8 affect any defense available to a defendant in a health care
9 lawsuit or action under any other provision of Federal law.

10 **SEC. 220. STATE FLEXIBILITY AND PROTECTION OF**
11 **STATES' RIGHTS.**

12 (a) HEALTH CARE LAWSUITS.—The provisions gov-
13 erning health care lawsuits set forth in this subtitle pre-
14 empt, subject to subsections (b) and (c), State law to the
15 extent that State law prevents the application of any pro-
16 visions of law established by or under this subtitle. The
17 provisions governing health care lawsuits set forth in this
18 subtitle supersede chapter 171 of title 28, United States
19 Code, to the extent that such chapter—

20 (1) provides for a greater amount of damages
21 or contingent fees, a longer period in which a health
22 care lawsuit may be commenced, or a reduced appli-
23 cability or scope of periodic payment of future dam-
24 ages, than provided in this subtitle; or

1 (2) prohibits the introduction of evidence re-
2 garding collateral source benefits, or mandates or
3 permits subrogation or a lien on collateral source
4 benefits.

5 (b) PROTECTION OF STATES' RIGHTS AND OTHER
6 LAWS.—(1) Any issue that is not governed by any provi-
7 sion of law established by or under this subtitle (including
8 State standards of negligence) shall be governed by other-
9 wise applicable State or Federal law.

10 (2) This subtitle shall not preempt or supersede any
11 State or Federal law that imposes greater procedural or
12 substantive protections for health care providers and
13 health care organizations from liability, loss, or damages
14 than those provided by this subtitle or create a cause of
15 action.

16 (c) STATE FLEXIBILITY.—No provision of this sub-
17 title shall be construed to preempt—

18 (1) any State law (whether effective before, on,
19 or after the date of the enactment of this subtitle)
20 that specifies a particular monetary amount of com-
21 pensatory or punitive damages (or the total amount
22 of damages) that may be awarded in a health care
23 lawsuit, regardless of whether such monetary
24 amount is greater or lesser than is provided for
25 under this subtitle, notwithstanding section 4(a); or

1 (2) any defense available to a party in a health
2 care lawsuit under any other provision of State or
3 Federal law.

4 **SEC. 221. APPLICABILITY; EFFECTIVE DATE.**

5 This subtitle shall apply to any health care lawsuit
6 brought in a Federal or State court, or subject to an alter-
7 native dispute resolution system, that is initiated on or
8 after the date of the enactment of this subtitle, except that
9 any health care lawsuit arising from an injury occurring
10 prior to the date of the enactment of this subtitle shall
11 be governed by the applicable statute of limitations provi-
12 sions in effect at the time the injury occurred.

13 **SEC. 222. SENSE OF CONGRESS.**

14 It is the sense of Congress that a health insurer
15 should be liable for damages for harm caused when it
16 makes a decision as to what care is medically necessary
17 and appropriate.

1 **Subtitle C—Accelerating the De-**
2 **ployment of Health Information**
3 **Technology**

4 **PART 1—ENHANCED COORDINATION AND ADOP-**
5 **TION OF HEALTH INFORMATION TECH-**
6 **NOLOGY**

7 **SEC. 231. STRATEGIC PLAN FOR COORDINATING IMPLE-**
8 **MENTATION OF MEDICARE AND MEDICAID**
9 **HEALTH INFORMATION TECHNOLOGY INCEN-**
10 **TIVE PAYMENTS.**

11 Section 3001(c) of the Public Health Service Act (42
12 U.S.C. 300jj–11(c)) is amended by adding at the end the
13 following new paragraph:

14 “(9) STRATEGIC PLAN FOR MEDICARE AND
15 MEDICAID EHR PAYMENT INCENTIVES AND ADJUST-
16 MENTS.—Not later than 90 days after the date of
17 the enactment of the Medical Rights and Reform
18 Act of 2009, the National Coordinator shall publish
19 a strategic plan including—

20 “(A) timelines for applying the incentive
21 payments and incentive adjustments applicable
22 to eligible providers, eligible hospitals, and eligi-
23 ble professionals under sections 1848(a),
24 1848(o), 1853(l), 1853(m), 1886(n),
25 1814(l)(3), 1886(b)(3)(B)(ix), and

1 1903(a)(3)(F) during the 18-month period fol-
2 lowing such date of enactment, including speci-
3 fying specific steps by date that providers and
4 hospitals must take to be eligible for such in-
5 centive payments; and

6 “(B) a specific plan to educate health care
7 providers, consumers, and vendors of health in-
8 formation technology about how eligible pro-
9 viders, eligible hospitals, and eligible profes-
10 sionals may become compliant with require-
11 ments under such sections for purposes of eligi-
12 bility for incentive payments under such sec-
13 tions.”.

14 **SEC. 232. PROCEDURES TO ENSURE TIMELY UPDATING OF**
15 **STANDARDS THAT ENABLE ELECTRONIC EX-**
16 **CHANGES.**

17 Section 1174(b) of the Social Security Act (42 U.S.C.
18 1320d-3(b)) is amended—

19 (1) in paragraph (1)—

20 (A) in the first sentence, by inserting “and
21 in accordance with paragraph (3)” before the
22 period; and

23 (B) by adding at the end the following new
24 sentence: “For purposes of this subsection and

1 section 1173(c)(2), the term ‘modification’ in-
2 cludes a new version or a version upgrade”; and
3 (2) by adding at the end the following new
4 paragraph:

5 “(3) EXPEDITED PROCEDURES FOR ADOPTION
6 OF ADDITIONS AND MODIFICATIONS TO STAND-
7 ARDS.—

8 “(A) IN GENERAL.—For purposes of para-
9 graph (1), the Secretary shall provide for an ex-
10 pedited upgrade program (in this paragraph re-
11 ferred to as the ‘upgrade program’), in accord-
12 ance with this paragraph, to develop and ap-
13 prove additions and modifications to the stand-
14 ards adopted under section 1173(a) to improve
15 the quality of such standards or to extend the
16 functionality of such standards to meet evolving
17 requirements in health care.

18 “(B) PUBLICATION OF NOTICES.—Under
19 the upgrade program:

20 “(i) VOLUNTARY NOTICE OF INITI-
21 ATION OF PROCESS.—Not later than 30
22 days after the date the Secretary receives
23 a notice from a standard setting organiza-
24 tion that the organization is initiating a
25 process to develop an addition or modifica-

1 tion to a standard adopted under section
2 1173(a), the Secretary shall publish a no-
3 tice in the Federal Register that—

4 “(I) identifies the subject matter
5 of the addition or modification;

6 “(II) provides a description of
7 how persons may participate in the
8 development process; and

9 “(III) invites public participation
10 in such process.

11 “(ii) VOLUNTARY NOTICE OF PRE-
12 LIMINARY DRAFT OF ADDITIONS OR MODI-
13 FICATIONS TO STANDARDS.—Not later
14 than 30 days after the date the Secretary
15 receives a notice from a standard setting
16 organization that the organization has pre-
17 pared a preliminary draft of an addition or
18 modification to a standard adopted by sec-
19 tion 1173(a), the Secretary shall publish a
20 notice in the Federal Register that—

21 “(I) identifies the subject matter
22 of (and summarizes) the addition or
23 modification;

24 “(II) specifies the procedure for
25 obtaining the draft;

1 “(III) provides a description of
2 how persons may submit comments in
3 writing and at any public hearing or
4 meeting held by the organization on
5 the addition or modification; and

6 “(IV) invites submission of such
7 comments and participation in such
8 hearing or meeting without requiring
9 the public to pay a fee to participate.

10 “(iii) NOTICE OF PROPOSED ADDITION
11 OR MODIFICATION TO STANDARDS.—Not
12 later than 30 days after the date the Sec-
13 retary receives a notice from a standard
14 setting organization that the organization
15 has a proposed addition or modification to
16 a standard adopted under section 1173(a)
17 that the organization intends to submit
18 under subparagraph (D)(iii), the Secretary
19 shall publish a notice in the Federal Reg-
20 ister that contains, with respect to the pro-
21 posed addition or modification, the infor-
22 mation required in the notice under clause
23 (ii) with respect to the addition or modi-
24 fication.

1 “(iv) CONSTRUCTION.—Nothing in
2 this paragraph shall be construed as re-
3 quiring a standard setting organization to
4 request the notices described in clauses (i)
5 and (ii) with respect to an addition or
6 modification to a standard in order to
7 qualify for an expedited determination
8 under subparagraph (C) with respect to a
9 proposal submitted to the Secretary for
10 adoption of such addition or modification.

11 “(C) PROVISION OF EXPEDITED DETER-
12 MINATION.—Under the upgrade program and
13 with respect to a proposal by a standard setting
14 organization for an addition or modification to
15 a standard adopted under section 1173(a), if
16 the Secretary determines that the standard set-
17 ting organization developed such addition or
18 modification in accordance with the require-
19 ments of subparagraph (D) and the National
20 Committee on Vital and Health Statistics rec-
21 ommends approval of such addition or modifica-
22 tion under subparagraph (E), the Secretary
23 shall provide for expedited treatment of such
24 proposal in accordance with subparagraph (F).

1 “(D) REQUIREMENTS.—The requirements
2 under this subparagraph with respect to a pro-
3 posed addition or modification to a standard by
4 a standard setting organization are the fol-
5 lowing:

6 “(i) REQUEST FOR PUBLICATION OF
7 NOTICE.—The standard setting organiza-
8 tion submits to the Secretary a request for
9 publication in the Federal Register of a no-
10 tice described in subparagraph (B)(iii) for
11 the proposed addition or modification.

12 “(ii) PROCESS FOR RECEIPT AND
13 CONSIDERATION OF PUBLIC COMMENT.—
14 The standard setting organization provides
15 for a process through which, after the pub-
16 lication of the notice referred to under
17 clause (i), the organization—

18 “(I) receives and responds to
19 public comments submitted on a time-
20 ly basis on the proposed addition or
21 modification before submitting such
22 proposed addition or modification to
23 the National Committee on Vital and
24 Health Statistics under clause (iii);

1 “(II) makes publicly available a
2 written explanation for its response in
3 the proposed addition or modification
4 to comments submitted on a timely
5 basis; and

6 “(III) makes public comments re-
7 ceived under clause (I) available, or
8 provides access to such comments, to
9 the Secretary.

10 “(iii) SUBMITTAL OF FINAL PRO-
11 POSED ADDITION OR MODIFICATION TO
12 NCVHS.—After completion of the process
13 under clause (ii), the standard setting or-
14 ganization submits the proposed addition
15 or modification to the National Committee
16 on Vital and Health Statistics for review
17 and consideration under subparagraph (E).
18 Such submission shall include information
19 on the organization’s compliance with the
20 notice and comment requirements (and re-
21 sponses to those comments) under clause
22 (ii).

23 “(E) HEARING AND RECOMMENDATIONS
24 BY NATIONAL COMMITTEE ON VITAL AND
25 HEALTH STATISTICS.—Under the upgrade pro-

1 gram, upon receipt of a proposal submitted by
2 a standard setting organization under subpara-
3 graph (D)(iii) for the adoption of an addition or
4 modification to a standard, the National Com-
5 mittee on Vital and Health Statistics shall pro-
6 vide notice to the public and a reasonable op-
7 portunity for public testimony at a hearing on
8 such addition or modification. The Secretary
9 may participate in such hearing in such capac-
10 ity (including presiding ex officio) as the Sec-
11 retary shall determine appropriate. Not later
12 than 90 days after the date of receipt of the
13 proposal, the Committee shall submit to the
14 Secretary its recommendation to adopt (or not
15 adopt) the proposed addition or modification.

16 “(F) DETERMINATION BY SECRETARY TO
17 ACCEPT OR REJECT NATIONAL COMMITTEE ON
18 VITAL AND HEALTH STATISTICS RECOMMENDA-
19 TION.—

20 “(i) TIMELY DETERMINATION.—

21 Under the upgrade program, if the Na-
22 tional Committee on Vital and Health Sta-
23 tistics submits to the Secretary a rec-
24 ommendation under subparagraph (E) to
25 adopt a proposed addition or modification,

1 not later than 90 days after the date of re-
2 ceipt of such recommendation the Sec-
3 retary shall make a determination to ac-
4 cept or reject the recommendation and
5 shall publish notice of such determination
6 in the Federal Register not later than 30
7 days after the date of the determination.

8 “(ii) CONTENTS OF NOTICE.—If the
9 determination is to reject the recommenda-
10 tion, such notice shall include the reasons
11 for the rejection. If the determination is to
12 accept the recommendation, as part of
13 such notice the Secretary shall promulgate
14 the modified standard (including the ac-
15 cepted proposed addition or modification
16 accepted).

17 “(iii) LIMITATION ON CONSIDER-
18 ATION.—The Secretary shall not consider a
19 proposal under this subparagraph unless
20 the Secretary determines that the require-
21 ments of subparagraph (D) (including pub-
22 lication of notice and opportunity for pub-
23 lic comment) have been met with respect to
24 the proposal.

1 “(G) EXEMPTION FROM PAPERWORK RE-
2 DUCTION ACT.—Chapter 35 of title 44, United
3 States Code, shall not apply to a final rule pro-
4 mulgated under subparagraph (F).”.

5 **SEC. 233. STUDY TO IMPROVE PRESERVATION AND PRO-**
6 **TECTION OF SECURITY AND CONFIDEN-**
7 **TIALITY OF HEALTH INFORMATION.**

8 (a) IN GENERAL.—The Secretary of Health and
9 Human Services shall conduct a study of the following:

10 (1) Current Federal security and confidentiality
11 standards to determine the strengths and weak-
12 nesses of such standards for purposes of protecting
13 the security and confidentiality of individually identi-
14 fiable health information while taking into account
15 the need for timely and efficient exchanges of health
16 information to improve quality of care and ensure
17 the availability of health information necessary to
18 make medical decisions at the location in which the
19 medical care involved is provided.

20 (2) The extent to which current security and
21 confidentiality standards and State laws relating to
22 security and confidentiality of individually identifi-
23 able health information should be reconciled to
24 produce uniform standards, especially in the case of
25 data that is shared by health care providers for pa-

1 tient care and other activities across State borders
2 that would often result in more than one set of such
3 standards that would apply.

4 (b) REPORT.—Not later than 9 months after the date
5 of the enactment of this subtitle, the Secretary of Health
6 and Human Services shall submit to Congress a report
7 on the study under subsection (a) and shall include in such
8 report recommendations for improving the current Federal
9 security and confidentiality standards, including rec-
10 ommendations for a mechanism to track breaches to the
11 security or confidentiality of individually identifiable
12 health information and for appropriate penalties to apply
13 in the case of such a breach and including proposals to
14 address issues examined in subsection (a)(2).

15 (c) PRESERVATION OF CURRENT SECURITY AND
16 CONFIDENTIALITY STANDARDS BEFORE SUBMITTAL OF
17 REPORT.—None of the provisions of this subtitle or
18 amendments made by this subtitle may limit, or require
19 issuance of a regulation that would limit, the effect of a
20 current Federal security and confidentiality standard be-
21 fore the date of the submittal of the report under sub-
22 section (b).

23 (d) CURRENT FEDERAL SECURITY AND CONFIDEN-
24 TIALITY STANDARDS DEFINED.—For purposes of this sec-
25 tion, the term “current Federal security and confiden-

1 tiality standards” means the Federal privacy standards es-
2 tablished pursuant to section 264(c) of the Health Insur-
3 ance Portability and Accountability Act of 1996 (42
4 U.S.C. 1320d–2 note) and security standards established
5 under section 1173(d) of the Social Security Act.

6 **SEC. 234. ASSISTING DOCTORS TO OBTAIN PROFICIENT**
7 **AND TRANSMISSIBLE HEALTH INFORMATION**
8 **TECHNOLOGY.**

9 (a) IN GENERAL.—Section 179 of the Internal Rev-
10 enue Code of 1986 (relating to election to expense certain
11 depreciable assets) is amended by adding at the end the
12 following new subsection:

13 “(f) HEALTH CARE INFORMATION TECHNOLOGY.—

14 “(1) IN GENERAL.—In the case of qualified
15 health care information technology purchased by a
16 medical care provider and placed in service during a
17 taxable year—

18 “(A) subsection (b)(1) shall be applied by
19 substituting ‘\$250,000’ for ‘\$125,000’;

20 “(B) subsection (b)(2) shall be applied by
21 substituting ‘\$600,000’ for ‘\$500,000’; and

22 “(C) subsection (b)(5)(A) shall be applied
23 by substituting ‘\$250,000 and \$600,000’ for
24 ‘\$125,000 and \$500,000’.

1 “(2) DEFINITIONS.—For purposes of this sub-
2 section—

3 “(A) QUALIFIED HEALTH CARE INFORMA-
4 TION TECHNOLOGY.—The term ‘qualified health
5 care information technology’ means section 179
6 property which—

7 “(i) has been certified pursuant to
8 section 3001(c)(3) of the Public Health
9 Service Act; and

10 “(ii) is used primarily for the elec-
11 tronic creation, maintenance, and exchange
12 of medical care information to provide or
13 improve the quality or efficiency of medical
14 care.

15 “(B) MEDICAL CARE PROVIDER.—The
16 term ‘medical care provider’ means any person
17 engaged in the trade or business of providing
18 medical care.

19 “(C) MEDICAL CARE.—The term ‘medical
20 care’ has the meaning given such term by sec-
21 tion 213(d).”.

22 (b) EFFECTIVE DATE.—The amendment made by
23 this section shall apply to property placed in service after
24 December 31, 2009.

1 **SEC. 235. EXPANSION OF STARK AND ANTI-KICKBACK EX-**
2 **CEPTIONS FOR ELECTRONIC HEALTH**
3 **RECORDS ARRANGEMENTS.**

4 (a) STARK EXCEPTION.—In applying section 1877(e)
5 of the Social Security Act (42 U.S.C. 1395(e)), with re-
6 spect to a regulation implementing such section by pro-
7 viding an exception to the prohibition against making cer-
8 tain physician referrals in the case of the offering or pay-
9 ment of nonmonetary remuneration (consisting of items
10 and services in the form of software or information tech-
11 nology and training services) necessary and used predomi-
12 nantly to create, maintain, transmit, or receive electronic
13 health records, the Secretary of Health and Human Serv-
14 ices shall—

15 (1) not limit the period in which such an excep-
16 tion under such a regulation applies;

17 (2) not require the physician to pay any per-
18 centage of the cost of such nonmonetary remunera-
19 tion; and

20 (3) apply the exception to such items and serv-
21 ices in the form of hardware and maintenance serv-
22 ices, in addition to such items and services in the
23 form of software or information technology and
24 training services.

25 (b) ANTI-KICKBACK EXCEPTION.—In applying sec-
26 tion 1128B(b)(3)(E) of the Social Security Act (42 U.S.C.

1 1320a–7b(b)(3)(E)), with respect to a regulation imple-
2 menting such section by providing an exception to the pro-
3 hibition against offering, paying, soliciting, or receiving re-
4 munerations in order to induce or reward referrals making
5 certain physician referrals in the case of the offering, pay-
6 ment, solicitation, or receipt of remuneration (consisting
7 of certain arrangements involving interoperable electronic
8 health records software or information technology and
9 training services) necessary and used predominantly to
10 create, maintain, transmit, or receive electronic health
11 records, the Secretary of Health and Human Services
12 shall—

13 (1) not limit the period in which such an excep-
14 tion under such a regulation applies;

15 (2) not require the recipient of such remunera-
16 tion to pay any percentage of the cost of such remu-
17 neration; and

18 (3) apply the exception to such arrangements
19 involving interoperable electronic health records
20 hardware and maintenance services, in addition to
21 software or information technology and training
22 services.

1 **SEC. 236. APPLICATION OF MEDICARE EHR INCENTIVES**
2 **AND ADJUSTMENTS TO ADDITIONAL PRO-**
3 **VIDERS.**

4 (a) APPLICATION OF EHR MEDICARE INCENTIVE
5 PAYMENTS AND ADJUSTMENTS TO NURSE PRACTI-
6 TIONER, PHYSICIAN ASSISTANTS, AND CLINICAL NURSE
7 SPECIALISTS.—

8 (1) INCENTIVE PAYMENT.—Section
9 1848(o)(5)(C) of the Social Security Act is amended
10 by inserting “, and a practitioner described in sec-
11 tion 1842(b)(18)(C)(i)” after “1861(r)”.

12 (2) INCENTIVE ADJUSTMENT.—Section
13 1848(a)(7)(E)(iii) of such Act is amended by insert-
14 ing “, and a practitioner described in section
15 1842(b)(18)(C)(i)” after “1861(r)”.

16 (b) APPLICATION OF EHR MEDICARE INCENTIVE
17 PAYMENTS AND ADJUSTMENTS TO SNFs, HOME HEALTH
18 AGENCIES, IRFs, LTCHs, ASCs, AND LONG-TERM CARE
19 PHARMACIES.—

20 (1) IN GENERAL.—The Secretary of Health and
21 Human Services shall establish a methodology to—

22 (A) determine eligible entities described in
23 paragraph (2) that are to be considered mean-
24 ingful EHR users in a manner similar to how
25 eligible hospitals are determined to be mean-
26 ingful EHR users for purposes of sections 1886(n)

1 and 1886(b)(3)(B)(ix) of the Social Security
2 Act; and

3 (B) apply the provisions of such sections to
4 such eligible entities in a similar manner as
5 they apply to hospitals under such section.

6 (2) ELIGIBLE ENTITIES DESCRIBED.—Eligible
7 entities described in this paragraph are the fol-
8 lowing:

9 (A) Skilled nursing facilities.

10 (B) Home health agencies.

11 (C) Inpatient rehabilitation facilities .

12 (D) Ambulatory surgical centers.

13 (E) Long-term care pharmacies.

14 (F) Long-term care hospitals.

15 **PART 2—TELEHEALTH ENHANCEMENT**

16 **Subpart A—Medicare Program**

17 **SEC. 241. EXPANSION AND IMPROVEMENT OF TELEHEALTH** 18 **SERVICES.**

19 (a) EXPANDING ACCESS TO TELEHEALTH SERVICES
20 TO ALL AREAS.—Section 1834(m)(4)(C)(i) of the Social
21 Security Act (42 U.S.C. 1395m(m)(4)(C)(i)) is amended
22 in paragraph (4)(C)(i) by striking “and only if such site
23 is located” and all that follows and inserting “without re-
24 gard to the geographic area within the United States
25 where the site is located.”.

1 (b) EXPANSION OF USE OF STORE-AND-FORWARD
2 TECHNOLOGY.—The second sentence of section
3 1834(m)(1) of such Act (42 U.S.C. 1395m(m)(1)) is
4 amended by inserting “and any telehealth program that
5 has been the recipient of any Federal support from the
6 Centers for Medicare & Medicaid Services, the Indian
7 Health Service, or the Health Services and Resources Ad-
8 ministration” after “Alaska or Hawaii”.

9 (c) EFFECTIVE DATE.—The amendments made by
10 this section shall apply to services furnished on or after
11 January 1, 2010.

12 **SEC. 242. INCREASE IN NUMBER OF TYPES OF ORIGI-**
13 **NATING SITES; CLARIFICATION.**

14 (a) INCREASE.—Paragraph (4)(C)(ii) of section
15 1834(m) of the Social Security Act (42 U.S.C. 1395m(m))
16 is amended by adding at the end the following new sub-
17 clause:

18 “(IX) A renal dialysis facility.”.

19 (b) CLARIFICATION OF INTENT OF THE TERM ORIGI-
20 NATING SITE.—Such section is further amended by add-
21 ing at the end the following new paragraph:

22 “(5) CONSTRUCTION.—In applying the term
23 ‘originating site’ under this subsection, the Secretary
24 shall apply the term only for the purpose of deter-
25 mining whether a site is eligible to receive a facility

1 fee. Nothing in the application of such term under
2 this subsection shall be construed as affecting the
3 ability of an eligible practitioner to submit claims for
4 telehealth services that are provided to other sites
5 that have telehealth systems and capabilities.”.

6 (c) EFFECTIVE DATE.—The amendments made by
7 this section shall apply to services furnished on or after
8 January 1, 2010.

9 **SEC. 243. EXPANSION OF ELIGIBLE TELEHEALTH PRO-**
10 **VIDERS AND CREDENTIALING OF TELEMEDI-**
11 **CINE PRACTITIONERS.**

12 (a) EXPANSION OF ELIGIBLE TELEHEALTH PRO-
13 VIDERS.—Section 1834(m)(1) of the Social Security Act
14 (42 U.S.C. 1395m(m)(1)) is amended—

15 (1) in paragraph (1)—

16 (A) by striking “or a practitioner” and in-
17 serting “, a practitioner”;

18 (B) by inserting “, or other telehealth pro-
19 vider” after “1842(b)(18)(C)”;

20 (C) by striking “or practitioner” and in-
21 serting “, practitioner, or provider”;

22 (2) in paragraphs (2), (3)(A), and (4), by strik-
23 ing “or practitioner” and inserting “, practitioner,
24 or other telehealth provider” each place it appears;
25 and

1 (3) in paragraph (4), by adding at the end the
2 following new subparagraph:

3 “(G) TELEHEALTH PROVIDER.—The term
4 ‘telehealth provider’ means any supplier or pro-
5 vider of services (other than a physician or
6 practitioner) that is eligible to provide other
7 health services under this title.”.

8 (b) CREDENTIALING TELEMEDICINE PRACTI-
9 TIONERS.—Section 1834(m) of such Act is amended by
10 adding at the end the following new paragraph:

11 “(5) HOSPITAL CREDENTIALING OF TELEMEDI-
12 CINE PRACTITIONERS.—A telemedicine practitioner
13 that is credentialed by a hospital in compliance with
14 the Joint Commission Standards for Telemedicine
15 shall be considered in compliance with Medicare con-
16 dition of participation and reimbursement
17 credentialing requirements for telemedicine serv-
18 ices.”.

19 **SEC. 244. ACCESS TO TELEHEALTH SERVICES IN THE**
20 **HOME.**

21 (a) IN GENERAL.—Section 1895 of the Social Secu-
22 rity Act (42 U.S.C. 1395fff(e)) is amended by adding at
23 the end the following new subsection:

24 “(f) COVERAGE OF TELEHEALTH SERVICES.—

1 “(1) IN GENERAL.—The Secretary shall include
2 telehealth services that are furnished via a tele-
3 communication system by a home health agency to
4 an individual receiving home health services under
5 section 1814(a)(2)(C) or 1835(a)(2)(A) as a home
6 health visit for purposes of eligibility and payment
7 under this title if the telehealth services—

8 “(A) are ordered as part of a plan of care
9 certified by a physician pursuant to section
10 1814(a)(2)(C) or 1835(a)(2)(A);

11 “(B) do not substitute for in-person home
12 health services ordered as part of a plan of care
13 certified by a physician pursuant to such re-
14 spective section; and

15 “(C) are considered the equivalent of a
16 visit under criteria developed by the Secretary
17 under paragraph (3).

18 “(2) PHYSICIAN CERTIFICATION.—Nothing in
19 this section shall be construed as waiving the re-
20 quirement for a physician certification under section
21 1814(a)(2)(C) or 1835(a)(2)(A) for the payment for
22 home health services, whether or not furnished via
23 a telecommunication system.

24 “(3) CRITERIA FOR VISIT EQUIVALENCY.—

1 “(A) STANDARDS.—The Secretary shall es-
2 tablish standards and qualifications for catego-
3 rizing and coding under HCPCS codes tele-
4 health services under this subsection as equiva-
5 lent to an in-person visit for purposes of eligi-
6 bility and payment for home health services
7 under this title. In establishing the standards
8 and qualifications, the Secretary may distin-
9 guish between varying modes and modalities of
10 telehealth services and shall consider—

11 “(i) the nature and amount of service
12 time involved; and

13 “(ii) the functions of the telecommuni-
14 cations.

15 “(B) LIMITATION.—A telecommunication
16 that consists solely of a telephone audio con-
17 versation, facsimile, electronic text mail, or con-
18 sultation between two health care practitioners
19 is not considered a visit under this subsection.

20 “(4) TELEHEALTH SERVICE.—

21 “(A) DEFINITION.—For purposes of this
22 subsection, the term ‘telehealth service’ means
23 technology-based professional consultations, pa-
24 tient monitoring, patient training services, clin-
25 ical observation, assessment, or treatment, and

1 any additional services that utilize technologies
2 specified by the Secretary as HCPCS codes de-
3 veloped under paragraph (3).

4 “(B) UPDATE OF HCPCS CODES.—The
5 Secretary shall establish a process for the up-
6 dating, not less frequently than annually, of
7 HCPCS codes for telehealth services.

8 “(5) CONDITIONS FOR PAYMENT AND COV-
9 ERAGE.—Nothing in this subsection shall be con-
10 strued as waiving any condition of payment under
11 sections 1814(a)(2)(C) or 1835(a)(2)(A) or exclu-
12 sion of coverage under section 1862(a)(1).

13 “(6) COST REPORTING.—Notwithstanding any
14 provision to the contrary, the Secretary shall provide
15 that the costs of telehealth services under this sub-
16 section shall be reported as a reimbursable cost cen-
17 ter on any cost report submitted by a home health
18 agency to the Secretary.”.

19 (b) EFFECTIVE DATE.—

20 (1) The amendment made by subsection (a)
21 shall apply to telehealth services furnished on or
22 after October 1, 2010. The Secretary of Health and
23 Human Services shall develop and implement cri-
24 teria and standards under section 1895(f)(3) of the

1 Social Security Act, as amended by subsection (a),
2 by no later than July 1, 2010.

3 (2) In the event that the Secretary has not
4 complied with these deadlines, beginning October 1,
5 2010, a home health visit for purpose of eligibility
6 and payment under title XVIII of the Social Secu-
7 rity Act shall include telehealth services under sec-
8 tion 1895(f) of such Act with the aggregate of tele-
9 communication encounters in a 24-hour period con-
10 sidered the equivalent of one in-person visit.

11 **SEC. 245. COVERAGE OF HOME HEALTH REMOTE PATIENT**
12 **MANAGEMENT SERVICES FOR CHRONIC**
13 **HEALTH CONDITIONS.**

14 (a) **MEDICARE COVERAGE.**—

15 (1) **IN GENERAL.**—Section 1861(s)(2) of the
16 Social Security Act (42 U.S.C. 1395x(s)(2)) is
17 amended—

18 (A) in subparagraph (DD), by striking
19 “and” at the end;

20 (B) in subparagraph (EE), by adding
21 “and” at the end; and

22 (C) by inserting after subparagraph (EE)
23 the following new subparagraph:

24 “(FF) home health remote patient management
25 services (as defined in subsection (hhh));”.

1 (2) SERVICES DESCRIBED.—Section 1861 of
2 such Act (42 U.S.C. 1395x) is amended by adding
3 at the end the following new subsection:

4 “(hhh) HOME HEALTH REMOTE PATIENT MANAGE-
5 MENT SERVICES FOR CHRONIC HEALTH CONDITIONS.—

6 (1) The term ‘remote patient management services’ means
7 the remote monitoring, evaluation, and management of an
8 individual with a covered chronic health condition (as de-
9 fined in paragraph (2)) through the utilization of a system
10 of technology that allows a remote interface to collect and
11 transmit clinical data between the individual and a home
12 health agency, in accordance with a plan of care estab-
13 lished by a physician, for the purposes of clinical review
14 or response by the home health agency. Such term, with
15 respect to an individual, does not include any remote mon-
16 itoring, evaluation, or management of the individual if
17 such remote monitoring, evaluation, or management, re-
18 spectively, is included as a home health visit under section
19 1895(f) for purposes of payment under this title.

20 “(2) For purposes of paragraph (1), the term ‘cov-
21 ered chronic health condition’ means any chronic health
22 condition specified by the Secretary.”.

23 (b) PAYMENT.—

1 (1) IN GENERAL.—Section 1834 of such Act
2 (42 U.S.C. 1395l) is amended by adding at the end
3 the following new subsection:

4 “(n) HOME HEALTH REMOTE PATIENT MANAGE-
5 MENT SERVICES.—

6 “(1) IN GENERAL.—The Secretary shall estab-
7 lish a fee schedule for home health remote patient
8 management services (as defined in section
9 1861(hhh)) for which payment is made under this
10 part. The fee schedule shall be designed in a manner
11 so that, on an annual basis, the aggregate payment
12 amounts under this title for such services approxi-
13 mates 50 percent of the savings amount described in
14 paragraph (2) for such year.

15 “(2) SAVINGS DESCRIBED.—

16 “(A) IN GENERAL.—For purposes of para-
17 graph (1), the savings amount described in this
18 paragraph for a year is the amount (if any), as
19 estimated by the Secretary before the beginning
20 of the year, by which—

21 “(i) the product described in subpara-
22 graph (B) for the year, exceeds

23 “(ii) the total payments under this
24 part and part A for items and services fur-
25 nished to individuals receiving home health

1 remote patient management services at any
2 time during the year.

3 “(B) PRODUCT DESCRIBED.—The product
4 described in this subparagraph for a year is the
5 product of—

6 “(i) the average per capita total pay-
7 ments under this part and part A for items
8 and services furnished during the year to
9 individuals not described in subparagraph
10 (A)(ii), adjusted to remove case mix dif-
11 ferences between such individuals not de-
12 scribed in such subparagraph and the indi-
13 viduals described in such subparagraph;
14 and

15 “(ii) the number of individuals under
16 subparagraph (A)(ii) for the year.

17 “(3) LIMITATION.—In no case may payments
18 under this subsection result in the aggregate expend-
19 itures under this title (including payments under
20 this subsection) exceeding the amount that the Sec-
21 retary estimates would have been expended if cov-
22 erage under this title for home health patient man-
23 agement services was not provided.

24 “(4) CLARIFICATION.—Payments under the fee
25 schedule under this subsection, with respect to an

1 individual, shall be in addition to any other pay-
2 ments that a home health agency would otherwise
3 receive under this title for items and services fur-
4 nished to such individual and shall have no effect on
5 the amount of such other payments.

6 “(5) PAYMENT TRANSFER.—There shall be
7 transferred from the Federal Hospital Insurance
8 Trust Fund under section 1817 to the Federal Sup-
9 plementary Medical Insurance Trust Fund under
10 section 1841 each year an amount equivalent to the
11 product of—

12 “(A) expenditures under this subsection
13 for the year, and

14 “(B) the ratio of the portion of the savings
15 described in paragraph (2) for the year that are
16 attributable to part A, to the total savings de-
17 scribed in such paragraph for the year.”.

18 (2) CONFORMING AMENDMENT.—Section
19 1833(a)(1) of such Act (42 U.S.C. 1395l(1)) is
20 amended—

21 (A) by striking “and (W)” and inserting
22 “(W)”; and

23 (B) by inserting before the semicolon at
24 the end the following: “, (X) with respect to
25 home health remote patient management serv-

1 ices (as defined in section 1861(hhh)), the
2 amounts paid shall be the amount determined
3 under the fee schedule established under section
4 1834(n)".

5 (c) **EXPANSION OF HOME HEALTH REMOTE PA-**
6 **TIENT MANAGEMENT SERVICES COVERAGE TO ADDI-**
7 **TIONAL CHRONIC HEALTH CONDITIONS.**—The Secretary
8 of Health and Human Services is authorized to carry out
9 pilot projects for purposes of determining the extent to
10 which the coverage under title XVIII of the Social Security
11 Act of home health remote patient management services
12 (as defined in paragraph (1) of section 1861(hhh) of such
13 Act, as added by subsection (a)) should be extended to
14 individuals with chronic health conditions other than those
15 initially specified by the Secretary under paragraph (2)
16 of such section.

17 (d) **EFFECTIVE DATE.**—The amendments made by
18 subsections (a), (b), and (c) shall apply to services fur-
19 nished on or after January 1, 2010.

20 **SEC. 246. SENSE OF CONGRESS ON THE USE OF REMOTE**
21 **PATIENT MANAGEMENT SERVICES.**

22 (a) **FINDINGS.**—Congress finds as follows:

23 (1) Remote patient management services can
24 make chronic disease management more effective

1 and efficient for patients and for the health care sys-
2 tem.

3 (2) By collecting, analyzing, and transmitting
4 clinical health information to a health care provider,
5 remote patient management services allow patients
6 and providers to manage the medical condition of
7 patients in a consistent and real time fashion.

8 (3) Utilization of remote patient management
9 services not only improves the quality of care given
10 to patients, it also reduces the need for frequent of-
11 fice appointments, costly emergency room visits, and
12 unnecessary hospitalizations.

13 (4) Management the medical condition or dis-
14 ease of a patient from the patient's home reduces
15 the need for face to face provider interactions. Use
16 of remote patient management services minimizes
17 unnecessary travel and missed work and provides
18 particular value to patients residing in rural or un-
19 derserved communities who would otherwise face po-
20 tentially significant access barriers to receiving need-
21 ed care.

22 (5) Among the areas in which remote patient
23 management services are emerging in health care
24 are the treatment of congestive heart failure, diabe-
25 tes, cardiac arrhythmia, epilepsy, and sleep apnea.

1 Prompt transmission of clinical data on each of
2 these conditions, to the health care provider or the
3 patient as appropriate, is essential to providing time-
4 ly and appropriate therapeutic interventions which
5 can then reduce expensive hospitalizations.

6 (6) Despite these benefits, remote patient man-
7 agement services have failed to diffuse rapidly. A
8 significant barrier to wider adoption is the relative
9 lack of payment mechanisms in fee for service Medi-
10 care to reimburse for remote, non face to face pa-
11 tient management.

12 (7) Elimination of this barrier to new remote
13 patient management services should be encouraged
14 by requiring reimbursement under the Medicare pro-
15 gram for providers' time spent analyzing and re-
16 sponding to patient data transmitted by remote
17 technologies.

18 (8) Reimbursement under the Medicare pro-
19 gram for health care providers' time spent analyzing
20 and responding to data transmitted to providers by
21 remote technologies should be made on a separate
22 basis and should not be combined with payments for
23 others services (also referred to as "bundled pay-
24 ments").

1 (9) Payment codes used for reporting and bill-
2 ing for payment for providers' remote patient man-
3 agement services should be revised or adjusted, as
4 appropriate, to encourage the application of such
5 services for other medical conditions.

6 (b) SENSE OF CONGRESS.—It is the sense of the
7 Congress that—

8 (1) remote patient management services are in-
9 tegral to improvement in the delivery, care, and effi-
10 ciency of health care services furnished in the
11 United States; and

12 (2) the Administrator of the Centers for Medi-
13 care & Medicaid Services should be encouraged to—

14 (A) expand the types of medical conditions
15 for which the use of remote patient manage-
16 ment services are reimbursed under the Medi-
17 care program;

18 (B) provide for separate, non-bundled pay-
19 ment under the Medicare program for remote
20 patient management services; and

21 (C) create, revise and adjust, as appro-
22 priate, codes for the accurate reporting and bill-
23 ing for payment for remote patient manage-
24 ment services.

1 **SEC. 247. TELEHEALTH ADVISORY COMMITTEE.**

2 (a) IN GENERAL.—Section 1834(m)(4)(F)(ii) of the
3 Social Security Act (42 U.S.C. 1395m(m)(4)(F)(ii)) is
4 amended by adding at the end the following sentences:
5 “Such process shall require the Secretary to take into ac-
6 count the recommendations of the Telehealth Advisory
7 Committee (as established under section 247(b) of the
8 Medical Rights and Reform Act of 2009) when adding or
9 deleting services (and HCPCS codes) and in establishing
10 policies of the Centers for Medicare & Medicaid Services
11 regarding the delivery of telehealth services. If the Sec-
12 retary does not implement a recommendation of the Tele-
13 health Advisory Committee, the Secretary shall publish in
14 the Federal Register a statement regarding the reason
15 such recommendation was not implemented.”.

16 (b) TELEHEALTH ADVISORY COMMITTEE.—

17 (1) ESTABLISHMENT.—On and after the date
18 that is 6 months after the date of enactment of this
19 subtitle, the Secretary of Health and Human Serv-
20 ices (in this subsection referred to as the “Sec-
21 retary”) shall have in place a Telehealth Advisory
22 Committee (in this subsection referred to as the
23 “Advisory Committee”) to make recommendations to
24 the Secretary on—

1 (A) policies of the Centers for Medicare &
2 Medicaid Services regarding the delivery of tele-
3 health services; and

4 (B) the appropriate addition or deletion of
5 services (and HCPCS codes) to those specified
6 in paragraph (4)(F)(i) of section 1834(m) of
7 the Social Security Act (42 U.S.C. 1395m(m))
8 for authorized payment under paragraph (1) of
9 such section.

10 (2) MEMBERSHIP; TERMS.—

11 (A) MEMBERSHIP.—

12 (i) IN GENERAL.—The Advisory Com-
13 mittee shall be composed of 9 members, to
14 be appointed by the Secretary, of whom—

15 (I) five shall be practicing physi-
16 cians;

17 (II) two shall be practicing non-
18 physician health care providers; and

19 (III) two shall be administrators
20 of telehealth programs.

21 (ii) REQUIREMENTS FOR APPOINTING
22 MEMBERS.—In appointing members of the
23 Advisory Committee, the Secretary shall—

1 (I) ensure that each member has
2 prior experience with the practice of
3 telemedicine or telehealth;

4 (II) give preference to individuals
5 who are currently providing telemedi-
6 cine or telehealth services or who are
7 involved in telemedicine or telehealth
8 programs;

9 (III) ensure that the membership
10 of the Advisory Committee represents
11 a balance of specialties and geo-
12 graphic regions; and

13 (IV) take into account the rec-
14 ommendations of stakeholders.

15 (B) TERMS.—The members of the Advi-
16 sory Committee shall serve for such term as the
17 Secretary may specify.

18 (C) CONFLICTS OF INTEREST.—An advi-
19 sory committee member may not participate
20 with respect to a particular matter considered
21 in an advisory committee meeting if such mem-
22 ber (or an immediate family member of such
23 member) has a financial interest that could be
24 affected by the advice given to the Secretary
25 with respect to such matter.

1 (3) MEETINGS.—The Advisory Committee shall
2 meet twice per year and at such other times as the
3 Advisory Committee may provide.

4 (4) PERMANENT COMMITTEE.—Section 14 of
5 the Federal Advisory Committee Act (5 U.S.C.
6 App.) shall not apply to the Advisory Committee.

7 (5) WAIVER OF ADMINISTRATIVE LIMITA-
8 TION.—The Secretary shall establish the Advisory
9 Committee notwithstanding any limitation that may
10 apply to the number of advisory committees that
11 may be established (within the Department of
12 Health and Human Services or otherwise).

13 **Subpart B—HRSA Grant Program**

14 **SEC. 250. GRANT PROGRAM FOR THE DEVELOPMENT OF**
15 **TELEHEALTH NETWORKS.**

16 (a) IN GENERAL.—The Secretary of Health and
17 Human Services (in this section referred to as the “Sec-
18 retary”), acting through the Director of the Office for the
19 Advancement of Telehealth (of the Health Resources and
20 Services Administration), shall make grants to eligible en-
21 tities (as described in subsection (b)(2)) for the purpose
22 of expanding access to health care services for individuals
23 in rural areas, frontier areas, and urban medically under-
24 served areas through the use of telehealth.

25 (b) ELIGIBLE ENTITIES.—

1 (1) APPLICATION.—To be eligible to receive a
2 grant under this section, an eligible entity described
3 in paragraph (2) shall, in consultation with the
4 State office of rural health or other appropriate
5 State entity, prepare and submit to the Secretary an
6 application, at such time, in such manner, and con-
7 taining such information as the Secretary may re-
8 quire, including the following:

9 (A) A description of the anticipated need
10 for the grant.

11 (B) A description of the activities which
12 the entity intends to carry out using amounts
13 provided under the grant.

14 (C) A plan for continuing the project after
15 Federal support under this section is ended.

16 (D) A description of the manner in which
17 the activities funded under the grant will meet
18 health care needs of underserved rural popu-
19 lations within the State.

20 (E) A description of how the local commu-
21 nity or region to be served by the network or
22 proposed network will be involved in the devel-
23 opment and ongoing operations of the network.

24 (F) The source and amount of non-Federal
25 funds the entity would pledge for the project.

1 (G) A showing of the long-term viability of
2 the project and evidence of health care provider
3 commitment to the network.

4 The application should demonstrate the manner in
5 which the project will promote the integration of
6 telehealth in the community so as to avoid redun-
7 dancy of technology and achieve economies of scale.

8 (2) ELIGIBLE ENTITIES.—

9 (A) IN GENERAL.—An eligible entity de-
10 scribed in this paragraph is a hospital or other
11 health care provider in a health care network of
12 community-based health care providers that in-
13 cludes at least—

14 (i) two of the organizations described
15 in subparagraph (B); and

16 (ii) one of the institutions and entities
17 described in subparagraph (C),

18 if the institution or entity is able to dem-
19 onstrate use of the network for purposes of
20 education or economic development (as required
21 by the Secretary).

22 (B) ORGANIZATIONS DESCRIBED.—The or-
23 ganizations described in this subparagraph are
24 the following:

1 (i) Community or migrant health cen-
2 ters.

3 (ii) Local health departments.

4 (iii) Nonprofit hospitals.

5 (iv) Private practice health profes-
6 sionals, including community and rural
7 health clinics.

8 (v) Other publicly funded health or so-
9 cial services agencies.

10 (vi) Skilled nursing facilities.

11 (vii) County mental health and other
12 publicly funded mental health facilities.

13 (viii) Providers of home health serv-
14 ices.

15 (ix) Renal dialysis facilities.

16 (C) INSTITUTIONS AND ENTITIES DE-
17 SCRIBED.—The institutions and entities de-
18 scribed in this subparagraph are the following:

19 (i) A public school.

20 (ii) A public library.

21 (iii) A university or college.

22 (iv) A local government entity.

23 (v) A local health entity.

24 (vi) A health-related nonprofit founda-
25 tion.

1 (vii) An academic health center.

2 An eligible entity may include for-profit entities so
3 long as the recipient of the grant is a not-for-profit
4 entity.

5 (c) PREFERENCE.—The Secretary shall establish pro-
6 cedures to prioritize financial assistance under this section
7 based upon the following considerations:

8 (1) The applicant is a health care provider in
9 a health care network or a health care provider that
10 proposes to form such a network that furnishes or
11 proposes to furnish services in a medically under-
12 served area, health professional shortage area, or
13 mental health professional shortage area.

14 (2) The applicant is able to demonstrate broad
15 geographic coverage in the rural or medically under-
16 served areas of the State, or States in which the ap-
17 plicant is located.

18 (3) The applicant proposes to use Federal
19 funds to develop plans for, or to establish, telehealth
20 systems that will link rural hospitals and rural
21 health care providers to other hospitals, health care
22 providers, and patients.

23 (4) The applicant will use the amounts provided
24 for a range of health care applications and to pro-

1 mote greater efficiency in the use of health care re-
2 sources.

3 (5) The applicant is able to demonstrate the
4 long-term viability of projects through cost participa-
5 tion (cash or in-kind).

6 (6) The applicant is able to demonstrate finan-
7 cial, institutional, and community support for the
8 long-term viability of the network.

9 (7) The applicant is able to provide a detailed
10 plan for coordinating system use by eligible entities
11 so that health care services are given a priority over
12 non-clinical uses.

13 (d) MAXIMUM AMOUNT OF ASSISTANCE TO INDIVIDUAL
14 RECIPIENTS.—The Secretary shall establish, by
15 regulation, the terms and conditions of the grant and the
16 maximum amount of a grant award to be made available
17 to an individual recipient for each fiscal year under this
18 section. The Secretary shall cause to have published in the
19 Federal Register or the “HRSA Preview” notice of the
20 terms and conditions of a grant under this section and
21 the maximum amount of such a grant for a fiscal year.

22 (e) USE OF AMOUNTS.—The recipient of a grant
23 under this section may use sums received under such
24 grant for the acquisition of telehealth equipment and

1 modifications or improvements of telecommunications fa-
2 cilities including the following:

3 (1) The development and acquisition through
4 lease or purchase of computer hardware and soft-
5 ware, audio and video equipment, computer network
6 equipment, interactive equipment, data terminal
7 equipment, and other facilities and equipment that
8 would further the purposes of this section.

9 (2) The provision of technical assistance and in-
10 struction for the development and use of such pro-
11 gramming equipment or facilities.

12 (3) The development and acquisition of instruc-
13 tional programming.

14 (4) Demonstration projects for teaching or
15 training medical students, residents, and other
16 health profession students in rural or medically un-
17 derserved training sites about the application of tele-
18 health.

19 (5) The provision of telenursing services de-
20 signed to enhance care coordination and promote pa-
21 tient self-management skills.

22 (6) The provision of services designed to pro-
23 mote patient understanding and adherence to na-
24 tional guidelines for common chronic diseases, such
25 as congestive heart failure or diabetes.

1 (7) Transmission costs, maintenance of equip-
2 ment, and compensation of specialists and referring
3 health care providers, when no other form of reim-
4 bursement is available.

5 (8) Development of projects to use telehealth to
6 facilitate collaboration between health care providers.

7 (9) Electronic archival of patient records.

8 (10) Collection and analysis of usage statistics
9 and data that can be used to document the cost-ef-
10 fectiveness of the telehealth services.

11 (11) Such other uses that are consistent with
12 achieving the purposes of this section as approved by
13 the Secretary.

14 (f) PROHIBITED USES.—Sums received under a
15 grant under this section may not be used for any of the
16 following:

17 (1) To acquire real property.

18 (2) Expenditures to purchase or lease equip-
19 ment to the extent the expenditures would exceed
20 more than 40 percent of the total grant funds.

21 (3) To purchase or install transmission equip-
22 ment off the premises of the telehealth site and any
23 transmission costs not directly related to the grant.

1 (4) For construction, except that such funds
2 may be expended for minor renovations relating to
3 the installation of equipment.

4 (5) Expenditures for indirect costs (as deter-
5 mined by the Secretary) to the extent the expendi-
6 tures would exceed more than 15 percent of the total
7 grant.

8 (g) ADMINISTRATION.—

9 (1) NONDUPLICATION.—The Secretary shall en-
10 sure that facilities constructed using grants provided
11 under this section do not duplicate adequately estab-
12 lished telehealth networks.

13 (2) COORDINATION WITH OTHER AGENCIES.—
14 The Secretary shall coordinate, to the extent prac-
15 ticable, with other Federal and State agencies and
16 not-for-profit organizations, operating similar grant
17 programs to pool resources for funding meritorious
18 proposals.

19 (3) INFORMATIONAL EFFORTS.—The Secretary
20 shall establish and implement procedures to carry
21 out outreach activities to advise potential end users
22 located in rural and medically underserved areas of
23 each State about the program authorized by this
24 section.

1 (h) PROMPT IMPLEMENTATION.—The Secretary shall
2 take such actions as are necessary to carry out the grant
3 program as expeditiously as possible.

4 (i) AUTHORIZATION OF APPROPRIATIONS.—There
5 are authorized to be appropriated to carry out this section
6 \$10,000,000 for fiscal year 2010, and such sums as may
7 be necessary for each of the fiscal years 2011 through
8 2014.

9 **SEC. 251. REAUTHORIZATION OF TELEHEALTH NETWORK**
10 **AND TELEHEALTH RESOURCE CENTERS**
11 **GRANT PROGRAMS.**

12 Subsection (s) of section 330I of the Public Health
13 Service Act (42 U.S.C. 254c–14) is amended—

14 (1) in paragraph (1)—

15 (A) by striking “and” before “such sums”;

16 and

17 (B) by inserting “\$10,000,000 for fiscal
18 year 2010, and such sums as may be necessary
19 for each of fiscal years 2011 through 2014” be-
20 fore the semicolon; and

21 (2) in paragraph (2)—

22 (A) by striking “and” before “such sums”;

23 and

24 (B) by inserting “\$10,000,000 for fiscal
25 year 2010, and such sums as may be necessary

1 for each of fiscal years 2011 through 2014” be-
2 fore the semicolon.

3 **Subtitle D—Eliminating Waste,**
4 **Fraud, and Abuse**

5 **SEC. 261. SITE INSPECTIONS; BACKGROUND CHECKS; DE-**
6 **NIAL AND SUSPENSION OF BILLING PRIVI-**
7 **LEGES.**

8 (a) SITE INSPECTIONS FOR DME SUPPLIERS, COM-
9 MUNITY MENTAL HEALTH CENTERS, AND OTHER PRO-
10 VIDER GROUPS.—Title XVIII of the Social Security Act
11 (42 U.S.C. 1395 et seq.) is amended by adding at the end
12 the following:

13 “SITE INSPECTIONS FOR DME SUPPLIERS, COMMUNITY
14 MENTAL HEALTH CENTERS, AND OTHER PROVIDER
15 GROUPS

16 “SEC. 1898. (a) SITE INSPECTIONS.—

17 “(1) IN GENERAL.—The Secretary shall con-
18 duct a site inspection for each applicable provider
19 (as defined in paragraph (2)) that applies to enroll
20 under this title in order to provide items or services
21 under this title. Such site inspection shall be in addi-
22 tion to any other site inspection that the Secretary
23 would otherwise conduct with regard to an applica-
24 ble provider.

25 “(2) APPLICABLE PROVIDER DEFINED.—

1 “(A) IN GENERAL.—Except as provided in
2 subparagraph (B), in this section the term ‘ap-
3 plicable provider’ means—

4 “(i) a supplier of durable medical
5 equipment (including items described in
6 section 1834(a)(13));

7 “(ii) a supplier of prosthetics,
8 orthotics, or supplies (including items de-
9 scribed in paragraphs (8) and (9) of sec-
10 tion 1861(s));

11 “(iii) a community mental health cen-
12 ter; or

13 “(iv) any other provider group, as de-
14 termined by the Secretary (including sup-
15 pliers, both participating suppliers and
16 non-participating suppliers, as such terms
17 are defined for purposes of section 1842).

18 “(B) EXCEPTION.—In this section, the
19 term ‘applicable provider’ does not include—

20 “(i) a physician that provides durable
21 medical equipment (as described in sub-
22 paragraph (A)(i)) or prosthetics, orthotics,
23 or supplies (as described in subparagraph
24 (A)(ii)) to an individual as incident to an
25 office visit by such individual; or

1 “(ii) a hospital that provides durable
2 medical equipment (as described in sub-
3 paragraph (A)(i)) or prosthetics, orthotics,
4 or supplies (as described in subparagraph
5 (A)(ii)) to an individual as incident to an
6 emergency room visit by such individual.

7 “(b) STANDARDS AND REQUIREMENTS.—In con-
8 ducting the site inspection pursuant to subsection (a), the
9 Secretary shall ensure that the site being inspected is in
10 full compliance with all the conditions and standards of
11 participation and requirements for obtaining billing privi-
12 leges under this title.

13 “(c) TIME.—The Secretary shall conduct the site in-
14 spection for an applicable provider prior to the issuance
15 of billing privileges under this title to such provider.

16 “(d) TIMELY REVIEW.—The Secretary shall provide
17 for procedures to ensure that the site inspection required
18 under this section does not unreasonably delay the
19 issuance of billing privileges under this title to an applica-
20 ble provider.”.

21 (b) BACKGROUND CHECKS.—Title XVIII of the So-
22 cial Security Act (42 U.S.C. 1395 et seq.) (as amended
23 by subsection (a)) is amended by adding at the end the
24 following new section:

1 “BACKGROUND CHECKS; DENIAL AND SUSPENSION OF
2 BILLING PRIVILEGES

3 “SEC. 1899. (a) BACKGROUND CHECK REQUIRED.—

4 Except as provided in subsection (b), the Secretary shall
5 conduct a background check on any individual or entity
6 that enrolls under this title for the purpose of furnishing
7 any item or service under this title, including any indi-
8 vidual or entity that is a supplier, a person with an owner-
9 ship or control interest, a managing employee (as defined
10 in section 1126(b)), or an authorized or delegated official
11 of the individual or entity. In performing the background
12 check, the Secretary shall—

13 “(1) conduct the background check before au-
14 thORIZING billing privileges under this title to the in-
15 dividual or entity, respectively;

16 “(2) include a search of criminal records in the
17 background check;

18 “(3) provide for procedures that ensure the
19 background check does not unreasonably delay the
20 authorization of billing privileges under this title to
21 an eligible individual or entity, respectively; and

22 “(4) establish criteria for targeted reviews when
23 the individual or entity renews participation under
24 this title, with respect to the background check of
25 the individual or entity, respectively, to detect

1 changes in ownership, bankruptcies, or felonies by
2 the individual or entity.

3 “(b) USE OF STATE LICENSING PROCEDURE.—The
4 Secretary may use the results of a State licensing proce-
5 dure as a background check under subsection (a) if the
6 State licensing procedure meets the requirements of such
7 subsection.

8 “(c) ATTORNEY GENERAL REQUIRED TO PROVIDE
9 INFORMATION.—

10 “(1) IN GENERAL.—Upon request of the Sec-
11 retary, the Attorney General shall provide the crimi-
12 nal background check information referred to in sub-
13 section (a)(2) to the Secretary.

14 “(2) RESTRICTION ON USE OF DISCLOSED IN-
15 FORMATION.—The Secretary may only use the infor-
16 mation disclosed under subsection (a) for the pur-
17 pose of carrying out the Secretary’s responsibilities
18 under this title.

19 “(d) REFUSAL TO AUTHORIZE BILLING PRIVI-
20 LEGES.—

21 “(1) AUTHORITY.—In addition to any other
22 remedy available to the Secretary, the Secretary may
23 refuse to authorize billing privileges under this title
24 to an individual or entity if the Secretary deter-
25 mines, after a background check conducted under

1 this section, that such individual or entity, respec-
2 tively, has a history of acts that indicate authoriza-
3 tion of billing privileges under this title to such indi-
4 vidual or entity, respectively, would be detrimental
5 to the best interests of the program or program
6 beneficiaries. Such acts may include—

7 “(A) any bankruptcy;

8 “(B) any act resulting in a civil judgment
9 against such individual or entity; or

10 “(C) any felony conviction under Federal
11 or State law.

12 “(2) REPORTING OF REFUSAL TO AUTHORIZE
13 BILLING PRIVILEGES TO THE HEALTHCARE INTEG-
14 RITY AND PROTECTION DATA BANK (HIPDB).—

15 “(A) IN GENERAL.—Subject to subpara-
16 graph (B), a determination under paragraph
17 (1) to refuse to authorize billing privileges
18 under this title to an individual or entity as a
19 result of a background check conducted under
20 this section shall be reported to the healthcare
21 integrity and protection data bank established
22 under section 1128E in accordance with the
23 procedures for reporting final adverse actions
24 taken against a health care provider, supplier,
25 or practitioner under that section.

1 “(B) EXCEPTION.—Any determination de-
2 scribed in subparagraph (A) that the Secretary
3 specifies is not appropriate for inclusion in the
4 healthcare integrity and protection data bank
5 established under section 1128E shall not be
6 reported to such data bank.”.

7 (c) DENIAL AND SUSPENSION OF BILLING PRIVI-
8 LEGES.—Section 1899 of the Social Security Act, as
9 added by subsection (b), is amended by adding at the end
10 the following new subsection:

11 “(e) AUTHORITY TO SUSPEND BILLING PRIVILEGES
12 OR REFUSE TO AUTHORIZE ADDITIONAL BILLING PRIVI-
13 LEGES.—

14 “(1) IN GENERAL.—The Secretary may suspend
15 any billing privilege under this title authorized for
16 an individual or entity or refuse to authorize any ad-
17 ditional billing privilege under this title to such indi-
18 vidual or entity if—

19 “(A) such individual or entity, respectively,
20 has an outstanding overpayment due to the
21 Secretary under this title;

22 “(B) payments under this title to such in-
23 dividual or entity, respectively, have been sus-
24 pended; or

1 “(C) 100 percent of the payment claims
2 under this title for such individual or entity, re-
3 spectively, are reviewed on a pre-payment basis.

4 “(2) APPLICATION TO RESTRUCTURED ENTI-
5 TIES.—In the case that an individual or entity is
6 subject to a suspension or refusal of billing privileges
7 under this section, if the Secretary determines that
8 the ownership or management of a new entity is
9 under the control or management of such an indi-
10 vidual or entity subject to such a suspension or re-
11 fusal, the new entity shall be subject to any such ap-
12 plicable suspension or refusal in the same manner
13 and to the same extent as the initial individual or
14 entity involved had been subject to such applicable
15 suspension or refusal.

16 “(3) DURATION OF SUSPENSION.—A suspen-
17 sion of billing privileges under this subsection, with
18 respect to an individual or entity, shall be in effect
19 beginning on the date of the Secretary’s determina-
20 tion that the offense was committed and ending not
21 earlier than such date on which all applicable over-
22 payments and other applicable outstanding debts
23 have been paid and all applicable payment suspen-
24 sions have been lifted.”.

25 (d) REGULATIONS; EFFECTIVE DATE.—

1 (1) REGULATIONS.—Not later than one year
2 after the date of the enactment of this Act, the Sec-
3 retary of Health and Human Services shall promul-
4 gate such regulations as are necessary to implement
5 the amendments made by subsections (a), (b), and
6 (c).

7 (2) EFFECTIVE DATES.—

8 (A) SITE INSPECTIONS AND BACKGROUND
9 CHECKS.—The amendments made by sub-
10 sections (a) and (b) shall apply to applications
11 to enroll under title XVIII of the Social Secu-
12 rity Act received by the Secretary of Health and
13 Human Services on or after the first day of the
14 first year beginning after the date of the enact-
15 ment of this Act.

16 (B) DENIALS AND SUSPENSIONS OF BILL-
17 ING PRIVILEGES.—The amendment made by
18 subsection (c) shall apply to overpayments or
19 debts in existence on or after the date of the
20 enactment of this Act, regardless of whether the
21 final determination, with respect to such over-
22 payment or debt, was made before, on, or after
23 such date.

24 (e) USE OF MEDICARE INTEGRITY PROGRAM
25 FUNDS.—The Secretary of Health and Human Services

1 may use funds appropriated or transferred for purposes
2 of carrying out the Medicare integrity program established
3 under section 1893 of the Social Security Act (42 U.S.C.
4 1395ddd) to carry out the provisions of sections 1898 and
5 1899 of that Act (as added by subsections (a) and (b)).

6 **SEC. 262. REGISTRATION AND BACKGROUND CHECKS OF**
7 **BILLING AGENCIES AND INDIVIDUALS.**

8 (a) IN GENERAL.—Title XVIII of the Social Security
9 Act (42 U.S.C. 1395 et seq.) (as amended by section 2(b))
10 is amended by adding at the end the following new section:

11 “REGISTRATION AND BACKGROUND CHECKS OF BILLING
12 AGENCIES AND INDIVIDUALS; IDENTIFICATION NUM-
13 BERS REQUIRED FOR PROVIDERS AND SUPPLIERS

14 “SEC. 1899A. (a) REGISTRATION.—

15 “(1) IN GENERAL.—The Secretary shall estab-
16 lish procedures, including modifying the Provider
17 Enrollment and Chain Ownership System (PECOS)
18 administered by the Centers for Medicare & Med-
19 icaid Services, to provide for the registration of all
20 applicable persons in accordance with this section.

21 “(2) REQUIRED APPLICATION.—Each applicable
22 person shall submit a registration application to the
23 Secretary at such time, in such manner, and accom-
24 panied by such information as the Secretary may re-
25 quire.

1 “(3) IDENTIFICATION NUMBER.—If the Sec-
2 retary approves an application submitted under sub-
3 section (b), the Secretary shall assign a unique iden-
4 tification number to the applicable person.

5 “(4) REQUIREMENT.—Every claim for reim-
6 bursement under this title that is compiled or sub-
7 mitted by an applicable person shall contain the
8 identification number that is assigned to the applica-
9 ble person pursuant to subsection (c).

10 “(5) TIMELY REVIEW.—The Secretary shall
11 provide for procedures that ensure the timely consid-
12 eration and determination regarding approval of ap-
13 plications under this subsection.

14 “(6) DEFINITION OF APPLICABLE PERSON.—In
15 this section, the term ‘applicable person’ means any
16 individual or entity that compiles or submits claims
17 for reimbursement under this title to the Secretary
18 on behalf of any individual or entity.

19 “(b) BACKGROUND CHECKS.—

20 “(1) IN GENERAL.—Except as provided in paragraph
21 (2), the Secretary shall conduct a background check on
22 any applicable person that registers under subsection (a).
23 In performing the background check, the Secretary
24 shall—

1 “(A) conduct the background check before
2 issuing a unique identification number to the appli-
3 cable person;

4 “(B) include a search of criminal records in the
5 background check;

6 “(C) provide for procedures that ensure the
7 background check does not unreasonably delay the
8 issuance of the unique identification number to an
9 eligible applicable person; and

10 “(D) establish criteria for periodic targeted re-
11 views with respect to the background check of the
12 applicable person.

13 “(2) USE OF STATE LICENSING PROCEDURE.—The
14 Secretary may use the results of a State licensing proce-
15 dure as a background check under paragraph (1) if the
16 State licensing procedure meets the requirements of such
17 paragraph.

18 “(3) ATTORNEY GENERAL REQUIRED TO PROVIDE
19 INFORMATION.—

20 “(A) IN GENERAL.—Upon request of the Sec-
21 retary, the Attorney General shall provide the crimi-
22 nal background check information referred to in
23 paragraph (1)(B) to the Secretary.

24 “(B) RESTRICTION ON USE OF DISCLOSED IN-
25 FORMATION.—The Secretary may only use the infor-

1 mation disclosed under paragraph (1) for the pur-
2 pose of carrying out the Secretary’s responsibilities
3 under this title.

4 “(4) REFUSAL TO ISSUE UNIQUE IDENTIFICATION
5 NUMBER.—In addition to any other remedy available to
6 the Secretary, the Secretary may refuse to issue a unique
7 identification number described in subsection (a)(3) to an
8 applicable person if the Secretary determines, after a
9 background check conducted under this subsection, that
10 such person has a history of acts that indicate issuance
11 of such number under this title to such person would be
12 detrimental to the best interests of the program or pro-
13 gram beneficiaries. Such acts may include—

14 “(A) any bankruptcy;

15 “(B) any act resulting in a civil judgment
16 against such person; or

17 “(C) any felony conviction under Federal or
18 State law.

19 “(c) IDENTIFICATION NUMBERS FOR PROVIDERS
20 AND SUPPLIERS.—The Secretary shall establish proce-
21 dures to ensure that each provider of services and each
22 supplier that submits claims for reimbursement under this
23 title to the Secretary is assigned a unique identification
24 number.”.

1 (b) PERMISSIVE EXCLUSION.—Section 1128(b) of
2 the Social Security Act (42 U.S.C. 1320a–7(b)) is amend-
3 ed by adding at the end the following:

4 “(16) FRAUD BY APPLICABLE PERSON.—An ap-
5 plicable person (as defined in section 1899A(a)(6))
6 that the Secretary determines knowingly submitted
7 or caused to be submitted a claim for reimbursement
8 under title XVIII that the applicable person knows
9 or should know is false or fraudulent.”.

10 (c) REGULATIONS; EFFECTIVE DATE.—

11 (1) REGULATIONS.—Not later than one year
12 after the date of the enactment of this Act, the Sec-
13 retary of Health and Human Services shall promul-
14 gate such regulations as are necessary to implement
15 the amendments made by subsections (a) and (b).

16 (2) EFFECTIVE DATE.—The amendments made
17 by subsections (a) and (b) shall apply to applicable
18 persons and other entities on and after the first day
19 of the first year beginning after the date of the en-
20 actment of this Act.

21 **SEC. 263. EXPANDED ACCESS TO THE HEALTHCARE INTEG-**
22 **RITY AND PROTECTION DATA BANK (HIPDB).**

23 (a) IN GENERAL.—Section 1128E(d)(1) of the Social
24 Security Act (42 U.S.C. 1320a–7e(d)(1)) is amended to
25 read as follows:

1 “(1) AVAILABILITY.—The information in the
2 data bank maintained under this section shall be
3 available to—

4 “(A) Federal and State government agen-
5 cies and health plans, and any health care pro-
6 vider, supplier, or practitioner entering an em-
7 ployment or contractual relationship with an in-
8 dividual or entity who could potentially be the
9 subject of a final adverse action, where the con-
10 tract involves the furnishing of items or services
11 reimbursed by one or more Federal health care
12 programs (regardless of whether the individual
13 or entity is paid by the programs directly, or
14 whether the items or services are reimbursed di-
15 rectly or indirectly through the claims of a di-
16 rect provider); and

17 “(B) utilization and quality control peer
18 review organizations and accreditation entities
19 as defined by the Secretary, including but not
20 limited to organizations described in part B of
21 this title and in section 1154(a)(4)(C).”.

22 (b) NO FEES FOR USE OF HIPDB BY ENTITIES
23 CONTRACTING WITH MEDICARE.—Section 1128E(d)(2)
24 of the Social Security Act (42 U.S.C. 1320a–7e(d)(2)) is
25 amended by striking “Federal agencies” and inserting

1 “Federal agencies or other entities, such as fiscal inter-
2 mediaries and carriers, acting under contract on behalf of
3 such agencies”.

4 (c) CRIMINAL PENALTY FOR MISUSE OF INFORMA-
5 TION.—Section 1128B(b) of the Social Security Act (42
6 U.S.C. 1320a–7b(b)) is amended by adding at the end the
7 following:

8 “(4) Whoever knowingly uses information maintained
9 in the healthcare integrity and protection data bank main-
10 tained in accordance with section 1128E for a purpose
11 other than a purpose authorized under that section shall
12 be imprisoned for not more than three years or fined
13 under title 18, United States Code, or both.”.

14 (d) EFFECTIVE DATE.—The amendments made by
15 this section shall take effect on the date of the enactment
16 of this Act.

17 **SEC. 264. LIABILITY OF MEDICARE ADMINISTRATIVE CON-**
18 **TRACTORS FOR CLAIMS SUBMITTED BY EX-**
19 **CLUDED PROVIDERS.**

20 (a) REIMBURSEMENT TO THE SECRETARY FOR
21 AMOUNTS PAID TO EXCLUDED PROVIDERS.—Section
22 1874A(b) of the Social Security Act (42 U.S.C.
23 1395kk(b)) is amended by adding at the end the following
24 new paragraph:

1 “(6) REIMBURSEMENTS TO SECRETARY FOR
2 AMOUNTS PAID TO EXCLUDED PROVIDERS.—The
3 Secretary shall not enter into a contract with a
4 Medicare administrative contractor under this sec-
5 tion unless the contractor agrees to reimburse the
6 Secretary for any amounts paid by the contractor
7 for a service under this title which is furnished by
8 an individual or entity during any period for which
9 the individual or entity is excluded, pursuant to sec-
10 tion 1128, 1128A, or 1156, from participation in the
11 health care program under this title if the amounts
12 are paid after the 60-day period beginning on the
13 date the Secretary provides notice of the exclusion to
14 the contractor, unless the payment was made as a
15 result of incorrect information provided by the Sec-
16 retary or the individual or entity excluded from par-
17 ticipation has concealed or altered their identity.”.

18 (b) CONFORMING REPEAL OF MANDATORY PAYMENT
19 RULE.—Section 1862(e) of the Social Security Act (42
20 U.S.C. 1395y(e)) is amended—

21 (1) in paragraph (1)(B), by striking “and when
22 the person” and all that follows through “person”;
23 and

24 (2) by amending paragraph (2) to read as fol-
25 lows:

1 “(2) No individual or entity may bill (or collect any
2 amount from) any individual for any item or service for
3 which payment is denied under paragraph (1). No indi-
4 vidual is liable for payment of any amounts billed for such
5 an item or service in violation of the preceding sentence.”.

6 (c) EFFECTIVE DATE.—

7 (1) IN GENERAL.—The amendments made by
8 this section shall apply to claims for payment sub-
9 mitted on or after the date of the enactment of this
10 Act.

11 (2) CONTRACT MODIFICATION.—The Secretary
12 of Health and Human Services shall take such steps
13 as may be necessary to modify contracts entered
14 into, renewed, or extended prior to the date of the
15 enactment of this Act to conform such contracts to
16 the provisions of this section.

17 **SEC. 265. COMMUNITY MENTAL HEALTH CENTERS.**

18 (a) IN GENERAL.—Section 1861(ff)(3)(B) of the So-
19 cial Security Act (42 U.S.C. 1395x(ff)(3)(B)) is amended
20 by striking “entity that—” and all that follows and insert-
21 ing the following: “entity that—

22 “(i) provides the community mental health serv-
23 ices specified in paragraph (1) of section 1913(c) of
24 the Public Health Service Act;

1 “(ii) meets applicable certification or licensing
2 requirements for community mental health centers
3 in the State in which it is located;

4 “(iii) provides a significant share of its services
5 to individuals who are not eligible for benefits under
6 this title; and

7 “(iv) meets such additional standards or re-
8 quirements for obtaining billing privileges under this
9 title as the Secretary may specify to ensure—

10 “(I) the health and safety of beneficiaries
11 receiving such services; or

12 “(II) the furnishing of such services in an
13 effective and efficient manner.”.

14 (b) RESTRICTION.—Section 1861(ff)(3)(A) of such
15 Act (42 U.S.C. 1395x(ff)(3)(A)) is amended by inserting
16 “other than in an individual’s home or in an inpatient or
17 residential setting” before the period.

18 (c) EFFECTIVE DATE.—The amendments made by
19 this section shall apply to items and services furnished on
20 or after the first day of the sixth month that begins after
21 the date of the enactment of this Act.

1 **SEC. 266. LIMITING THE DISCHARGE OF DEBTS IN BANK-**
2 **RUPTCY PROCEEDINGS IN CASES WHERE A**
3 **HEALTH CARE PROVIDER OR A SUPPLIER EN-**
4 **GAGES IN FRAUDULENT ACTIVITY.**

5 (a) IN GENERAL.—

6 (1) CIVIL MONETARY PENALTIES.—Section
7 1128A(a) of the Social Security Act (42 U.S.C.
8 1320a-7a(a)) is amended by adding at the end the
9 following: “Notwithstanding any other provision of
10 law, amounts made payable under this section are
11 not dischargeable under section 727, 944, 1141,
12 1228, or 1328 of title 11, United States Code, or
13 any other provision of such title.”.

14 (2) RECOVERY OF OVERPAYMENT TO PRO-
15 VIDERS OF SERVICES UNDER PART A OF MEDI-
16 CARE.—Section 1815(d) of the Social Security Act
17 (42 U.S.C. 1395g(d)) is amended—

18 (A) by inserting “(1)” after “(d)”; and

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

20 “(2) Notwithstanding any other provision of law,
21 amounts due to the Secretary under this section are not
22 dischargeable under section 727, 944, 1141, 1228, or
23 1328 of title 11, United States Code, or any other provi-
24 sion of such title if the overpayment was the result of
25 fraudulent activity, as may be defined by the Secretary.”.

1 (3) RECOVERY OF OVERPAYMENT OF BENEFITS
2 UNDER PART b OF MEDICARE.—Section 1833(j) of
3 the Social Security Act (42 U.S.C. 1395l(j)) is
4 amended—

5 (A) by inserting “(1)” after “(j)”; and

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

7 “(2) Notwithstanding any other provision of law,
8 amounts due to the Secretary under this section are not
9 dischargeable under section 727, 944, 1141, 1228, or
10 1328 of title 11, United States Code, or any other provi-
11 sion of such title if the overpayment was the result of
12 fraudulent activity, as may be defined by the Secretary.”.

13 (4) COLLECTION OF PAST-DUE OBLIGATIONS
14 ARISING FROM BREACH OF SCHOLARSHIP AND LOAN
15 CONTRACT.—Section 1892(a) of the Social Security
16 Act (42 U.S.C. 1395ccc(a)) is amended by adding at
17 the end the following:

18 “(5) Notwithstanding any other provision of
19 law, amounts due to the Secretary under this section
20 are not dischargeable under section 727, 944, 1141,
21 1228, or 1328 of title 11, United States Code, or
22 any other provision of such title.”.

23 (b) EFFECTIVE DATE.—The amendments made by
24 subsection (a) shall apply to bankruptcy petitions filed
25 after the date of the enactment of this Act.

1 **SEC. 267. ILLEGAL DISTRIBUTION OF A MEDICARE OR MED-**
2 **ICAID BENEFICIARY IDENTIFICATION OR**
3 **BILLING PRIVILEGES.**

4 Section 1128B(b) of the Social Security Act (42
5 U.S.C. 1320a-7b(b)), as amended by section 4(e), is
6 amended by adding at the end the following:

7 “(5) Whoever knowingly, intentionally, and with the
8 intent to defraud purchases, sells or distributes, or ar-
9 ranges for the purchase, sale, or distribution of two or
10 more Medicare or Medicaid beneficiary identification num-
11 bers or billing privileges under title XVIII or title XIX
12 shall be imprisoned for not more than three years or fined
13 under title 18, United States Code (or, if greater, an
14 amount equal to the monetary loss to the Federal and any
15 State government as a result of such acts), or both.”.

16 **SEC. 268. TREATMENT OF CERTAIN SOCIAL SECURITY ACT**
17 **CRIMES AS FEDERAL HEALTH CARE OF-**
18 **FENSES.**

19 (a) IN GENERAL.—Section 24(a) of title 18, United
20 States Code, is amended—

21 (1) by striking the period at the end of para-
22 graph (2) and inserting “; or”; and

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

24 “(3) section 1128B of the Social Security Act
25 (42 U.S.C. 1320a-7b).”.

1 (b) EFFECTIVE DATE.—The amendment made by
2 subsection (a) shall take effect on the date of the enact-
3 ment of this Act and apply to acts committed on or after
4 the date of the enactment of this Act.

5 **SEC. 269. AUTHORITY OF OFFICE OF INSPECTOR GENERAL**
6 **OF THE DEPARTMENT OF HEALTH AND**
7 **HUMAN SERVICES.**

8 (a) AUTHORITY.—Notwithstanding any other provi-
9 sion of law, upon designation by the Inspector General of
10 the Department of Health and Human Services, any
11 criminal investigator of the Office of Inspector General of
12 such department may, in accordance with guidelines
13 issued by the Secretary of Health and Human Services
14 and approved by the Attorney General, while engaged in
15 activities within the lawful jurisdiction of such Inspector
16 General—

17 (1) obtain and execute any warrant or other
18 process issued under the authority of the United
19 States;

20 (2) make an arrest without a warrant for—

21 (A) any offense against the United States
22 committed in the presence of such investigator;
23 or

24 (B) any felony offense against the United
25 States, if such investigator has reasonable cause

1 to believe that the person to be arrested has
2 committed or is committing that felony offense;
3 and

4 (3) exercise any other authority necessary to
5 carry out the authority described in paragraphs (1)
6 and (2).

7 (b) FUNDS.—The Office of Inspector General of the
8 Department of Health and Human Services may receive
9 and expend funds that represent the equitable share from
10 the forfeiture of property in investigations in which the
11 Office of Inspector General participated, and that are
12 transferred to the Office of Inspector General by the De-
13 partment of Justice, the Department of the Treasury, or
14 the United States Postal Service. Such equitable sharing
15 funds shall be deposited in a separate account and shall
16 remain available until expended.

17 **SEC. 270. UNIVERSAL PRODUCT NUMBERS ON CLAIMS**
18 **FORMS FOR REIMBURSEMENT UNDER THE**
19 **MEDICARE PROGRAM.**

20 (a) UPNS ON CLAIMS FORMS FOR REIMBURSEMENT
21 UNDER THE MEDICARE PROGRAM.—

22 (1) ACCOMMODATION OF UPNS ON MEDICARE
23 CLAIMS FORMS.—Not later than February 1, 2011,
24 all claims forms developed or used by the Secretary
25 of Health and Human Services for reimbursement

1 under the Medicare program under title XVIII of
2 the Social Security Act (42 U.S.C. 1395 et seq.)
3 shall accommodate the use of universal product
4 numbers for a UPN covered item.

5 (2) REQUIREMENT FOR PAYMENT OF CLAIMS.—
6 Title XVIII of the Social Security Act (42 U.S.C.
7 1395 et seq.), as amended by sections 2 and 3, is
8 amended by adding at the end the following new sec-
9 tion:

10 “USE OF UNIVERSAL PRODUCT NUMBERS

11 “SEC. 1899B. (a) IN GENERAL.—No payment shall
12 be made under this title for any claim for reimbursement
13 for any UPN covered item unless the claim contains the
14 universal product number of the UPN covered item.

15 “(b) DEFINITIONS.—In this section:

16 “(1) UPN COVERED ITEM.—

17 “(A) IN GENERAL.—Except as provided in
18 subparagraph (B), the term ‘UPN covered
19 item’ means—

20 “(i) a covered item as that term is de-
21 fined in section 1834(a)(13);

22 “(ii) an item described in paragraph
23 (8) or (9) of section 1861(s);

24 “(iii) an item described in paragraph
25 (5) of section 1861(s); and

1 “(iv) any other item for which pay-
2 ment is made under this title that the Sec-
3 retary determines to be appropriate.

4 “(B) EXCLUSION.—The term ‘UPN cov-
5 ered item’ does not include a customized item
6 for which payment is made under this title.

7 “(2) UNIVERSAL PRODUCT NUMBER.—The
8 term ‘universal product number’ means a number
9 that is—

10 “(A) affixed by the manufacturer to each
11 individual UPN covered item that uniquely
12 identifies the item at each packaging level; and

13 “(B) based on commercially acceptable
14 identification standards such as, but not limited
15 to, standards established by the Uniform Code
16 Council-International Article Numbering Sys-
17 tem or the Health Industry Business Commu-
18 nication Council.”.

19 (3) DEVELOPMENT AND IMPLEMENTATION OF
20 PROCEDURES.—

21 (A) INFORMATION INCLUDED IN UPN.—

22 The Secretary of Health and Human Services,
23 in consultation with manufacturers and entities
24 with appropriate expertise, shall determine the
25 relevant descriptive information appropriate for

1 inclusion in a universal product number for a
2 UPN covered item.

3 (B) REVIEW OF PROCEDURE.—From the
4 information obtained by the use of universal
5 product numbers on claims for reimbursement
6 under the Medicare program, the Secretary of
7 Health and Human Services, in consultation
8 with interested parties, shall periodically review
9 the UPN covered items billed under the Health
10 Care Financing Administration Common Proce-
11 dure Coding System and adjust such coding
12 system to ensure that functionally equivalent
13 UPN covered items are billed and reimbursed
14 under the same codes.

15 (4) EFFECTIVE DATE.—The amendment made
16 by paragraph (2) shall apply to claims for reim-
17 bursement submitted on and after February 1,
18 2011.

19 (b) STUDY AND REPORTS TO CONGRESS.—

20 (1) STUDY.—The Secretary of Health and
21 Human Services shall conduct a study on the results
22 of the implementation of the provisions in para-
23 graphs (1) and (3) of subsection (a) and the amend-
24 ment to the Social Security Act in paragraph (2) of
25 such subsection.

1 (2) REPORTS.—

2 (A) PROGRESS REPORT.—Not later than
3 six months after the date of the enactment of
4 this Act, the Secretary of Health and Human
5 Services shall submit to Congress a report that
6 contains a detailed description of the progress
7 of the matters studied pursuant to paragraph
8 (1).

9 (B) IMPLEMENTATION.—Not later than 18
10 months after the date of the enactment of this
11 Act, and annually thereafter for three years, the
12 Secretary of Health and Human Services shall
13 submit to Congress a report that contains a de-
14 tailed description of the results of the study
15 conducted pursuant to paragraph (1), together
16 with the Secretary's recommendations regard-
17 ing the use of universal product numbers and
18 the use of data obtained from the use of such
19 numbers.

20 (c) DEFINITIONS.—In this section:

21 (1) UPN COVERED ITEM.—The term “UPN
22 covered item” has the meaning given such term in
23 section 1899B(b)(1) of the Social Security Act (as
24 added by subsection (a)(2)).

1 (2) UNIVERSAL PRODUCT NUMBER.—The term
2 “universal product number” has the meaning given
3 such term in section 1899B(b)(2) of the Social Secu-
4 rity Act (as added by subsection (a)(2)).

5 (d) AUTHORIZATION OF APPROPRIATIONS.—There
6 are authorized to be appropriated such sums as may be
7 necessary for the purpose of carrying out the provisions
8 in paragraphs (1) and (3) of subsection (a), subsection
9 (b), and section 1899B of the Social Security Act (as
10 added by subsection (a)(2)).

11 **Subtitle E—Promoting Health and**
12 **Preventing Chronic Disease**
13 **Through Prevention and**
14 **Wellness Programs**

15 **SEC. 281. FINDINGS.**

16 Congress finds the following:

17 (1) Keeping people healthy and preventing dis-
18 ease must be an important part of improving our
19 Federal health system.

20 (2) More than 133 million Americans, which ac-
21 counts for 45 percent of the U.S. population, have
22 at least one chronic condition.

23 (3) With the growth in obesity, especially
24 among younger Americans, the diagnosis of child-
25 hood chronic diseases has almost quadrupled over

1 the past four decades and is expected to continue to
2 rise.

3 (4) Chronic diseases are the leading causes of
4 preventable death and disability in the United
5 States, accounting for 7 out of every 10 deaths and
6 killing more than 1,700,000 people in the United
7 States every year.

8 (5) Two-thirds of the increase in health care
9 spending is due to increased prevalence of treated
10 chronic disease.

11 (6) Seventy-five percent of the nation's aggre-
12 gate health care spending is on treating patients
13 with chronic disease, and the vast majority of these
14 diseases are preventable. Unfortunately, less than
15 one percent of total health care spending goes to-
16 ward prevention.

17 (7) According to a recent study, treatment of
18 the seven most common chronic diseases, coupled
19 with productivity losses, cost the U.S. economy more
20 than \$1 trillion dollars annually. It has been esti-
21 mated that modest reductions in unhealthy behaviors
22 could prevent or delay 40 million cases of chronic ill-
23 ness per year.

24 (8) Chronic diseases are burdensome to Amer-
25 ican businesses. Not only does a sicker American

1 workforce have higher health care costs, but it is
2 also less productive. Chronic illnesses lead to absen-
3 teeism and decreased effectiveness while at work due
4 to illness.

5 (9) Prevention not only saves lives, it is highly
6 cost-effective. One study concluded that an invest-
7 ment of \$10 per person per year in proven commu-
8 nity-based programs to increase physical activity,
9 improve nutrition, and prevent smoking and other
10 tobacco use could save the country more than \$16
11 billion annually within five years. This is a return of
12 \$5.60 for every \$1 spent.

13 **SEC. 282. TAX CREDIT TO EMPLOYERS FOR COSTS OF IM-**
14 **PLEMENTING PREVENTION AND WELLNESS**
15 **PROGRAMS.**

16 (a) IN GENERAL.—Subpart D of part IV of sub-
17 chapter A of chapter 1 of the Internal Revenue Code of
18 1986 (relating to business related credits) is amended by
19 adding at the end the following:

20 **“SEC. 45R. PREVENTION AND WELLNESS PROGRAM CRED-**
21 **IT.**

22 “(a) ALLOWANCE OF CREDIT.—

23 “(1) IN GENERAL.—For purposes of section 38,
24 the prevention and wellness credit determined under
25 this section for any taxable year during the credit

1 period with respect to an employer is an amount
2 equal to 50 percent of the costs paid or incurred by
3 the employer in connection with a qualified preven-
4 tion and wellness during the taxable year. For pur-
5 poses of the preceding sentence, in the case of any
6 qualified prevention and wellness offered as part of
7 an employer-provided group health plan, including
8 health insurance offered in connection with such
9 plan, only costs attributable to the qualified preven-
10 tion and wellness and not to the group health plan
11 or health insurance coverage may be taken into ac-
12 count.

13 “(2) LIMITATION.—The amount of credit al-
14 lowed under paragraph (1) for any taxable year shall
15 not exceed the sum of—

16 “(A) the product of \$200 and the number
17 of employees of the employer not in excess of
18 200 employees, plus

19 “(B) the product of \$100 and the number
20 of employees of the employer in excess of 200
21 employees.

22 “(b) QUALIFIED PREVENTION AND WELLNESS.—For
23 purposes of this section—

1 “(1) QUALIFIED PREVENTION AND
2 WELLNESS.—The term ‘qualified prevention and
3 wellness’ means a program which—

4 “(A) consists of any 3 of the prevention
5 and wellness components described in sub-
6 section (c), and

7 “(B) which is certified by the Secretary of
8 Health and Human Services, in coordination
9 with the Director of the Center for Disease
10 Control and Prevention, as a qualified preven-
11 tion and wellness under this section.

12 “(2) PROGRAMS MUST BE CONSISTENT WITH
13 RESEARCH AND BEST PRACTICES.—

14 “(A) IN GENERAL.—The Secretary of
15 Health and Human Services shall not certify a
16 program as a qualified prevention and wellness
17 unless the program—

18 “(i) is consistent with evidence-based
19 research and best practices, as identified
20 by persons with expertise in employer
21 health promotion and prevention and
22 wellness,

23 “(ii) includes multiple, evidence-based
24 strategies which are based on the existing
25 and emerging research and careful sci-

1 entific reviews, including the Guide to
2 Community Preventive Services, the Guide
3 to Clinical Preventive Services, and the
4 National Registry for Effective Programs,
5 and

6 “(iii) includes strategies which focus
7 on employee populations with a disproportio-
8 nate burden of health problems.

9 “(B) PERIODIC UPDATING AND REVIEW.—

10 The Secretary of Health and Human Services
11 shall establish procedures for periodic review of
12 programs under this subsection. Such proce-
13 dures shall require revisions of programs if nec-
14 essary to ensure compliance with the require-
15 ments of this section and require updating of
16 the programs to the extent the Secretary, in co-
17 ordination with the Director of the Centers for
18 Disease Control and Prevention, determines
19 necessary to reflect new scientific findings.

20 “(3) HEALTH LITERACY.—The Secretary of
21 Health and Human Services shall, as part of the
22 certification process, encourage employees to make
23 the programs culturally competent and to meet the
24 health literacy needs of the employees covered by the
25 programs.

1 “(c) PREVENTION AND WELLNESS PROGRAM COM-
2 PONENTS.—For purposes of this section, the prevention
3 and wellness components described in this subsection are
4 the following:

5 “(1) HEALTH AWARENESS COMPONENT.—A
6 health awareness component which provides for the
7 following:

8 “(A) HEALTH EDUCATION.—The dissemi-
9 nation of health information which addresses
10 the specific needs and health risks of employees.

11 “(B) HEALTH SCREENINGS.—The oppor-
12 tunity for periodic screenings for health prob-
13 lems and referrals for appropriate follow up
14 measures.

15 “(2) EMPLOYEE ENGAGEMENT COMPONENT.—
16 An employee engagement component which provides
17 for—

18 “(A) the establishment of a committee to
19 actively engage employees in worksite preven-
20 tion and wellness through worksite assessments
21 and program planning, delivery, evaluation, and
22 improvement efforts, and

23 “(B) the tracking of employee participa-
24 tion.

1 “(3) BEHAVIORAL CHANGE COMPONENT.—A
2 behavioral change component which provides for al-
3 tering employee lifestyles to encourage healthy living
4 through counseling, seminars, on-line programs, or
5 self-help materials which provide technical assistance
6 and problem solving skills. Such component may in-
7 clude programs relating to—

8 “(A) tobacco use,

9 “(B) obesity,

10 “(C) stress management,

11 “(D) physical fitness,

12 “(E) nutrition,

13 “(F) substance abuse,

14 “(G) depression, and

15 “(H) mental health promotion (including
16 anxiety).

17 “(4) SUPPORTIVE ENVIRONMENT COMPO-
18 NENT.—A supportive environment component which
19 includes the following:

20 “(A) ON-SITE POLICIES.—Policies and
21 services at the worksite which promote a
22 healthy lifestyle, including policies relating to—

23 “(i) tobacco use at the worksite,

1 “(ii) the nutrition of food available at
2 the worksite through cafeterias and vend-
3 ing options,

4 “(iii) minimizing stress and promoting
5 positive mental health in the workplace,

6 “(iv) where applicable, accessible and
7 attractive stairs, and

8 “(v) the encouragement of physical
9 activity before, during, and after work
10 hours.

11 “(B) PARTICIPATION INCENTIVES.—

12 “(i) IN GENERAL.—Qualified incentive
13 benefits for each employee who participates
14 in the health screenings described in para-
15 graph (1)(B) or the behavioral change pro-
16 grams described in paragraph (3).

17 “(ii) QUALIFIED INCENTIVE BEN-
18 EFIT.—For purposes of clause (i), the
19 term ‘qualified incentive benefit’ means
20 any benefit which is approved by the Sec-
21 retary of Health and Human Services, in
22 coordination with the Director of the Cen-
23 ters for Disease Control and Prevention.

24 “(C) EMPLOYEE INPUT.—The opportunity
25 for employees to participate in the management

1 of any qualified prevention and wellness to
2 which this section applies.

3 “(d) PARTICIPATION REQUIREMENT.—

4 “(1) IN GENERAL.—No credit shall be allowed
5 under subsection (a) unless the Secretary of Health
6 and Human Services, in coordination with the Direc-
7 tor of the Centers for Disease Control and Preven-
8 tion, certifies, as a part of any certification described
9 in subsection (b), that each prevention and wellness
10 component of the qualified prevention and wellness
11 applies to all qualified employees of the employer.
12 The Secretary of Health and Human Services shall
13 prescribe rules under which an employer shall not be
14 treated as failing to meet the requirements of this
15 subsection merely because the employer provides
16 specialized programs for employees with specific
17 health needs or unusual employment requirements or
18 provides a pilot program to test new wellness strate-
19 gies.

20 “(2) QUALIFIED EMPLOYEE.—For purposes of
21 paragraph (1), the term ‘qualified employee’
22 means—

23 “(A) for employers offering health insur-
24 ance coverage, an employee who is eligible for
25 such coverage, or

1 “(B) for employers not offering health in-
2 surance coverage, an employee who works an
3 average of not less than 25 hours per week dur-
4 ing the taxable year.

5 “(e) OTHER DEFINITIONS AND SPECIAL RULES.—
6 For purposes of this section—

7 “(1) EMPLOYEE AND EMPLOYER.—

8 “(A) PARTNERS AND PARTNERSHIPS.—
9 The term ‘employee’ includes a partner and the
10 term ‘employer’ includes a partnership.

11 “(B) CERTAIN RULES TO APPLY.—Rules
12 similar to the rules of section 52 shall apply.

13 “(2) CERTAIN COSTS NOT INCLUDED.—Costs
14 paid or incurred by an employer for food or health
15 insurance shall not be taken into account under sub-
16 section (a).

17 “(3) NO CREDIT WHERE GRANT AWARDED.—
18 No credit shall be allowable under subsection (a)
19 with respect to any qualified prevention and wellness
20 of any taxpayer (other than an eligible employer de-
21 scribed in subsection (f)(2)(A)) who receives a grant
22 provided by the United States, a State, or a political
23 subdivision of a State for use in connection with
24 such program. The Secretary shall prescribe rules
25 providing for the waiver of this paragraph with re-

1 spect to any grant which does not constitute a sig-
2 nificant portion of the funding for the qualified pre-
3 vention and wellness.

4 “(4) CREDIT PERIOD.—

5 “(A) IN GENERAL.—The term ‘credit pe-
6 riod’ means the period of 10 consecutive taxable
7 years beginning with the taxable year in which
8 the qualified prevention and wellness is first
9 certified under this section.

10 “(B) SPECIAL RULE FOR EXISTING PRO-
11 GRAMS.—In the case of an employer (or prede-
12 cessor) which operates a prevention and
13 wellness for its employees on the date of the en-
14 actment of this section, subparagraph (A) shall
15 be applied by substituting ‘3 consecutive taxable
16 years’ for ‘10 consecutive taxable years’. The
17 Secretary shall prescribe rules under which this
18 subsection shall not apply if an employer is re-
19 quired to make substantial modifications in the
20 existing prevention and wellness in order to
21 qualify such program for certification as a
22 qualified prevention and wellness.

23 “(C) CONTROLLED GROUPS.—For pur-
24 poses of this paragraph, all persons treated as
25 a single employer under subsection (b), (c),

1 (m), or (o) of section 414 shall be treated as a
2 single employer.

3 “(f) PORTION OF CREDIT MADE REFUNDABLE.—

4 “(1) IN GENERAL.—In the case of an eligible
5 employer of an employee, the aggregate credits al-
6 lowed to a taxpayer under subpart C shall be in-
7 creased by the lesser of—

8 “(A) the credit which would be allowed
9 under this section without regard to this sub-
10 section and the limitation under section 38(c),
11 or

12 “(B) the amount by which the aggregate
13 amount of credits allowed by this subpart (de-
14 termined without regard to this subsection)
15 would increase if the limitation imposed by sec-
16 tion 38(c) for any taxable year were increased
17 by the amount of employer payroll taxes im-
18 posed on the taxpayer during the calendar year
19 in which the taxable year begins.

20 The amount of the credit allowed under this sub-
21 section shall not be treated as a credit allowed under
22 this subpart and shall reduce the amount of the
23 credit otherwise allowable under subsection (a) with-
24 out regard to section 38(c).

1 “(2) ELIGIBLE EMPLOYER.—For purposes of
2 this subsection, the term ‘eligible employer’ means
3 an employer which is—

4 “(A) a State or political subdivision there-
5 of, the District of Columbia, a possession of the
6 United States, or an agency or instrumentality
7 of any of the foregoing, or

8 “(B) any organization described in section
9 501(c) of the Internal Revenue Code of 1986
10 which is exempt from taxation under section
11 501(a) of such Code.

12 “(3) EMPLOYER PAYROLL TAXES.—For pur-
13 poses of this subsection—

14 “(A) IN GENERAL.—The term ‘employer
15 payroll taxes’ means the taxes imposed by—

16 “(i) section 3111(b), and

17 “(ii) sections 3211(a) and 3221(a)
18 (determined at a rate equal to the rate
19 under section 3111(b)).

20 “(B) SPECIAL RULE.—A rule similar to
21 the rule of section 24(d)(2)(C) shall apply for
22 purposes of subparagraph (A).

23 “(g) TERMINATION.—This section shall not apply to
24 any amount paid or incurred after December 31, 2017.”.

1 (b) TREATMENT AS GENERAL BUSINESS CREDIT.—
2 Subsection (b) of section 38 of the Internal Revenue Code
3 of 1986 (relating to general business credit) is amended
4 by striking “plus” at the end of paragraph (34), by strik-
5 ing the period at the end of paragraph (35) and inserting
6 “, plus”, and by adding at the end the following:

7 “(36) the prevention and wellness credit deter-
8 mined under section 45R.”.

9 (c) DENIAL OF DOUBLE BENEFIT.—Section 280C of
10 the Internal Revenue Code of 1986 (relating to certain
11 expenses for which credits are allowable) is amended by
12 adding at the end the following new subsection:

13 “(g) PREVENTION AND WELLNESS PROGRAM CRED-
14 IT.—

15 “(1) IN GENERAL.—No deduction shall be al-
16 lowed for that portion of the costs paid or incurred
17 for a qualified prevention and wellness (within the
18 meaning of section 45R) allowable as a deduction for
19 the taxable year which is equal to the amount of the
20 credit allowable for the taxable year under section
21 45R.

22 “(2) SIMILAR RULE WHERE TAXPAYER CAP-
23 ITALIZES RATHER THAN DEDUCTS EXPENSES.—If—

24 “(A) the amount of the credit determined
25 for the taxable year under section 45R, exceeds

1 “(B) the amount allowable as a deduction
2 for such taxable year for a qualified prevention
3 and wellness,
4 the amount chargeable to capital account for the
5 taxable year for such expenses shall be reduced by
6 the amount of such excess.

7 “(3) CONTROLLED GROUPS.—In the case of a
8 corporation which is a member of a controlled group
9 of corporations (within the meaning of section
10 41(f)(5)) or a trade or business which is treated as
11 being under common control with other trades or
12 business (within the meaning of section
13 41(f)(1)(B)), this subsection shall be applied under
14 rules prescribed by the Secretary similar to the rules
15 applicable under subparagraphs (A) and (B) of sec-
16 tion 41(f)(1).”.

17 (d) CLERICAL AMENDMENT.—The table of sections
18 for subpart D of part IV of subchapter A of chapter 1
19 of the Internal Revenue Code of 1986 is amended by add-
20 ing at the end the following:

 “Sec. 45R. Prevention and wellness program credit.”.

21 (e) EFFECTIVE DATE.—The amendments made by
22 this section shall apply to taxable years beginning after
23 December 31, 2009.

24 (f) OUTREACH.—

1 (1) IN GENERAL.—The Secretary of the Treas-
2 ury, in conjunction with the Director of the Centers
3 for Disease Control and members of the business
4 community, shall institute an outreach program to
5 inform businesses about the availability of the pre-
6 vention and wellness credit under section 45R of the
7 Internal Revenue Code of 1986 as well as to educate
8 businesses on how to develop programs according to
9 recognized and promising practices and on how to
10 measure the success of implemented programs.

11 (2) AUTHORIZATION OF APPROPRIATIONS.—
12 There are authorized to be appropriated such sums
13 as are necessary to carry out the outreach program
14 described in paragraph (1).

15 **SEC. 283. GRANTS TO INCREASE PHYSICAL ACTIVITY AND**
16 **EMOTIONAL WELLNESS, IMPROVE NUTRI-**
17 **TION, AND PROMOTE HEALTHY EATING BE-**
18 **HAVIORS.**

19 Part Q of title III of the Public Health Service Act
20 (42 U.S.C. 280h et seq.) is amended by striking section
21 399W and inserting the following:

1 **“SEC. 399W. GRANTS TO INCREASE PHYSICAL ACTIVITY**
2 **AND EMOTIONAL WELLNESS, IMPROVE NU-**
3 **TRITION, AND PROMOTE HEALTHY EATING**
4 **BEHAVIORS AND HEALTHY LIVING.**

5 “(a) ESTABLISHMENT.—

6 “(1) IN GENERAL.—The Secretary, acting
7 through the Director of the Centers for Disease
8 Control and Prevention and in coordination with the
9 Administrator of the Health Resources and Services
10 Administration, the Director of the Indian Health
11 Service, the Secretary of Education, the Secretary of
12 Agriculture, the Secretary of the Interior, the Direc-
13 tor of the National Institutes of Health, the Director
14 of the Office of Women’s Health, and the heads of
15 other appropriate agencies, shall award competitive
16 grants to eligible entities to plan and implement pre-
17 vention and wellness programs that promote health
18 and wellness and prevent chronic disease. Such
19 grants may be awarded to target at-risk populations
20 including youth, health disparity populations (as de-
21 fined in section 485E(d)), and the underserved.

22 “(2) TERM.—The Secretary shall award grants
23 under this subsection for a period not to exceed 4
24 years.

25 “(b) AWARD OF GRANTS.—An eligible entity desiring
26 a grant under this section shall submit an application to

1 the Secretary at such time, in such manner, and con-
2 taining such information as the Secretary may require, in-
3 cluding—

4 “(1) a plan describing a comprehensive pro-
5 gram of approaches to encourage healthy living,
6 emotional wellness, healthy eating behaviors, and
7 healthy levels of physical activity;

8 “(2) the manner in which the eligible entity will
9 coordinate with appropriate State and local authori-
10 ties and community-based organizations, including
11 but not limited to—

12 “(A) State and local educational agencies;

13 “(B) departments of health;

14 “(C) State directors of programs under
15 section 17 of the Child Nutrition Act of 1966
16 (42 U.S.C. 1786); and

17 “(D) community-based organizations serv-
18 ing youth; and

19 “(3) the manner in which the applicant will
20 evaluate the effectiveness of the program carried out
21 under this section.

22 “(c) COORDINATION.—In awarding grants under this
23 section, the Secretary shall ensure that the proposed pro-
24 grams show a history of addressing these issues, have pro-
25 gram evaluations that show success, and are coordinated

1 in substance and format with programs currently funded
2 through other Federal agencies and operating within the
3 community.

4 “(d) ELIGIBLE ENTITY.—In this section, the term
5 ‘eligible entity’ means—

6 “(1) a city, county, tribe, territory, or State;

7 “(2) a State educational agency;

8 “(3) a tribal educational agency;

9 “(4) a local educational agency;

10 “(5) a federally qualified health center (as de-
11 fined in section 1861(aa)(4) of the Social Security
12 Act);

13 “(6) a rural health clinic;

14 “(7) a health department;

15 “(8) an Indian Health Service hospital or clinic;

16 “(9) an Indian tribal health facility;

17 “(10) an urban Indian facility;

18 “(11) any health provider;

19 “(12) an accredited university or college;

20 “(13) a youth serving organization;

21 “(14) a community-based organization; or

22 “(15) any other entity determined appropriate
23 by the Secretary.

24 “(e) USE OF FUNDS.—An eligible entity that receives
25 a grant under this section shall use the funds made avail-

1 able through the grant to plan and implement prevention
2 and wellness programs that promote health and wellness
3 and prevent chronic disease.

4 “(f) MATCHING FUNDS.—In awarding grants under
5 subsection (a), the Secretary may give priority to eligible
6 entities who provide matching contributions. Such non-
7 Federal contributions may be cash or in-kind, fairly evalu-
8 ated, including plant, equipment, training, curriculum, or
9 a preexisting evaluation framework.

10 “(g) TECHNICAL ASSISTANCE.—The Secretary may
11 set aside an amount not to exceed 10 percent of the total
12 amount appropriated for a fiscal year under subsection (j)
13 to permit the Director of the Centers for Disease Control
14 and Prevention to provide grantees with technical support
15 in the development, implementation, and evaluation of pre-
16 vention and wellness programs under this section and to
17 disseminate information about effective strategies and
18 interventions in promoting health and wellness and pre-
19 venting chronic disease.

20 “(h) LIMITATION ON ADMINISTRATIVE COSTS.—An
21 eligible entity awarded a grant under this section may not
22 use more than 10 percent of funds awarded under such
23 grant for administrative expenses.

24 “(i) REPORT.—Not later than 6 years after the date
25 of enactment of this section the Director of the Centers

1 for Disease Control and Prevention shall review the results
2 of the grants awarded under this section and other related
3 research and identify prevention and wellness programs
4 that have demonstrated effectiveness in promoting health
5 and wellness and preventing chronic disease. Such review
6 shall include an identification of model curricula, best
7 practices, and lessons learned, as well as recommendations
8 for next steps to promote health and wellness and prevent
9 chronic disease. Information derived from such review, in-
10 cluding model prevention and wellness program curricula,
11 shall be disseminated to the public.

12 “(j) DEFINITION.—In this section, the term ‘preven-
13 tion and wellness program’ means a program that consists
14 of a combination of activities that are designed to increase
15 awareness, assess risks, educate, and promote voluntary
16 behavior change to improve the health of an individual,
17 modify his or her consumer health behavior, enhance his
18 or her personal well-being and productivity, and prevent
19 illness and injury.

20 “(k) AUTHORIZATION OF APPROPRIATIONS.—There
21 are authorized to be appropriated to carry out this section,
22 \$60,000,000 for fiscal year 2010, and such sums as may
23 be necessary for each of fiscal years 2011 through 2014.”.

1 **SEC. 284. PREVENTION AND WELLNESS PROGRAMS FOR IN-**
 2 **DIVIDUALS AND FAMILIES.**

3 (a) IN GENERAL.—The Secretary of Health and
 4 Human Services shall encourage States to work with in-
 5 surance companies on ways to promote and incentivize the
 6 participation of individuals and families in prevention and
 7 wellness programs, such as through insurance premium
 8 reductions.

9 (b) DEFINITION.—In this section, the term “preven-
 10 tion and wellness program” means a program that con-
 11 sists of a combination of activities that are designed to
 12 increase awareness, assess risks, educate, and promote
 13 voluntary behavior change to improve the health of an in-
 14 dividual, modify his or her consumer health behavior, en-
 15 hance his or her personal well-being and productivity, and
 16 prevent illness and injury.

17 **TITLE III—EXPANDING ACCESS**
 18 **TO HEALTH CARE**
 19 **Subtitle A—State Innovation**
 20 **Program**

21 **SEC. 301. ENSURING AFFORDABILITY AND ACCESS**
 22 **THROUGH UNIVERSAL ACCESS PROGRAMS.**

23 (a) STATE REQUIREMENT.—

24 (1) IN GENERAL.—Not later than 2 years after
 25 the date of the enactment of this Act, in order to
 26 qualify for preferences and increased flexibility

1 under section 412(a), each State shall implement at
2 least one of the following programs for the purposes
3 of mitigating the cost to insurers of providing insur-
4 ance to high risk individuals in the State:

5 (A) a qualified State reinsurance program
6 defined in subsection (b); or

7 (B) a subsection (c) qualified State high
8 risk pool program defined in subsection (c)(1).

9 (2) FUNDING.—As a condition of qualifying for
10 preferences and increased flexibility under section
11 412(a), a State shall—

12 (A) make available non-Federal contribu-
13 tions, as specified by the Secretary, to ensure
14 the continuing stability of any program imple-
15 mented by the State under paragraph (1); and

16 (B) at the time of application, submit to
17 the Secretary of Health and Human Services a
18 budget plan, including assurances that the
19 State has in place a method to satisfy the re-
20 quirement under subparagraph (A).

21 (b) QUALIFIED STATE REINSURANCE PROGRAM.—

22 (1) QUALIFIED STATE REINSURANCE PROGRAM
23 DEFINED.—For purposes of this section, the term
24 “qualified State reinsurance program” means a pro-
25 gram that is operated by a State or a program au-

1 thorized by the State to provide reinsurance for
2 health insurance coverage offered in the individual
3 or small group market.

4 (2) FORM OF PROGRAM.—A qualified State re-
5 insurance program may provide reinsurance—

6 (A) on a prospective or retrospective basis;

7 (B) that protects health insurance issuers
8 against the annual aggregate spending of their
9 enrollees; and

10 (C) that provides purchase protection
11 against individual catastrophic costs.

12 (3) SATISFACTION OF HIPAA REQUIREMENT.—
13 Section 2745(g)(1) of the Public Health Service Act
14 is amended by adding at the end the following new
15 subparagraph:

16 “(B) TREATMENT OF CERTAIN REINSUR-
17 ANCE PROGRAMS.—For purposes of subpara-
18 graph (A), the term ‘qualified high risk pool’
19 includes a qualified State reinsurance program
20 under the Medical Rights and Reform Act of
21 2009.”.

22 (c) SUBSECTION (C) QUALIFYING STATE HIGH RISK
23 POOL.—

24 (1) DEFINED.—For purposes of this section,
25 the term “subsection (c) qualified State high risk

1 pool program” means a program that operates a
2 high risk pool that—

3 (A) is a qualified high risk pool under sec-
4 tion 2745(g)(1)(A) of the Public Health Service
5 Act; and

6 (B) meets all of the following require-
7 ments:

8 (i) The high risk pool provides a vari-
9 ety of types of coverage, including at least
10 one high deductible health plan that may
11 be coupled with a health savings account.

12 (ii) The high risk pool is funded with
13 a stable funding source that is not solely
14 dependent on an appropriation from the
15 State legislature.

16 (iii) The high risk pool has no waiting
17 list and no pre-existing condition exclu-
18 sionary periods so that all eligible residents
19 who are seeking coverage through the pool
20 can receive coverage through the pool.

21 (iv) The high risk pool allows for cov-
22 erage of individuals who, but for the 24-
23 month disability waiting period under sec-
24 tion 226(b) of the Social Security Act,

1 would be eligible for Medicare during the
2 period of such waiting period.

3 (v) The high risk pool does not charge
4 participants a premium that is more than
5 150 percent of the average premium for
6 coverage in the individual market in that
7 State.

8 (vi) The high risk pool conducts edu-
9 cation and outreach initiatives so that resi-
10 dents and insurance brokers understand
11 that the pool is available to eligible resi-
12 dents.

13 (2) RELATION TO SECTION 2745.—Section
14 2745(g)(1) of the Public Health Service Act is fur-
15 ther amended—

16 (A) in subparagraph (A), by striking “The
17 term” and inserting “Subject to subparagraph
18 (C), the term”; and

19 (B) by adding at the end the following new
20 subparagraph:

21 “(C) UPDATED DEFINITION.—Beginning
22 on the last day of the 2-year period beginning
23 in the date of the enactment of the Medical
24 Rights and Reform Act of 2009, the term
25 ‘qualified high risk pool’ means a pool that

1 meets the requirements of subparagraph (A) of
 2 this paragraph and the requirements of section
 3 411(c)(1) of such Act.”.

4 (3) RELATION TO CURRENT QUALIFIED HIGH
 5 RISK POOL PROGRAM OPERATING A QUALIFIED HIGH
 6 RISK POOL.—In the case of a State that is operating
 7 a qualified high risk pool under section 2745 of the
 8 Public Health Service Act as of the date of the en-
 9 actment of this Act, the State may use current fund-
 10 ing sources to transition from the operation of such
 11 a pool to—

12 (A) the operation of a qualified State rein-
 13 surance program described in subsection (b); or

14 (B) a qualified high risk pool under section
 15 2745(g)(1)(C) of the Public Health Service Act.

16 (d) WAIVERS.—In order to accommodate new and in-
 17 novative programs, the Secretary may waive such require-
 18 ments of this section for qualified State reinsurance pro-
 19 grams and for subsection (c) qualifying State high risk
 20 pools as the Secretary deems appropriate.

21 **SEC. 302. ENHANCED FEDERAL FUNDING AND REDUCED**
 22 **RED-TAPE FOR STATE EFFORTS TO IMPROVE**
 23 **ACCESS TO HEALTH INSURANCE COVERAGE.**

24 (a) BENEFITS OF OPERATING A UNIVERSAL ACCESS
 25 PROGRAM.—

1 (1) INCREASED FLEXIBILITY FOR STATES.—In
2 the case of a State that conducts an universal access
3 program described in section 301(a), the require-
4 ments of section 1115 of the Social Security Act (42
5 U.S.C. 1315) shall not apply to activities conducted
6 by a State through a State innovation program de-
7 scribed in section 303.

8 (2) PREFERENCE FOR COMPETITIVE GRANTS.—
9 Beginning 3 years after the date of the enactment
10 of this Act, in the case of a competitive grant for
11 which the only eligible entities are States, the Sec-
12 retary, in awarding such grant to a State, shall give
13 preference to any State with a program that meets
14 the requirements of paragraphs (1) and (2) of sec-
15 tion section 301(a).

16 (b) STATE INCENTIVES FOR STATES IMPLEMENTING
17 A STATE INNOVATION PROGRAM.—

18 (1) ONE-TIME PAYMENT FOR STATES IMPLE-
19 MENTING A STATE INNOVATION PROGRAM.—The
20 Secretary shall make a one-time payment to a State
21 that establishes a State innovation program under
22 section 303.

23 (2) ADDITIONAL PAYMENTS FOR STATES IM-
24 PLEMENTING A STATE INNOVATION PROGRAM.—

25 (A) ANNUAL PAYMENTS.—

1 (i) IN GENERAL.—The Secretary shall
2 make annual payments to a State that
3 meets the requirements under subpara-
4 graph (B).

5 (ii) LIMITATION.—The Secretary may
6 make payments under clause (i) to a State
7 for no more than a total period of 5 years,
8 after which period such payments shall be
9 subject to review by the Secretary.

10 (B) REQUIREMENTS FOR ADDITIONAL PAY-
11 MENTS.—A State meets the requirements of
12 this paragraph if the State—

13 (i) operates a State innovation pro-
14 gram;

15 (ii) conducts activities under at least
16 2 of the paragraphs in section 303;

17 (iii) operates a State transparency
18 program described in section 304; and

19 (iv) reduces the number of uninsured
20 individuals in the State without signifi-
21 cantly expanding programs that increase
22 direct spending for the Federal government
23 and State budgets.

24 (C) USE OF FUNDS.—The State shall use
25 funds from a payment under subparagraph (A)

1 to improve the State's universal access pro-
2 gram.

3 **SEC. 303. STATE INNOVATION PROGRAM DESCRIBED.**

4 For purposes of this subtitle, a State innovation pro-
5 gram is a program operated by a State that consists of
6 any of the following:

7 (1) A health plan finder described in section
8 305.

9 (2) Assistance for small businesses jointly pur-
10 chasing health insurance coverage through small
11 business health plans under section 306.

12 (3) An interstate compact on health insurance
13 regulation under section 307.

14 (4) The offering in the State of a basic cata-
15 strophic health benefit plan as defined in section
16 308(1).

17 **SEC. 304. STATE TRANSPARENCY PROGRAM DESCRIBED.**

18 For purposes of this subtitle, a State transparency
19 program is a program through which the State—

20 (1) partners with private groups (including
21 State medical associations) and, through such part-
22 nerships, obtains pricing and quality information re-
23 lated to health care services that are provided in the
24 State; and

1 (2) provides members of the public with access
2 to such information.

3 **SEC. 305. HEALTH PLAN FINDER.**

4 A health plan finder described under this section is
5 a program, operated by a State (or a State acting in co-
6 operation with other States) that—

7 (1) provides consumers with information about
8 the health insurance coverage available to such con-
9 sumer (including information about basic cata-
10 strophic health benefit plans described in section
11 303(5));

12 (2) connects consumers with health insurance
13 specialists who provide advice to such consumers on
14 which health insurance coverage would best serve the
15 individual needs of each such consumer (taking into
16 account the quality of the health care providers par-
17 ticipating in such in coverage); and

18 (3) may, at the option of the State, enroll indi-
19 viduals—

20 (A) who are eligible for the Medicaid pro-
21 gram under title XIX of the Social Security Act
22 in such program; and

23 (B) who are eligible for the State Chil-
24 dren's Health Insurance Program under title
25 XXI of such Act in such program.

1 **SEC. 306. SMALL BUSINESS HEALTH PLANS.**

2 For purposes of a State innovation program under
3 this subtitle, a State may assist small businesses in jointly
4 purchasing health insurance coverage through small busi-
5 ness health plans that allow such businesses to combine
6 purchasing and negotiating power and to pool risk in order
7 to obtain more affordable health care benefits for the em-
8 ployees of such businesses.

9 **SEC. 307. INTERSTATE COMPACTS ON HEALTH INSURANCE**
10 **REGULATION.**

11 For purposes of a State innovation program under
12 this subtitle, a State may establish an interstate compact
13 with one or more States to establish a common regulatory
14 system for health insurance coverage for the purpose of
15 increasing the availability and diversity of health insur-
16 ance coverage in the State, including provisions allowing
17 small businesses to form small business health plans (as
18 described in section 306) and permitting individuals to
19 purchase insurance across State lines.

20 **SEC. 308. DEFINITIONS.**

21 For purposes of this subtitle:

22 (1) **BASIC CATASTROPHIC HEALTH BENEFIT**
23 **PLAN.**—The term “basic catastrophic health benefits
24 plan” means health insurance coverage—

1 (A) that is a high deductible plan (as de-
2 fined under section 223(c)(2) of the Internal
3 Revenue Code of 1986); and

4 (B) that is not subject to benefit mandates
5 otherwise applicable under State law.

6 (2) HEALTH INSURANCE COVERAGE.—The term
7 “health insurance coverage” has the meaning given
8 such term under section 2791(b)(1) of the Public
9 Health Service Act.

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

12 (4) STATE.—The term “State” means the sev-
13 eral States, the District of Columbia, Guam, the
14 Commonwealth of Puerto Rico, the Northern Mar-
15 iana Islands, the Virgin Islands, American Samoa,
16 and the Trust Territory of the Pacific Islands.

17 (5) STATE INNOVATION PROGRAM.—The term
18 “State innovation program” means a program de-
19 scribed in section 303.

20 (6) UNIVERSAL ACCESS PROGRAM.—The term
21 “universal access program” means a program de-
22 scribed in section 301.

23 **SEC. 309. AUTHORIZATION FOR APPROPRIATIONS.**

24 There is authorized to be appropriated such sums as
25 are necessary to carry out the provisions of this subtitle.

1 **Subtitle B—Interstate Market for**
2 **Health Insurance**

3 **SEC. 311. SPECIFICATION OF CONSTITUTIONAL AUTHORITY**
4 **FOR ENACTMENT OF LAW.**

5 This subtitle is enacted pursuant to the power grant-
6 ed Congress under article I, section 8, clause 3, of the
7 United States Constitution.

8 **SEC. 312. FINDINGS.**

9 Congress finds the following:

10 (1) The application of numerous and significant
11 variations in State law impacts the ability of insur-
12 ers to offer, and individuals to obtain, affordable in-
13 dividual health insurance coverage, thereby impeding
14 commerce in individual health insurance coverage.

15 (2) Individual health insurance coverage is in-
16 creasingly offered through the Internet, other elec-
17 tronic means, and by mail, all of which are inher-
18 ently part of interstate commerce.

19 (3) In response to these issues, it is appropriate
20 to encourage increased efficiency in the offering of
21 individual health insurance coverage through a col-
22 laborative approach by the States in regulating this
23 coverage.

24 (4) The establishment of risk-retention groups
25 has provided a successful model for the sale of insur-

1 ance across State lines, as the acts establishing
 2 those groups allow insurance to be sold in multiple
 3 States but regulated by a single State.

4 **SEC. 313. COOPERATIVE GOVERNING OF INDIVIDUAL**
 5 **HEALTH INSURANCE COVERAGE.**

6 (a) IN GENERAL.—Title XXVII of the Public Health
 7 Service Act (42 U.S.C. 300gg et seq.) is amended by add-
 8 ing at the end the following new part:

9 **“PART D—COOPERATIVE GOVERNING OF**
 10 **INDIVIDUAL HEALTH INSURANCE COVERAGE**

11 **“SEC. 2795. DEFINITIONS.**

12 “In this part:

13 “(1) PRIMARY STATE.—The term ‘primary
 14 State’ means, with respect to individual health insur-
 15 ance coverage offered by a health insurance issuer,
 16 the State designated by the issuer as the State
 17 whose covered laws shall govern the health insurance
 18 issuer in the sale of such coverage under this part.
 19 An issuer, with respect to a particular policy, may
 20 only designate one such State as its primary State
 21 with respect to all such coverage it offers. Such an
 22 issuer may not change the designated primary State
 23 with respect to individual health insurance coverage
 24 once the policy is issued, except that such a change
 25 may be made upon renewal of the policy. With re-

1 spect to such designated State, the issuer is deemed
2 to be doing business in that State.

3 “(2) SECONDARY STATE.—The term ‘secondary
4 State’ means, with respect to individual health insur-
5 ance coverage offered by a health insurance issuer,
6 any State that is not the primary State. In the case
7 of a health insurance issuer that is selling a policy
8 in, or to a resident of, a secondary State, the issuer
9 is deemed to be doing business in that secondary
10 State.

11 “(3) HEALTH INSURANCE ISSUER.—The term
12 ‘health insurance issuer’ has the meaning given such
13 term in section 2791(b)(2), except that such an
14 issuer must be licensed in the primary State and be
15 qualified to sell individual health insurance coverage
16 in that State.

17 “(4) INDIVIDUAL HEALTH INSURANCE COV-
18 ERAGE.—The term ‘individual health insurance cov-
19 erage’ means health insurance coverage offered in
20 the individual market, as defined in section
21 2791(e)(1).

22 “(5) APPLICABLE STATE AUTHORITY.—The
23 term ‘applicable State authority’ means, with respect
24 to a health insurance issuer in a State, the State in-
25 surance commissioner or official or officials des-

1 ignated by the State to enforce the requirements of
2 this title for the State with respect to the issuer.

3 “(6) HAZARDOUS FINANCIAL CONDITION.—The
4 term ‘hazardous financial condition’ means that,
5 based on its present or reasonably anticipated finan-
6 cial condition, a health insurance issuer is unlikely
7 to be able—

8 “(A) to meet obligations to policyholders
9 with respect to known claims and reasonably
10 anticipated claims; or

11 “(B) to pay other obligations in the normal
12 course of business.

13 “(7) COVERED LAWS.—

14 “(A) IN GENERAL.—The term ‘covered
15 laws’ means the laws, rules, regulations, agree-
16 ments, and orders governing the insurance busi-
17 ness pertaining to—

18 “(i) individual health insurance cov-
19 erage issued by a health insurance issuer;

20 “(ii) the offer, sale, rating (including
21 medical underwriting), renewal, and
22 issuance of individual health insurance cov-
23 erage to an individual;

24 “(iii) the provision to an individual in
25 relation to individual health insurance cov-

1 erage of health care and insurance related
2 services;

3 “(iv) the provision to an individual in
4 relation to individual health insurance cov-
5 erage of management, operations, and in-
6 vestment activities of a health insurance
7 issuer; and

8 “(v) the provision to an individual in
9 relation to individual health insurance cov-
10 erage of loss control and claims adminis-
11 tration for a health insurance issuer with
12 respect to liability for which the issuer pro-
13 vides insurance.

14 “(B) EXCEPTION.—Such term does not in-
15 clude any law, rule, regulation, agreement, or
16 order governing the use of care or cost manage-
17 ment techniques, including any requirement re-
18 lated to provider contracting, network access or
19 adequacy, health care data collection, or quality
20 assurance.

21 “(8) STATE.—The term ‘State’ means the 50
22 States and includes the District of Columbia, Puerto
23 Rico, the Virgin Islands, Guam, American Samoa,
24 and the Northern Mariana Islands.

1 “(9) UNFAIR CLAIMS SETTLEMENT PRAC-
2 TICES.—The term ‘unfair claims settlement prac-
3 tices’ means only the following practices:

4 “(A) Knowingly misrepresenting to claim-
5 ants and insured individuals relevant facts or
6 policy provisions relating to coverage at issue.

7 “(B) Failing to acknowledge with reason-
8 able promptness pertinent communications with
9 respect to claims arising under policies.

10 “(C) Failing to adopt and implement rea-
11 sonable standards for the prompt investigation
12 and settlement of claims arising under policies.

13 “(D) Failing to effectuate prompt, fair,
14 and equitable settlement of claims submitted in
15 which liability has become reasonably clear.

16 “(E) Refusing to pay claims without con-
17 ducting a reasonable investigation.

18 “(F) Failing to affirm or deny coverage of
19 claims within a reasonable period of time after
20 having completed an investigation related to
21 those claims.

22 “(G) A pattern or practice of compelling
23 insured individuals or their beneficiaries to in-
24 stitute suits to recover amounts due under its
25 policies by offering substantially less than the

1 amounts ultimately recovered in suits brought
2 by them.

3 “(H) A pattern or practice of attempting
4 to settle or settling claims for less than the
5 amount that a reasonable person would believe
6 the insured individual or his or her beneficiary
7 was entitled by reference to written or printed
8 advertising material accompanying or made
9 part of an application.

10 “(I) Attempting to settle or settling claims
11 on the basis of an application that was materi-
12 ally altered without notice to, or knowledge or
13 consent of, the insured.

14 “(J) Failing to provide forms necessary to
15 present claims within 15 calendar days of a re-
16 quests with reasonable explanations regarding
17 their use.

18 “(K) Attempting to cancel a policy in less
19 time than that prescribed in the policy or by the
20 law of the primary State.

21 “(10) FRAUD AND ABUSE.—The term ‘fraud
22 and abuse’ means an act or omission committed by
23 a person who, knowingly and with intent to defraud,
24 commits, or conceals any material information con-
25 cerning, one or more of the following:

1 “(A) Presenting, causing to be presented
2 or preparing with knowledge or belief that it
3 will be presented to or by an insurer, a rein-
4 surer, broker or its agent, false information as
5 part of, in support of or concerning a fact ma-
6 terial to one or more of the following:

7 “(i) An application for the issuance or
8 renewal of an insurance policy or reinsur-
9 ance contract.

10 “(ii) The rating of an insurance policy
11 or reinsurance contract.

12 “(iii) A claim for payment or benefit
13 pursuant to an insurance policy or reinsur-
14 ance contract.

15 “(iv) Premiums paid on an insurance
16 policy or reinsurance contract.

17 “(v) Payments made in accordance
18 with the terms of an insurance policy or
19 reinsurance contract.

20 “(vi) A document filed with the com-
21 missioner or the chief insurance regulatory
22 official of another jurisdiction.

23 “(vii) The financial condition of an in-
24 surer or reinsurer.

1 “(viii) The formation, acquisition,
2 merger, reconsolidation, dissolution or
3 withdrawal from one or more lines of in-
4 surance or reinsurance in all or part of a
5 State by an insurer or reinsurer.

6 “(ix) The issuance of written evidence
7 of insurance.

8 “(x) The reinstatement of an insur-
9 ance policy.

10 “(B) Solicitation or acceptance of new or
11 renewal insurance risks on behalf of an insurer
12 reinsurer or other person engaged in the busi-
13 ness of insurance by a person who knows or
14 should know that the insurer or other person
15 responsible for the risk is insolvent at the time
16 of the transaction.

17 “(C) Transaction of the business of insur-
18 ance in violation of laws requiring a license, cer-
19 tificate of authority or other legal authority for
20 the transaction of the business of insurance.

21 “(D) Attempt to commit, aiding or abet-
22 ting in the commission of, or conspiracy to com-
23 mit the acts or omissions specified in this para-
24 graph.

1 **“SEC. 2796. APPLICATION OF LAW.**

2 “(a) IN GENERAL.—The covered laws of the primary
3 State shall apply to individual health insurance coverage
4 offered by a health insurance issuer in the primary State
5 and in any secondary State, but only if the coverage and
6 issuer comply with the conditions of this section with re-
7 spect to the offering of coverage in any secondary State.

8 “(b) EXEMPTIONS FROM COVERED LAWS IN A SEC-
9 ONDARY STATE.—Except as provided in this section, a
10 health insurance issuer with respect to its offer, sale, rat-
11 ing (including medical underwriting), renewal, and
12 issuance of individual health insurance coverage in any
13 secondary State is exempt from any covered laws of the
14 secondary State (and any rules, regulations, agreements,
15 or orders sought or issued by such State under or related
16 to such covered laws) to the extent that such laws would—

17 “(1) make unlawful, or regulate, directly or in-
18 directly, the operation of the health insurance issuer
19 operating in the secondary State, except that any
20 secondary State may require such an issuer—

21 “(A) to pay, on a nondiscriminatory basis,
22 applicable premium and other taxes (including
23 high risk pool assessments) which are levied on
24 insurers and surplus lines insurers, brokers, or
25 policyholders under the laws of the State;

1 “(B) to register with and designate the
2 State insurance commissioner as its agent solely
3 for the purpose of receiving service of legal doc-
4 uments or process;

5 “(C) to submit to an examination of its fi-
6 nancial condition by the State insurance com-
7 missioner in any State in which the issuer is
8 doing business to determine the issuer’s finan-
9 cial condition, if—

10 “(i) the State insurance commissioner
11 of the primary State has not done an ex-
12 amination within the period recommended
13 by the National Association of Insurance
14 Commissioners; and

15 “(ii) any such examination is con-
16 ducted in accordance with the examiners’
17 handbook of the National Association of
18 Insurance Commissioners and is coordi-
19 nated to avoid unjustified duplication and
20 unjustified repetition;

21 “(D) to comply with a lawful order
22 issued—

23 “(i) in a delinquency proceeding com-
24 menced by the State insurance commis-
25 sioner if there has been a finding of finan-

1 cial impairment under subparagraph (C);

2 or

3 “(ii) in a voluntary dissolution pro-
4 ceeding;

5 “(E) to comply with an injunction issued
6 by a court of competent jurisdiction, upon a pe-
7 tition by the State insurance commissioner al-
8 leging that the issuer is in hazardous financial
9 condition;

10 “(F) to participate, on a nondiscriminatory
11 basis, in any insurance insolvency guaranty as-
12 sociation or similar association to which a
13 health insurance issuer in the State is required
14 to belong;

15 “(G) to comply with any State law regard-
16 ing fraud and abuse (as defined in section
17 2795(10)), except that if the State seeks an in-
18 junction regarding the conduct described in this
19 subparagraph, such injunction must be obtained
20 from a court of competent jurisdiction;

21 “(H) to comply with any State law regard-
22 ing unfair claims settlement practices (as de-
23 fined in section 2795(9)); or

24 “(I) to comply with the applicable require-
25 ments for independent review under section

1 2798 with respect to coverage offered in the
2 State;

3 “(2) require any individual health insurance
4 coverage issued by the issuer to be countersigned by
5 an insurance agent or broker residing in that Sec-
6 ondary State; or

7 “(3) otherwise discriminate against the issuer
8 issuing insurance in both the primary State and in
9 any secondary State.

10 “(c) CLEAR AND CONSPICUOUS DISCLOSURE.—A
11 health insurance issuer shall provide the following notice,
12 in 12-point bold type, in any insurance coverage offered
13 in a secondary State under this part by such a health in-
14 surance issuer and at renewal of the policy, with the 5
15 blank spaces therein being appropriately filled with the
16 name of the health insurance issuer, the name of primary
17 State, the name of the secondary State, the name of the
18 secondary State, and the name of the secondary State, re-
19 spectively, for the coverage concerned:

20 “Notice

21 ““This policy is issued by XXXXX and is gov-
22 erned by the laws and regulations of the State of
23 XXXXX, and it has met all the laws of that State
24 as determined by that State’s Department of Insur-
25 ance. This policy may be less expensive than others

1 because it is not subject to all of the insurance laws
2 and regulations of the State of XXXXX, including
3 coverage of some services or benefits mandated by
4 the law of the State of XXXXX. Additionally, this
5 policy is not subject to all of the consumer protec-
6 tion laws or restrictions on rate changes of the State
7 of XXXXX. As with all insurance products, before
8 purchasing this policy, you should carefully review
9 the policy and determine what health care services
10 the policy covers and what benefits it provides, in-
11 cluding any exclusions, limitations, or conditions for
12 such services or benefits.’.

13 “(d) PROHIBITION ON CERTAIN RECLASSIFICATIONS
14 AND PREMIUM INCREASES.—

15 “(1) IN GENERAL.—For purposes of this sec-
16 tion, a health insurance issuer that provides indi-
17 vidual health insurance coverage to an individual
18 under this part in a primary or secondary State may
19 not upon renewal—

20 “(A) move or reclassify the individual in-
21 sured under the health insurance coverage from
22 the class such individual is in at the time of
23 issue of the contract based on the health-status
24 related factors of the individual; or

1 “(B) increase the premiums assessed the
2 individual for such coverage based on a health
3 status-related factor or change of a health sta-
4 tus-related factor or the past or prospective
5 claim experience of the insured individual.

6 “(2) CONSTRUCTION.—Nothing in paragraph
7 (1) shall be construed to prohibit a health insurance
8 issuer—

9 “(A) from terminating or discontinuing
10 coverage or a class of coverage in accordance
11 with subsections (b) and (c) of section 2742;

12 “(B) from raising premium rates for all
13 policy holders within a class based on claims ex-
14 perience;

15 “(C) from changing premiums or offering
16 discounted premiums to individuals who engage
17 in wellness activities at intervals prescribed by
18 the issuer, if such premium changes or incen-
19 tives—

20 “(i) are disclosed to the consumer in
21 the insurance contract;

22 “(ii) are based on specific wellness ac-
23 tivities that are not applicable to all indi-
24 viduals; and

1 “(iii) are not obtainable by all individ-
2 uals to whom coverage is offered;

3 “(D) from reinstating lapsed coverage; or

4 “(E) from retroactively adjusting the rates
5 charged an insured individual if the initial rates
6 were set based on material misrepresentation by
7 the individual at the time of issue.

8 “(e) PRIOR OFFERING OF POLICY IN PRIMARY
9 STATE.—A health insurance issuer may not offer for sale
10 individual health insurance coverage in a secondary State
11 unless that coverage is currently offered for sale in the
12 primary State.

13 “(f) LICENSING OF AGENTS OR BROKERS FOR
14 HEALTH INSURANCE ISSUERS.—Any State may require
15 that a person acting, or offering to act, as an agent or
16 broker for a health insurance issuer with respect to the
17 offering of individual health insurance coverage obtain a
18 license from that State, with commissions or other com-
19 pensation subject to the provisions of the laws of that
20 State, except that a State may not impose any qualifica-
21 tion or requirement which discriminates against a non-
22 resident agent or broker.

23 “(g) DOCUMENTS FOR SUBMISSION TO STATE IN-
24 SURANCE COMMISSIONER.—Each health insurance issuer

1 issuing individual health insurance coverage in both pri-
2 mary and secondary States shall submit—

3 “(1) to the insurance commissioner of each
4 State in which it intends to offer such coverage, be-
5 fore it may offer individual health insurance cov-
6 erage in such State—

7 “(A) a copy of the plan of operation or fea-
8 sibility study or any similar statement of the
9 policy being offered and its coverage (which
10 shall include the name of its primary State and
11 its principal place of business);

12 “(B) written notice of any change in its
13 designation of its primary State; and

14 “(C) written notice from the issuer of the
15 issuer’s compliance with all the laws of the pri-
16 mary State; and

17 “(2) to the insurance commissioner of each sec-
18 ondary State in which it offers individual health in-
19 surance coverage, a copy of the issuer’s quarterly fi-
20 nancial statement submitted to the primary State,
21 which statement shall be certified by an independent
22 public accountant and contain a statement of opin-
23 ion on loss and loss adjustment expense reserves
24 made by—

1 “(A) a member of the American Academy
2 of Actuaries; or

3 “(B) a qualified loss reserve specialist.

4 “(h) POWER OF COURTS TO ENJOIN CONDUCT.—
5 Nothing in this section shall be construed to affect the
6 authority of any Federal or State court to enjoin—

7 “(1) the solicitation or sale of individual health
8 insurance coverage by a health insurance issuer to
9 any person or group who is not eligible for such in-
10 surance; or

11 “(2) the solicitation or sale of individual health
12 insurance coverage that violates the requirements of
13 the law of a secondary State which are described in
14 subparagraphs (A) through (H) of section
15 2796(b)(1).

16 “(i) POWER OF SECONDARY STATES TO TAKE AD-
17 MINISTRATIVE ACTION.—Nothing in this section shall be
18 construed to affect the authority of any State to enjoin
19 conduct in violation of that State’s laws described in sec-
20 tion 2796(b)(1).

21 “(j) STATE POWERS TO ENFORCE STATE LAWS.—

22 “(1) IN GENERAL.—Subject to the provisions of
23 subsection (b)(1)(G) (relating to injunctions) and
24 paragraph (2), nothing in this section shall be con-
25 strued to affect the authority of any State to make

1 use of any of its powers to enforce the laws of such
2 State with respect to which a health insurance issuer
3 is not exempt under subsection (b).

4 “(2) COURTS OF COMPETENT JURISDICTION.—

5 If a State seeks an injunction regarding the conduct
6 described in paragraphs (1) and (2) of subsection
7 (h), such injunction must be obtained from a Fed-
8 eral or State court of competent jurisdiction.

9 “(k) STATES’ AUTHORITY TO SUE.—Nothing in this
10 section shall affect the authority of any State to bring ac-
11 tion in any Federal or State court.

12 “(l) GENERALLY APPLICABLE LAWS.—Nothing in
13 this section shall be construed to affect the applicability
14 of State laws generally applicable to persons or corpora-
15 tions.

16 “(m) GUARANTEED AVAILABILITY OF COVERAGE TO
17 HIPAA ELIGIBLE INDIVIDUALS.—To the extent that a
18 health insurance issuer is offering coverage in a primary
19 State that does not accommodate residents of secondary
20 States or does not provide a working mechanism for resi-
21 dents of a secondary State, and the issuer is offering cov-
22 erage under this part in such secondary State which has
23 not adopted a qualified high risk pool as its acceptable
24 alternative mechanism (as defined in section 2744(c)(2)),
25 the issuer shall, with respect to any individual health in-

1 insurance coverage offered in a secondary State under this
2 part, comply with the guaranteed availability requirements
3 for eligible individuals in section 2741.

4 **“SEC. 2797. PRIMARY STATE MUST MEET FEDERAL FLOOR**
5 **BEFORE ISSUER MAY SELL INTO SECONDARY**
6 **STATES.**

7 “A health insurance issuer may not offer, sell, or
8 issue individual health insurance coverage in a secondary
9 State if the State insurance commissioner does not use
10 a risk-based capital formula for the determination of cap-
11 ital and surplus requirements for all health insurance
12 issuers.

13 **“SEC. 2798. INDEPENDENT EXTERNAL APPEALS PROCE-**
14 **DURES.**

15 “(a) **RIGHT TO EXTERNAL APPEAL.**—A health insur-
16 ance issuer may not offer, sell, or issue individual health
17 insurance coverage in a secondary State under the provi-
18 sions of this title unless—

19 “(1) both the secondary State and the primary
20 State have legislation or regulations in place estab-
21 lishing an independent review process for individuals
22 who are covered by individual health insurance cov-
23 erage, or

24 “(2) in any case in which the requirements of
25 subparagraph (A) are not met with respect to the ei-

1 ther of such States, the issuer provides an inde-
2 pendent review mechanism substantially identical (as
3 determined by the applicable State authority of such
4 State) to that prescribed in the ‘Health Carrier Ex-
5 ternal Review Model Act’ of the National Association
6 of Insurance Commissioners for all individuals who
7 purchase insurance coverage under the terms of this
8 part, except that, under such mechanism, the review
9 is conducted by an independent medical reviewer, or
10 a panel of such reviewers, with respect to whom the
11 requirements of subsection (b) are met.

12 “(b) QUALIFICATIONS OF INDEPENDENT MEDICAL
13 REVIEWERS.—In the case of any independent review
14 mechanism referred to in subsection (a)(2)—

15 “(1) IN GENERAL.—In referring a denial of a
16 claim to an independent medical reviewer, or to any
17 panel of such reviewers, to conduct independent
18 medical review, the issuer shall ensure that—

19 “(A) each independent medical reviewer
20 meets the qualifications described in paragraphs
21 (2) and (3);

22 “(B) with respect to each review, each re-
23 viewer meets the requirements of paragraph (4)
24 and the reviewer, or at least 1 reviewer on the

1 panel, meets the requirements described in
2 paragraph (5); and

3 “(C) compensation provided by the issuer
4 to each reviewer is consistent with paragraph
5 (6).

6 “(2) LICENSURE AND EXPERTISE.—Each inde-
7 pendent medical reviewer shall be a physician
8 (allopathic or osteopathic) or health care profes-
9 sional who—

10 “(A) is appropriately credentialed or li-
11 censed in 1 or more States to deliver health
12 care services; and

13 “(B) typically treats the condition, makes
14 the diagnosis, or provides the type of treatment
15 under review.

16 “(3) INDEPENDENCE.—

17 “(A) IN GENERAL.—Subject to subpara-
18 graph (B), each independent medical reviewer
19 in a case shall—

20 “(i) not be a related party (as defined
21 in paragraph (7));

22 “(ii) not have a material familial, fi-
23 nancial, or professional relationship with
24 such a party; and

1 “(iii) not otherwise have a conflict of
2 interest with such a party (as determined
3 under regulations).

4 “(B) EXCEPTION.—Nothing in subpara-
5 graph (A) shall be construed to—

6 “(i) prohibit an individual, solely on
7 the basis of affiliation with the issuer,
8 from serving as an independent medical re-
9 viewer if—

10 “(I) a non-affiliated individual is
11 not reasonably available;

12 “(II) the affiliated individual is
13 not involved in the provision of items
14 or services in the case under review;

15 “(III) the fact of such an affili-
16 ation is disclosed to the issuer and the
17 enrollee (or authorized representative)
18 and neither party objects; and

19 “(IV) the affiliated individual is
20 not an employee of the issuer and
21 does not provide services exclusively or
22 primarily to or on behalf of the issuer;

23 “(ii) prohibit an individual who has
24 staff privileges at the institution where the
25 treatment involved takes place from serv-

1 ing as an independent medical reviewer
2 merely on the basis of such affiliation if
3 the affiliation is disclosed to the issuer and
4 the enrollee (or authorized representative),
5 and neither party objects; or

6 “(iii) prohibit receipt of compensation
7 by an independent medical reviewer from
8 an entity if the compensation is provided
9 consistent with paragraph (6).

10 “(4) PRACTICING HEALTH CARE PROFESSIONAL
11 IN SAME FIELD.—

12 “(A) IN GENERAL.—In a case involving
13 treatment, or the provision of items or serv-
14 ices—

15 “(i) by a physician, a reviewer shall be
16 a practicing physician (allopathic or osteo-
17 pathic) of the same or similar specialty, as
18 a physician who, acting within the appro-
19 priate scope of practice within the State in
20 which the service is provided or rendered,
21 typically treats the condition, makes the
22 diagnosis, or provides the type of treat-
23 ment under review; or

24 “(ii) by a non-physician health care
25 professional, the reviewer, or at least 1

1 member of the review panel, shall be a
2 practicing non-physician health care pro-
3 fessional of the same or similar specialty
4 as the non-physician health care profes-
5 sional who, acting within the appropriate
6 scope of practice within the State in which
7 the service is provided or rendered, typi-
8 cally treats the condition, makes the diag-
9 nosis, or provides the type of treatment
10 under review.

11 “(B) PRACTICING DEFINED.—For pur-
12 poses of this paragraph, the term ‘practicing’
13 means, with respect to an individual who is a
14 physician or other health care professional, that
15 the individual provides health care services to
16 individual patients on average at least 2 days
17 per week.

18 “(5) PEDIATRIC EXPERTISE.—In the case of an
19 external review relating to a child, a reviewer shall
20 have expertise under paragraph (2) in pediatrics.

21 “(6) LIMITATIONS ON REVIEWER COMPENSA-
22 TION.—Compensation provided by the issuer to an
23 independent medical reviewer in connection with a
24 review under this section shall—

25 “(A) not exceed a reasonable level; and

1 “(B) not be contingent on the decision ren-
2 dered by the reviewer.

3 “(7) RELATED PARTY DEFINED.—For purposes
4 of this section, the term ‘related party’ means, with
5 respect to a denial of a claim under a coverage relat-
6 ing to an enrollee, any of the following:

7 “(A) The issuer involved, or any fiduciary,
8 officer, director, or employee of the issuer.

9 “(B) The enrollee (or authorized represent-
10 ative).

11 “(C) The health care professional that pro-
12 vides the items or services involved in the de-
13 nial.

14 “(D) The institution at which the items or
15 services (or treatment) involved in the denial
16 are provided.

17 “(E) The manufacturer of any drug or
18 other item that is included in the items or serv-
19 ices involved in the denial.

20 “(F) Any other party determined under
21 any regulations to have a substantial interest in
22 the denial involved.

23 “(8) DEFINITIONS.—For purposes of this sub-
24 section:

1 “(A) ENROLLEE.—The term ‘enrollee’
2 means, with respect to health insurance cov-
3 erage offered by a health insurance issuer, an
4 individual enrolled with the issuer to receive
5 such coverage.

6 “(B) HEALTH CARE PROFESSIONAL.—The
7 term ‘health care professional’ means an indi-
8 vidual who is licensed, accredited, or certified
9 under State law to provide specified health care
10 services and who is operating within the scope
11 of such licensure, accreditation, or certification.

12 **“SEC. 2799. ENFORCEMENT.**

13 “(a) IN GENERAL.—Subject to subsection (b), with
14 respect to specific individual health insurance coverage the
15 primary State for such coverage has sole jurisdiction to
16 enforce the primary State’s covered laws in the primary
17 State and any secondary State.

18 “(b) SECONDARY STATE’S AUTHORITY.—Nothing in
19 subsection (a) shall be construed to affect the authority
20 of a secondary State to enforce its laws as set forth in
21 the exception specified in section 2796(b)(1).

22 “(c) COURT INTERPRETATION.—In reviewing action
23 initiated by the applicable secondary State authority, the
24 court of competent jurisdiction shall apply the covered
25 laws of the primary State.

1 “(d) NOTICE OF COMPLIANCE FAILURE.—In the case
2 of individual health insurance coverage offered in a sec-
3 ondary State that fails to comply with the covered laws
4 of the primary State, the applicable State authority of the
5 secondary State may notify the applicable State authority
6 of the primary State.”.

7 (b) EFFECTIVE DATE.—The amendment made by
8 subsection (a) shall apply to individual health insurance
9 coverage offered, issued, or sold after the date that is one
10 year after the date of the enactment of this subtitle.

11 (c) GAO ONGOING STUDY AND REPORTS.—

12 (1) STUDY.—The Comptroller General of the
13 United States shall conduct an ongoing study con-
14 cerning the effect of the amendment made by sub-
15 section (a) on—

16 (A) the number of uninsured and under-in-
17 sured;

18 (B) the availability and cost of health in-
19 surance policies for individuals with pre-existing
20 medical conditions;

21 (C) the availability and cost of health in-
22 surance policies generally;

23 (D) the elimination or reduction of dif-
24 ferent types of benefits under health insurance
25 policies offered in different States; and

1 (E) cases of fraud or abuse relating to
 2 health insurance coverage offered under such
 3 amendment and the resolution of such cases.

4 (2) ANNUAL REPORTS.—The Comptroller Gen-
 5 eral shall submit to Congress an annual report, after
 6 the end of each of the 5 years following the effective
 7 date of the amendment made by subsection (a), on
 8 the ongoing study conducted under paragraph (1).

9 **SEC. 314. SEVERABILITY.**

10 If any provision of the Act or the application of such
 11 provision to any person or circumstance is held to be un-
 12 constitutional, the remainder of this subtitle and the appli-
 13 cation of the provisions of such to any other person or
 14 circumstance shall not be affected.

15 **Subtitle C—Young Adult**
 16 **Healthcare Coverage**

17 **SEC. 321. REQUIRING THE OPTION OF EXTENSION OF DE-**
 18 **PENDENT COVERAGE FOR CERTAIN UNMAR-**
 19 **RIED, UNINSURED YOUNG ADULTS.**

20 (a) UNDER GROUP HEALTH PLANS.—

21 (1) EMPLOYEE RETIREMENT INCOME SECURITY
 22 ACT OF 1974 AMENDMENTS.—

23 (A) IN GENERAL.—The Employee Retire-
 24 ment Income Security Act of 1974 is amended

1 by inserting after section 703 the following new
2 section:

3 **“SEC. 704. REQUIRING THE OPTION OF EXTENSION OF DE-**
4 **PENDENT COVERAGE FOR CERTAIN UNMAR-**
5 **RIED, UNINSURED YOUNG ADULTS.**

6 “(a) IN GENERAL.—A group health plan and a health
7 insurance issuer offering health insurance coverage in con-
8 nection with a group health plan that provides coverage
9 for dependent children shall make available such coverage,
10 at the option of the participant involved, for one or more
11 qualified children (as defined in subsection (b)) of the par-
12 ticipant.

13 “(b) QUALIFIED CHILD DEFINED.—In this section,
14 the term ‘qualified child’ means, with respect to a partici-
15 pant in a group health plan or group health insurance cov-
16 erage, an individual who (but for age) would be treated
17 as a dependent child of the participant under such plan
18 or coverage and who—

19 “(1) is under 26 years of age;

20 “(2) is not married;

21 “(3) has no dependents;

22 “(4) is a citizen or national of the United
23 States; and

24 “(5) is not provided coverage as a participant,
25 beneficiary, or enrollee (other than under this sec-

1 tion) under any other creditable coverage (as defined
2 in section 701(c)(1)).

3 “(c) PREMIUMS.—Nothing in this section shall be
4 construed as preventing a group health plan or health in-
5 surance issuer with respect to group health insurance cov-
6 erage from increasing the premiums otherwise required for
7 coverage provided under this section.”.

8 (B) CLERICAL AMENDMENT.—The table of
9 contents of such Act is amended by inserting
10 after the item relating to section 703 the fol-
11 lowing new item:

 “704. Requiring the option of extension of dependent coverage for certain un-
 married young adults.”.

12 (2) PHSA.—Title XXVII of the Public Health
13 Service Act is amended by inserting after section
14 2702 the following new section:

15 **“SEC. 2703. REQUIRING THE OPTION OF EXTENSION OF DE-**
16 **PENDENT COVERAGE FOR CERTAIN UNMAR-**
17 **RIED, UNINSURED YOUNG ADULTS.**

18 “The provisions of section 704 of the Employee Re-
19 tirement Income Security Act of 1974 shall apply to health
20 insurance coverage offered by a health insurance issuer
21 in the individual market in the same manner as they apply
22 to health insurance coverage offered by a health insurance
23 issuer in connection with a group health plan in the small
24 or large group market.”.

1 (b) INDIVIDUAL HEALTH INSURANCE COVERAGE.—

2 Title XXVII of the Public Health Service Act is amended

3 by inserting after section 2745 the following new section:

4 **“SEC. 2746. REQUIRING THE OPTION OF EXTENSION OF DE-**

5 **PENDENT COVERAGE FOR CERTAIN UNMAR-**

6 **RIED YOUNG ADULTS.**

7 “The provisions of section 2703 shall apply to health

8 insurance coverage offered by a health insurance issuer

9 in the individual market in the same manner as they apply

10 to health insurance coverage offered by a health insurance

11 issuer in connection with a group health plan in the small

12 or large group market.”.

13 (c) EFFECTIVE DATES.—

14 (1) GROUP HEALTH PLANS.—

15 (A) IN GENERAL.—The amendments made

16 by subsection (a) shall apply to group health

17 plans for plan years beginning on or after the

18 date that is 90 days after the date of enactment

19 of this Act.

20 (B) SPECIAL RULE FOR COLLECTIVE BAR-

21 GAINING AGREEMENTS.—In the case of a group

22 health plan maintained pursuant to 1 or more

23 collective bargaining agreements between em-

24 ployee representatives and 1 or more employers,

25 any plan amendment made pursuant to a collec-

1 tive bargaining agreement relating to the plan
2 which amends the plan solely to conform to any
3 requirement added by an amendment made by
4 subsection (a) shall not be treated as a termi-
5 nation of such collective bargaining agreement.

6 (2) INDIVIDUAL HEALTH INSURANCE COV-
7 ERAGE.—Section 2746 of the Public Health Service
8 Act, as inserted by subsection (b), shall apply with
9 respect to health insurance coverage offered, sold,
10 issued, renewed, in effect, or operated in the indi-
11 vidual market after the first day of the first month
12 that begins more than 90 days after the date of the
13 enactment of this Act.

14 **TITLE IV—OFFSETS**

15 **SEC. 401. TRANSFER OF UNOBLIGATED STIMULUS FUNDS.**

16 (a) RESCISSION.—Effective on the date of the enact-
17 ment of this Act, any unobligated balances available on
18 such date of funds made available by division A of the
19 American Recovery and Reinvestment Act of 2009 (Public
20 Law 111–5), other than under the heading “Federal
21 Highway Administration-Highway Infrastructure Invest-
22 ment” in title XII of such division, are rescinded and such
23 provisions are repealed.

24 (b) REPEAL.—The provisions of division B of the
25 American Recovery and Reinvestment Act of 2009 (Public

1 Law 111-5), other than titles I and II of such division
2 are repealed.

3 (c) TRANSFER OF FUNDS.—The total amount re-
4 scinded by this section shall be deposited in the Federal
5 Treasury.

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