H. R. 4529

To provide for the reform of health care, the Social Security system, the tax code for individuals and business, job training, and the budget process.

IN THE HOUSE OF REPRESENTATIVES

JANUARY 27, 2010

Mr. RYAN of Wisconsin (for himself, Mr. BARTLETT, Mrs. BLACKBURN, Mr. BURGESS, Mr. CAMPBELL, Mr. HENSARLING, Mr. NUNES, and Mr. PRICE of Georgia) introduced the following bill; which was referred to the Committee on Ways and Means, and in addition to the Committees on Energy and Commerce, Education and Labor, Rules, the Budget, and the Judiciary, for a period to be subsequently determined by the Speaker, in each case for consideration of such provisions as fall within the jurisdiction of the committee concerned.

A BILL

To provide for the reform of health care, the Social Security system, the tax code for individuals and business, job training, and the budget process.

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

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

4. (a) Short Title.—This Act may be cited as the
5. “Roadmap for America’s Future Act of 2010”.

6. (b) Table of Contents.—The table of contents for
7. this Act is as follows:
Sec. 1. Short title; table of contents.
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1 SEC. 2. FINDINGS AND PURPOSE.

2 (a) FINDINGS.—The Congress finds as follows:

3 (1) The Congressional Budget Office, the Gov-
4 ernment Accountability Office, and the Federal Re-
5 serve have all found that Social Security, Medicare,
6 and Medicaid, as currently structured, will result in
7 unsustainable levels of spending, deficits, and debt.

8 (2) Although Americans remain committed to
9 the missions of these initiatives, the goals can no
10 longer be met on models created nearly 80 years
11 ago—with large, centralized institutions, especially
government, serving as sole providers for an increas-
12 ingly dependent population.
(3) The continuing failure to enact solutions makes these problems more intractable with each succeeding year.

(4) Among the inescapable signs are the following: an unsustainable path of Government spending; levels of projected debt that threaten to bankrupt the country; trillions of dollars of unfunded liabilities in the Government’s major benefit programs; and the erosion of Americans’ security and confidence in health care and retirement.

(5) These conditions pose significant potential burdens not only for the Government, but for the United States economy as well, threatening its ability to continue raising standards of living, and its leadership in an increasingly international marketplace.

(6) A comprehensive plan is needed, and this legislation aims to gain control of Federal spending, deficits, and debt while energizing the productive capacities of Americans to generate sustained economic growth.

(b) PURPOSE.—The purpose of this Act is as follows:

(1) HEALTH CARE REFORM.—To provide access to health care coverage for uninsured Americans by establishing a new tax credit; to reform health insur-
ance markets, high-risk pools, and electronic health records; and to create a new agency to promote the dissemination of industry-defined health care price and quality data.

(2) **MEDICAID AND SCHIP REFORM.**—To ensure health care coverage for those who need it most and can be sustained, reforms the Medicaid and SCHIP to expand coverage options for beneficiaries, gives greater flexibility, and slows the growth in spending.

(3) **MEDICARE REFORM.**—To ensure the Medicare benefit continues to provide health care coverage for seniors by establishing modernizing the program to slowly phase in reforms for those younger than 55 years of age, and to make the program permanently solvent and fiscally sustainable.

(4) **SOCIAL SECURITY REFORM.**—To reform Social Security to ensure retirement security for future generations and to make it solvent for the foreseeable future; to address inequities in the system and provide millions of Americans with the opportunity to build a retirement nest egg that they can pass on to their heirs.

(5) **INDIVIDUAL INCOME TAX REFORM.**—To offer taxpayers a choice in paying their Federal income taxes; to allow individuals to choose between
the current tax code or a highly simplified tax sys-
tem with virtually no deductions or credits (apart
from an individual health care credit), two low tax
rates and a generous standard deduction and per-
sonal exemption; to fully repeal the alternative min-
imum tax (AMT), eliminate the tax on interest, cap-
ital gains and dividends in order to promote saving;
and to repeal the estate tax.

(6) BUSINESS TAX REFORM.—To eliminate the
United States corporate income tax and establishes
a border-adjustable business consumption tax in its
place; to provide a new method of business taxation
that will level the playing field for United States
businesses to compete with foreign businesses and
will promote sustained economic growth, investment
and job creation in America.

(7) JOB TRAINING.—To assist working Ameri-
cans in an increasingly global economy, reforms 49
job training programs across eight agencies to en-
hance transparency, accountability, and perform-
ance.

(8) BUDGET PROCESS.—To keep total spending
of the Government under control, nondefense discre-
tionary spending limits are set forth, a limit on total
outlays as a percentage of the gross domestic
produce is established, and the process is reformed
to put a greater focus on long-term budgetary
trends.

TITLE I—HEALTH CARE REFORM
Subtitle A—Expanding Patient’s
Health Care Choices
PART 1—STATE-BASED HEALTH CARE
EXCHANGES
SEC. 101. STATE-BASED HEALTH CARE EXCHANGES.

(a) State-Based Health Care Exchanges.—

(1) In general.—The Secretary of Health and
Human Services (referred to in this part as the
“Secretary”) shall establish a process for the review
of applications submitted by States for the establish-
ment and implementation of State-based health care
Exchanges (referred to in this part as a “State Ex-
change”) and for the certification of such Ex-
changes. The Secretary shall certify a State Ex-
change if the Secretary determines that such Ex-
change meets the requirements of this part.

(2) Continued certification.—The certifi-
cation of a State Exchange under subsection (a)
shall remain in effect until the Secretary determines
that the Exchange has failed to meet any of the re-
quirements under this part.
SEC. 102. REQUIREMENTS.

(a) General Requirements for Certification.—An application for certification under section 101(a) shall demonstrate compliance with the following:

(1) Purpose.—The primary purpose of a State Exchange shall be the facilitation of the individual purchase of innovative private health insurance and the creation of a market where private health plans compete for enrollees based on price and quality.

(2) Administration.—A State shall ensure the operation of the State Exchange through direct contracts with the health insurance plans that are participating in the State Exchange or through a contract with a third party administrator for the operation of the Exchange.

(3) Plan Participation.—A State shall not restrict or otherwise limit the ability of a health insurance plan to participate in, and offer health insurance coverage through, the State Exchange, so long as the health insurance issuers involved are duly licensed under State insurance laws applicable to all health insurance issuers in the State and otherwise comply with the requirements of this part.

(4) Premiums.—

(A) Amount.—A State shall not determine premium or cost sharing amounts for health in-
insurance coverage offered through the State Ex-
change.

(B) COLLECTION METHOD.—A State shall
ensure the existence of an effective and efficient
method for the collection of premiums for
health insurance coverage offered through the
State Exchange.

(b) BENEFIT PARITY WITH MEMBERS OF CON-
gress.—With respect to health insurance issuers offering
health insurance coverage through the State Exchange,
the State shall not impose any requirement that such
issuers provide coverage that includes benefits different
than requirements on plans offered to Members of Con-
gress under chapter 89 of title 5, United States Code.

(c) FACILITATING UNIVERSAL COVERAGE FOR
AMERICANS.—

(1) AUTOMATIC ENROLLMENT.—The State Ex-
change shall ensure that health insurance coverage
offered through the Exchange provides for the appli-
cation of uniform mechanisms that are designed to
courage and facilitate the enrollment of all eligible
individuals in Exchange-based health insurance cov-
verage. Such mechanisms shall include automatic en-
rollment through various venues, which may include
emergency rooms, the submission of State tax forms,
places of employment in the State, and State departments of motor vehicles.

(2) OTHER ENROLLMENT OPPORTUNITIES.—

(A) IN GENERAL.—The State Exchange shall ensure that health insurance coverage offered through the Exchange permits enrollment, and changes in enrollment, of individuals at the time such individuals become eligible individuals in the State.

(B) ANNUAL OPEN ENROLLMENT PERIODS.—The State Exchange shall ensure that health insurance coverage offered through the Exchange permits eligible individuals to annually change enrollment among the coverage offered through the Exchange, subject to subparagraph (A).

(C) INCENTIVES FOR CONTINUOUS ANNUAL COVERAGE.—The State Exchange shall include an incentive for eligible individuals to remain insured from plan year to plan year, and may include incentives such as State tax incentives or premium-based incentives.

(3) GUARANTEED ACCESS FOR INDIVIDUALS.—The State Exchange shall ensure that, with respect to health insurance coverage offered through the Ex-
change, all eligible individuals are able to enroll in
the coverage of their choice provided that such indi-
viduals agree to make applicable premium and cost
sharing payments.

(4) LIMITATION ON PRE-EXISTING CONDITION
EXCLUSIONS.—The State Exchange shall ensure
that health insurance coverage offered through the
Exchange meets the requirements of section 9801 of
the Internal Revenue Code of 1986 in the same
manner as if such coverage was a group health plan.

(5) OPT-OUT.—Nothing in this part shall be
construed to require that an individual be enrolled in
health insurance coverage.

(d) LIMITATION ON EXORBITANT PREMIUMS.—

(1) ESTABLISHMENT OF MECHANISM.—With
respect to health insurance coverage offered through
the State Exchange, the Exchange shall establish a
mechanisms to protect enrollees from the imposition
of excessive premiums, to reduce adverse selection,
and to share risk.

(2) MECHANISM OPTIONS.—The mechanisms
referred to in paragraph (1) may include the fol-
lowing:

(A) INDEPENDENT RISK ADJUSTMENT.—
The implementation of risk-adjustment among
health insurance coverage offered through the State Exchange through a contract entered into with a private, independent board. Such board shall include representation of health insurance issuers and State officials but shall be independently controlled. The State Exchange shall ensure that risk-adjustment implemented under this subparagraph shall be based on a blend of patient diagnoses and estimated costs.

(B) Health Security Pools.—The establishment (or continued operation under section 2745 of the Public Health Service Act) of a health security pool to guarantee high-risk individuals access to affordable, quality health care.

(C) Reinsurance.—The implementation of a successful reinsurance mechanisms to guarantee high-risk individuals access to affordable, quality health care.

(e) Medicaid and SCHIP Beneficiaries.—The State Exchange shall include procedures to permit eligible individuals who are receiving (or who are eligible to receive) health care under title XIX or XXI of the Social Security Act to enroll in health insurance coverage offered through the Exchange.
(f) Dissemination of Coverage Information.—

The State Exchange shall ensure that each health insurance issuer that provides health insurance coverage through the Exchange disseminate to eligible individuals and employers within the State information concerning health insurance coverage options, including the plans offered and premiums and benefits for such plans.

(g) Regional Options.—

(1) Interstate Compacts.—Two or more States that establish a State Exchange may enter into interstate compacts providing for the regulations of health insurance coverage offered within such States.

(2) Model Legislation.—States adopting model legislation as developed by the National Association of Insurance Commissioners shall be eligible to enter into an interstate compact as provided for in this section.

(3) Multi-State Pooling Arrangements.—State Exchanges may implement a multi-state health care coverage pooling arrangement under this part.

(h) Eligible Individual.—In this part, the term “eligible individual” means an individual who is—

(1) a citizen or national of the United States or an alien lawfully admitted to the United States for
permanent residence or otherwise residing in the United States under color of law;

(2) a resident of the State involved;

(3) not incarcerated; and

(4) not eligible for coverage under parts A and B (or C) of the Medicare program under title XVIII of the Social Security Act.

SEC. 103. STATE EXCHANGE INCENTIVES.

(a) GRANTS.—The Secretary may award grants, pursuant to subsection (b), to States for the development, implementation, and evaluation of certified State Exchanges and to provide more options and choice for individuals purchasing health insurance coverage.

(b) ONE-TIME INCREASE IN MEDICAID PAYMENT.—In the case of a State awarded a grant to carry out this section, the total amount of the Federal payment determined for the State under section 1913 of the Social Security Act (as amended by section 201 of this Act) for fiscal year 2011 shall be increased by an amount equal to 1 percent of the total amount of payments made to the State for fiscal year 2010 under section 1903(a) of the Social Security Act (42 U.S.C. 1396b(a)) for purposes of carrying out a grant awarded under this section. Amounts paid to a State pursuant to this subsection shall remain available until expended.
PART 2—FAIR TAX TREATMENT FOR ALL
AMERICANS TO AFFORD HEALTH CARE

SEC. 111. REFERENCE.
Except as otherwise expressly provided, whenever in this part an amendment or repeal is expressed in terms of an amendment to, or repeal of, a section or other provision, the reference shall be considered to be made to a section or other provision of the Internal Revenue Code of 1986.

Subpart A—Refundable and Advanceable Credit for Certain Health Insurance Coverage

SEC. 112. REFUNDABLE AND ADVANCEABLE CREDIT FOR CERTAIN HEALTH INSURANCE COVERAGE.

(a) ADVANCEABLE CREDIT.—Subpart A of part IV of subchapter A of chapter 1 (relating to nonrefundable personal credits) is amended by adding at the end the following new section:

“SEC. 25E. QUALIFIED HEALTH INSURANCE CREDIT.

“(a) ALLOWANCE OF CREDIT.—In the case of an individual, there shall be allowed as a credit against the tax imposed by this chapter for the taxable year the sum of the monthly limitations determined under subsection (b) for the taxpayer and the taxpayer’s spouse and dependents.

“(b) MONTHLY LIMITATION.—
“(1) IN GENERAL.—The monthly limitation for each month during the taxable year for an eligible individual is $\frac{1}{12}$th of—

“(A) the applicable adult amount, in the case that the eligible individual is the taxpayer or the taxpayer’s spouse,

“(B) the applicable adult amount, in the case that the eligible individual is an adult dependent, and

“(C) the applicable child amount, in the case that the eligible individual is a child dependent.

“(2) LIMITATION ON AGGREGATE AMOUNT.—Notwithstanding paragraph (1), the aggregate monthly limitations for the taxpayer and the taxpayer’s spouse and dependents for any month shall not exceed $\frac{1}{12}$th of the applicable aggregate amount.

“(3) NO CREDIT FOR INELIGIBLE MONTHS.—With respect to any individual, the monthly limitation shall be zero for any month for which such individual is not an eligible individual.

“(4) APPLICABLE AMOUNT.—

“(A) IN GENERAL.—For purposes of this section—
“(i) **APPLICABLE ADULT AMOUNT.**—
The applicable adult amount is $2,300.

“(ii) **APPLICABLE CHILD AMOUNT.**—
The applicable child amount is $1,700.

“(iii) **APPLICABLE AGGREGATE AMOUNT.**—The applicable aggregate amount is $5,700.

“(B) **COST-OF-LIVING ADJUSTMENTS.**—

“(i) **IN GENERAL.**—In the case of any taxable year beginning in a calendar year after 2011, each dollar amount contained in subparagraph (A) shall be increased by an amount equal to such dollar amount multiplied by the blended cost-of-living adjustment.

“(ii) **BLENDED COST-OF-LIVING ADJUSTMENT.**—For purposes of clause (i), the blended cost-of-living adjustment means one-half of the sum of—

“(I) the cost-of-living adjustment determined under section 1(f)(3) for the calendar year in which the taxable year begins by substituting ‘calendar year 2010’ for ‘calendar year 1992’ in subparagraph (B) thereof, plus
“(II) the cost-of-living adjustment determined under section 213(d)(10)(B)(ii) for the calendar year in which the taxable year begins by substituting ‘2010’ for ‘1996’ in subclause (II) thereof.

“(iii) Rounding.—Any increase determined under clause (i) shall be rounded to the nearest multiple of $10.

“(C) Revenue Neutrality Adjustments.—

“(i) In general.—In the case of any taxable year beginning in a calendar year after 2011, each dollar amount contained in subparagraph (A), as adjusted under subparagraph (B), shall be further adjusted (if necessary) such that the aggregate of such dollar amounts allowed as credits under this section for such taxable year equals but does not exceed the total increase in revenues in the Treasury resulting from the amendments made by sections 124 and 201 of the Roadmap for America’s Future Act of 2010 for such taxable year as estimated by the Secretary.
“(ii) DATE OF ADJUSTMENT.—The Secretary shall announce the adjustments for any taxable year under this subparagraph not later than the preceding October 1.

“(c) LIMITATION BASED ON AMOUNT OF TAX.—In the case of a taxable year to which section 26(a)(2) does not apply, the credit allowed under subsection (a) for the taxable year shall not exceed the excess of—

“(1) the sum of the regular tax liability (as defined in section 26(b)) plus the tax imposed by section 55, over

“(2) the sum of the credits allowable under this subpart (other than this section) and section 27 for the taxable year.

“(d) EXCESS CREDIT REFUNDABLE TO CERTAIN TAX-FAVORED ACCOUNTS.—If—

“(1) the credit which would be allowable under subsection (a) if only qualified refund eligible health insurance were taken into account under this section, exceeds

“(2) the limitation imposed by section 26 or subsection (e) for the taxable year,

such excess shall be paid by the Secretary into the designated account of the taxpayer.
“(e) ELIGIBLE INDIVIDUAL.—For purposes of this section—

“(1) IN GENERAL.—The term ‘eligible individual’ means, with respect to any month, an individual who—

“(A) is the taxpayer, the taxpayer’s spouse, or the taxpayer’s dependent, and

“(B) is covered under qualified health insurance as of the 1st day of such month.

“(2) MEDICARE COVERAGE, MEDICAID DISABILITY COVERAGE, AND MILITARY COVERAGE.—

The term ‘eligible individual’ shall not include any individual who for any month is—

“(A) entitled to benefits under part A of title XVIII of the Social Security Act or enrolled under part B of such title, and the individual is not a participant or beneficiary in a group health plan or large group health plan that is a primary plan (as defined in section 1862(b)(2)(A) of such Act),

“(B) enrolled by reason of disability in the program under title XIX of such Act, or

“(C) entitled to benefits under chapter 55 of title 10, United States Code, including under
the TRICARE program (as defined in section 1072(7) of such title).

“(3) IDENTIFICATION REQUIREMENTS.—The term ‘eligible individual’ shall not include any individual for any month unless the policy number associated with the qualified health insurance and the TIN of each eligible individual covered under such health insurance for such month are included on the return of tax for the taxable year in which such month occurs.

“(4) PRISONERS.—The term ‘eligible individual’ shall not include any individual for a month if, as of the first day of such month, such individual is imprisoned under Federal, State, or local authority.

“(5) ALIENS.—The term ‘eligible individual’ shall not include any alien individual who is not a lawful permanent resident of the United States.

“(f) HEALTH INSURANCE.—For purposes of this section—

“(1) QUALIFIED HEALTH INSURANCE.—The term ‘qualified health insurance’ means any insurance constituting medical care which (as determined under regulations prescribed by the Secretary)—

“(A) has a reasonable annual and lifetime benefit maximum, and
“(B) provides coverage for inpatient and outpatient care, emergency benefits, and physician care.

Such term does not include any insurance substantially all of the coverage of which is coverage described in section 223(c)(1)(B).

“(2) QUALIFIED REFUND ELIGIBLE HEALTH INSURANCE.—The term ‘qualified refund eligible health insurance’ means any qualified health insurance which is coverage under a group health plan (as defined in section 5000(b)(1)).

“(g) DESIGNATED ACCOUNTS.—

“(1) DESIGNATED ACCOUNT.—For purposes of this section, the term ‘designated account’ means any specified account established and maintained by the provider of the taxpayer’s qualified refund eligible health insurance—

“(A) which is designated by the taxpayer (in such form and manner as the Secretary may provide) on the return of tax for the taxable year,

“(B) which, under the terms of the account, accepts the payment described in subsection (d) on behalf of the taxpayer, and
“(C) which, under such terms, provides for the payment of expenses by the taxpayer or on behalf of such taxpayer by the trustee or custodian of such account, including payment to such provider.

“(2) SPECIFIED ACCOUNT.—For purposes of this paragraph, the term ‘specified account’ means—

“(A) any health savings account under section 223 or Archer MSA under section 220, or

“(B) any health insurance reserve account.

“(3) HEALTH INSURANCE RESERVE ACCOUNT.—For purposes of this subsection, the term ‘health insurance reserve account’ means a trust created or organized in the United States as a health insurance reserve account exclusively for the purpose of paying the qualified medical expenses (within the meaning of section 223(d)(2)) of the account beneficiary (as defined in section 223(d)(3)), but only if the written governing instrument creating the trust meets the requirements described in subparagraphs (B), (C), (D), and (E) of section 223(d)(1). Rules similar to the rules under subsections (g) and (h) of section 408 shall apply for purposes of this subparagraph.
“(4) Treatment of Payment.—Any payment under subsection (d) to a designated account shall not be taken into account with respect to any dollar limitation which applies with respect to contributions to such account (or to tax benefits with respect to such contributions).

“(h) Other Definitions.—For purposes of this section—

“(1) Dependent.—The term ‘dependent’ has the meaning given such term by section 152 (determined without regard to subsections (b)(1), (b)(2), and (d)(1)(B) thereof). An individual who is a child to whom section 152(e) applies shall be treated as a dependent of the custodial parent for a coverage month unless the custodial and noncustodial parent provide otherwise.

“(2) Adult.—The term ‘adult’ means an individual who is not a child.

“(3) Child.—The term ‘child’ means a qualifying child (as defined in section 152(e)).

“(i) Special Rules.—

“(1) Coordination with Medical Deduction.—Any amount paid by a taxpayer for insurance which is taken into account for purposes of determining the credit allowable to the taxpayer under
subsection (a) shall not be taken into account in computing the amount allowable to the taxpayer as a deduction under section 213(a) or 162(l).

“(2) Coordination with health care tax credit.—No credit shall be allowed under subsection (a) for any taxable year to any taxpayer and qualifying family members with respect to whom a credit under section 35 is allowed for such taxable year.

“(3) Denial of credit to dependents.—No credit shall be allowed under this section to any individual with respect to whom a deduction under section 151 is allowable to another taxpayer for a taxable year beginning in the calendar year in which such individual’s taxable year begins.

“(4) Married couples must file joint return.—

“(A) In general.—If the taxpayer is married at the close of the taxable year, the credit shall be allowed under subsection (a) only if the taxpayer and his spouse file a joint return for the taxable year.

“(B) Marital status; certain married individuals living apart.—Rules similar to the rules of paragraphs (3) and (4) of section
21(e) shall apply for purposes of this para-

graph.

“(5) Verification of Coverage, etc.—No
credit shall be allowed under this section with re-
spect to any individual unless such individual’s cov-
erage (and such related information as the Secretary
may require) is verified in such manner as the Sec-
retary may prescribe.

“(6) Insurance Which Covers Other Indi-

dividuals; Treatment of Payments.—Rules similar
to the rules of paragraphs (7) and (8) of section
35(g) shall apply for purposes of this section.

“(j) Coordination With Advance Payments.—

“(1) Reduction in Credit for Advance Pay-

ments.—With respect to any taxable year, the
amount which would (but for this subsection) be al-
lowed as a credit to the taxpayer under subsection
(a) shall be reduced (but not below zero) by the ag-
gregate amount paid on behalf of such taxpayer
under section 7527A for months beginning in such
taxable year.

“(2) Recapture of Excess Advance Pay-

ments.—If the aggregate amount paid on behalf of
the taxpayer under section 7527A for months begin-
ning in the taxable year exceeds the sum of the
monthly limitations determined under subsection (b) for the taxpayer and the taxpayer’s spouse and dependents for such months, then the tax imposed by this chapter for such taxable year shall be increased by the sum of—

“(A) such excess, plus

“(B) interest on such excess determined at the underpayment rate established under section 6621 for the period from the date of the payment under section 7527A to the date such excess is paid.

For purposes of subparagraph (B), an equal part of the aggregate amount of the excess shall be deemed to be attributable to payments made under section 7527A on the first day of each month beginning in such taxable year, unless the taxpayer establishes the date on which each such payment giving rise to such excess occurred, in which case subparagraph (B) shall be applied with respect to each date so established. The Secretary may rescind or waive all or any portion of any amount imposed by reason of subparagraph (B) if such excess was not the result of the actions of the taxpayer.”.
(b) ADVANCE PAYMENT OF CREDIT.—Chapter 77
(relating to miscellaneous provisions) is amended by in-
serting after section 7527 the following new section:

"SEC. 7527A. ADVANCE PAYMENT OF CREDIT FOR QUALI-
FIED REFUND ELIGIBLE HEALTH INSUR-
ANCE.

“(a) IN GENERAL.—The Secretary shall establish a
program for making payments on behalf of individuals to
providers of qualified refund eligible health insurance (as
defined in section 25E(f)(2)) for such individuals.

“(b) LIMITATION.—The Secretary may make pay-
ments under subsection (a) only to the extent that the Sec-
retary determines that the amount of such payments made
on behalf of any taxpayer for any month does not exceed
the sum of the monthly limitations determined under sec-
tion 25E(b) for the taxpayer and taxpayer’s spouse and
dependents for such month.”.

(c) INFORMATION REPORTING.—

(1) IN GENERAL.—Subpart B of part III of
subchapter A of chapter 61 (relating to information
concerning transactions with other persons) is
amended by inserting after section 6050W the fol-
lowing new section:
SEC. 6050X. RETURNS RELATING TO CREDIT FOR QUALIFIED REFUND ELIGIBLE HEALTH INSURANCE.

(a) Requirement of Reporting.—Every person who is entitled to receive payments for any month of any calendar year under section 7527A (relating to advance payment of credit for qualified refund eligible health insurance) with respect to any individual shall, at such time as the Secretary may prescribe, make the return described in subsection (b) with respect to each such individual.

(b) Form and Manner of Returns.—A return is described in this subsection if such return—

"(1) is in such form as the Secretary may prescribe, and

"(2) contains, with respect to each individual referred to in subsection (a)—

"(A) the name, address, and TIN of each such individual,

"(B) the months for which amounts payments under section 7527A were received,

"(C) the amount of each such payment,

"(D) the type of insurance coverage provided by such person with respect to such individual and the policy number associated with such coverage,
“(E) the name, address, and TIN of the
spouse and each dependent covered under such
coverage, and
“(F) such other information as the Sec-
retary may prescribe.
“(c) Statements To Be Furnished to Individ-
uals With Respect to Whom Information Is Re-
quired.—Every person required to make a return under
subsection (a) shall furnish to each individual whose name
is required to be set forth in such return a written state-
ment showing—
“(1) the contact information of the person re-
quired to make such return, and
“(2) the information required to be shown on
the return with respect to such individual.
The written statement required under the preceding sen-
tence shall be furnished on or before January 31 of the
year following the calendar year for which the return
under subsection (a) is required to be made.
“(d) Returns Which Would Be Required To Be
Made by 2 or More Persons.—Except to the extent
provided in regulations prescribed by the Secretary, in the
case of any amount received by any person on behalf of
another person, only the person first receiving such
amount shall be required to make the return under subsection (a).”.

(2) ASSESSABLE PENALTIES.—

(A) Subparagraph (B) of section 6724(d)(1) (relating to definitions) is amended by striking “or” at the end of clause (xxii), by striking “and” at the end of clause (xxiii) and inserting “or”, and by inserting after clause (xxiii) the following new clause:

“(xxiv) section 6050X (relating to returns relating to credit for qualified refund eligible health insurance), and”.

(B) Paragraph (2) of section 6724(d) is amended by striking “or” at the end of subparagraph (EE), by striking the period at the end of subparagraph (FF) and inserting “, or” and by inserting after subparagraph (FF) the following new subparagraph:

“(GG) section 6050X (relating to returns relating to credit for qualified refund eligible health insurance).”.

(d) CONFORMING AMENDMENTS.—

(1) Paragraph (2) of section 1324(b) of title 31, United States Code, is amended by inserting “25E,” before “35,”.
(2) (A) Section 24(b)(3)(B) is amended by inserting “, 25E,” after “25D”.

(B) Section 25(c)(1)(C)(ii) is amended by inserting “25E,” after “25D,”.

(C) Section 25B(g)(2) is amended by inserting “25E,” after “25D,”.

(D) Section 26(a)(1) is amended by inserting “25E,” after “25D,”.

(E) Section 30(e)(2)(B)(ii) is amended by inserting “25E,” after “25D,”.

(F) Section 30D(e)(2)(B)(ii) is amended by striking “and 25D” and inserting “, 25D, and 25E”.

(G) Section 904(i) is amended by inserting “25E,” after “25B,”.

(H) Section 1400C(d)(2) is amended by inserting “25E,” after “25D,”.

(3) The table of sections for subpart A of part IV of subchapter A of chapter 1 is amended by inserting after the item relating to section 25D the following new item:

“Sec. 25E. Qualified health insurance credit.”.

(4) The table of sections for chapter 77 is amended by inserting after the item relating to section 7527 the following new item:
(5) The table of sections for subpart B of part III of subchapter A of chapter 61 is amended by adding at the end the following new item:

“Sec. 6050X. Returns relating to credit for qualified refund eligible health insurance.”.

(e) Effective Date.—The amendments made by this section shall apply to taxable years beginning after December 31, 2010.

SEC. 113. REQUIRING EMPLOYER TRANSPARENCY ABOUT EMPLOYEE BENEFITS.

(a) In General.—Section 6051(a) (relating to W–2 requirement) is amended by striking “and” at the end of paragraph (12), by striking the period at the end of paragraph (13) and inserting “, and” and by inserting after paragraph (13) the following new paragraph:

“(14) the aggregate cost (within the meaning of section 4980B(f)(4)) for coverage of the employee under an accident or health plan which is excludable from the gross income of the employee under section 106(a) (other than coverage under a health flexible spending arrangement).”.

(b) Effective Date.—The amendments made by this section shall apply to statements for calendar years beginning after 2010.
SEC. 114. CHANGES TO EXISTING TAX PREFERENCES FOR
MEDICAL COVERAGE, ETC., FOR INDIVIDUALS
ELIGIBLE FOR QUALIFIED HEALTH INSUR-
ANCE CREDIT.

(a) EXCLUSION FOR CONTRIBUTIONS BY EMPLOYER
TO ACCIDENT AND HEALTH PLANS.—

(1) IN GENERAL.—Section 106 (relating to con-
tributions by employer to accident and health plans)
is amended by adding at the end the following new
subsection:

“(f) NO EXCLUSION FOR INDIVIDUALS ELIGIBLE
FOR QUALIFIED HEALTH INSURANCE CREDIT.—Sub-
section (a) shall not apply with respect to any employer-
provided coverage under an accident or health plan for any
individual for any month unless such individual is de-
scribed in paragraph (2) or (5) of section 25E(e) for such
month. The amount includible in gross income by reason
of this subsection shall be determined under rules similar
to the rules of section 4980B(f)(4).”.

(2) CONFORMING AMENDMENTS.—

(A) Section 106(b)(1) is amended—

(i) by inserting “gross income does
not include” before “amounts contrib-
uted”, and
(ii) by striking “shall be treated as employer-provided coverage for medical expenses under an accident or health plan”.

(B) Section 106(d)(1) is amended—

(i) by inserting “gross income does not include” before “amounts contributed”, and

(ii) by striking “shall be treated as employer-provided coverage for medical expenses under an accident or health plan”.

(b) Amounts Received Under Accident and Health Plans.—Section 105 (relating to amounts received under accident and health plans) is amended by adding at the end the following new subsection:

“(k) No Exclusion for Individuals Eligible for Qualified Health Insurance Credit.—Subsection (b) shall not apply with respect to any employer-provided coverage under an accident or health plan for any individual for any month unless such individual is described in paragraph (2) or (5) of section 25E(e) for such month.”.

(c) Special Rules for Health Insurance Costs of Self-employed Individuals.—Subsection (l) of section 162 (relating to special rules for health insurance
costs of self-employed individuals) is amended by adding at the end the following new paragraph:

“(6) NO DEDUCTION TO INDIVIDUALS ELIGIBLE FOR QUALIFIED HEALTH INSURANCE.—Paragraph (1) shall not apply for any individual for any month unless such individual is described in paragraph (2) or (5) of section 25E(e) for such month.”.

(d) EARNED INCOME CREDIT UNAFFECTED BY REPEALED EXCLUSIONS.—Subparagraph (B) of section 32(c)(2) is amended by redesignating clauses (v) and (vi) as clauses (vi) and (vii), respectively, and by inserting after clause (iv) the following new clause:

“(v) the earned income of an individual shall be computed without regard to sections 105(k) and 106(f),”.

(e) MODIFICATION OF DEDUCTION FOR MEDICAL EXPENSES.—Subsection (d) of section 213 is amended by adding at the end the following new paragraph:

“(12) PREMIUMS FOR QUALIFIED HEALTH INSURANCE.—The term ‘medical care’ does not include any amount paid as a premium for coverage of an eligible individual (as defined in section 25E(e)) under qualified health insurance (as defined in section 25E(f)) for any month.”.
(f) **REPORTING REQUIREMENT.**—Subsection (a) of section 6051 is amended by striking “and” at the end of paragraph (12), by striking the period at the end of paragraph (13) and inserting “and”, and by inserting after paragraph (13) the following new paragraph:

“(14) the total amount of employer-provided coverage under an accident or health plan which is includible in gross income by reason of sections 105(k) and 106(f).”.

(g) **RETIRED PUBLIC SAFETY OFFICERS.**—Section 402(l)(4)(D) is amended by adding at the end the following: “Such term shall not include any premium for coverage by an accident or health insurance plan for any month unless such individual is described in paragraph (2) or (5) of section 25E(e) for such month.”.

(h) **EFFECTIVE DATE.**—The amendments made by this section shall apply to taxable years beginning after December 31, 2010.

(i) **NO INTENT TO ENCOURAGE STATE TAXATION OF HEALTH BENEFITS.**—No intent to encourage any State to treat health benefits as taxable income for the purpose of increasing State income taxes may be inferred from the provisions of, and amendments made by, this section.
Subpart B—Health Savings Accounts

SEC. 121. IMPROVEMENTS TO HEALTH SAVINGS ACCOUNTS.

(a) INCREASE IN MONTHLY CONTRIBUTION LIMIT.—

(1) IN GENERAL.—Paragraph (2) of section 223(b) (relating to limitations) is amended to read as follows:

“(2) MONTHLY LIMITATION.—

“(A) IN GENERAL.—In the case of an eligible individual who has coverage under a high deductible health plan, the monthly limitation for any month of such coverage is 1/12 of the sum of—

“(i) the greater of—

“(I) the sum of the annual deductible and the other annual out-of-pocket expenses (other than for premiums) required to be paid under the plan by the eligible individual for covered benefits, or

“(II) in the case of an eligible individual who has—

“(aa) self-only coverage under a high deductible health plan as of the first day of such month, $3,000, or

“(bb) family coverage under a high deductible health plan as of the first day of such month, $6,000.
“(bb) family coverage under a high deductible health plan as of the first day of such month, $5,950, and

“(ii) in the case of an eligible individual who has coverage under a qualified long-term care insurance contract (as defined in section 7702B(b)), the lesser of—

“(I) the annual premium for such coverage, or

“(II) $1,000.

“(B) Special rules relating to out-of-pocket expenses.—

“(i) Reduction for separate plan.—The annual out-of-pocket expenses taken into account under subparagraph (A)(i)(I) with respect to any eligible individual shall be reduced by any out-of-pocket expense payable under a separate plan covering the individual.

“(ii) Secretarial authority.—The Secretary may by regulations provide that annual out-of-pocket expenses will not be taken into account under subparagraph (A)(i)(I) to the extent that there is only a
remote likelihood that such amounts will
be required to be paid.”.

(2) Application of special rules for mar-
rried individuals.—Paragraph (5) of section
223(b) (relating to limitations) is amended to read
as follows:

“(5) Special rules for married individ-
uals.—

“(A) In general.—In the case of individ-
uals who are married to each other and who are
both eligible individuals, the limitation under
paragraph (1) for each spouse shall be equal to
the spouse’s applicable share of the combined
marital limit.

“(B) Combined marital limit.—For
purposes of subparagraph (A), the combined
marital limit is the excess (if any) of—

“(i) the lesser of—

“(I) subject to subparagraph (C),
the sum of the limitations computed
separately under paragraph (1) for
each spouse (including any additional
contribution amount under paragraph
(3)), or
“(II) the dollar amount in effect under subsection (c)(2)(A)(ii)(II), over
“(ii) the aggregate amount paid to Archer MSAs of such spouses for the taxable year.
“(C) Special rule where both spouses have family coverage.—For purposes of subparagraph (B)(i)(I), if either spouse has family coverage which covers both spouses, both spouses shall be treated as having only such coverage (and if both spouses each have such coverage under different plans, shall be treated as having only family coverage with the plan with respect to which the lowest amount is determined under paragraph (2)(A)(i)(I)).
“(D) Applicable share.—For purposes of subparagraph (A), a spouse’s applicable share is ½ of the combined marital limit unless both spouses agree on a different division.
“(E) Couples not married entire year.—The Secretary shall prescribe rules for the application of this paragraph in the case of any taxable year for which the individuals were not married to each other during all months in-
cluded in the taxable year, including rules which allow individuals in appropriate cases to take into account coverage prior to marriage in computing the combined marital limit for purposes of this paragraph.”.

(3) SELF-ONLY COVERAGE.—Paragraph (4) of section 223(c) (relating to definitions and special rules) is amended to read as follows:

“(4) COVERAGE.—

“(A) FAMILY COVERAGE.—The term ‘family coverage’ means any coverage other than self-only coverage.

“(B) SELF-ONLY COVERAGE.—If more than 1 individual is covered by a high deductible health plan but only 1 of the individuals is an eligible individual, the coverage shall be treated as self-only coverage.”.

(4) CONFORMING AMENDMENTS.—

(A) Section 223(b)(3)(A) is amended by striking “subparagraphs (A) and (B) of”.

(B) Section 223(c)(2)(A) is amended—

(i) by striking “$1,000” in clause (i)(I) and inserting “$1,150”, and

(ii) by striking “$5,000” in clause (ii)(I) and inserting “$5,800”.
(C) Section 223(d)(1)(A)(ii)(I) is amended by striking “subsection (b)(2)(B)(ii)” and inserting “subsection (c)(2)(A)(ii)(II)”.

(D) Clause (ii) of section 223(c)(2)(D) is amended to read as follows:

“(ii) Certain items disregarded in computing monthly limitation.—Such plan’s annual deductible, and such plan’s annual out-of-pocket limitation, for services provided outside of such network shall not be taken into account for purposes of subsection (b)(2).”

(E) Subsection (g) of section 223 is amended to read as follows:

“(g) Cost-of-living adjustments.—

“(1) In general.—In the case of any taxable year beginning in a calendar year after 2010, each dollar amount contained in subsections (b)(2)(A) and (c)(2)(A) shall be increased by an amount equal to such dollar amount multiplied by the blended cost-of-living adjustment.

“(2) Blended cost-of-living adjustment.—For purposes of paragraph (1), the blended cost-of-living adjustment means one-half of the sum of—
“(A) the cost-of-living adjustment determined under section 1(f)(3) for the calendar year in which the taxable year begins by substituting ‘calendar year 2008’ for ‘calendar year 1992’ in subparagraph (B) thereof, plus

“(B) the cost-of-living adjustment determined under section 213(d)(10)(B)(ii) for the calendar year in which the taxable year begins by substituting ‘2008’ for ‘1996’ in subclause (II) thereof.

“(3) Rounding.—Any increase determined under paragraph (2) shall be rounded to the nearest multiple of $50.”.

(b) Use of Account for Individual High Deductible Health Plan Premiums.—Section 223(d)(2)(C) (relating to exceptions) is amended by striking “or” at the end of clause (iii), by striking the period at the end of clause (iv) and inserting “, or”, and by adding at the end the following new clause:

“(v) a high deductible health plan, but only if—

“(I) the plan is not a group health plan (as defined in section 5000(b)(1) without regard to section 5000(d)), and
“(II) the expenses are for coverage for a month with respect to which the account beneficiary is an eligible individual by reason of the coverage under the plan.

For purposes of clause (v), an arrangement which constitutes individual health insurance shall not be treated as a group health plan, notwithstanding that an employer or employee organization negotiates the cost of benefits of such arrangement.”.

(c) Safe Harbor for Absence of Maintenance of Chronic Disease.—Section 223(c)(2)(C) (safe harbor for absence of preventive care deductible) is amended—

(1) by inserting “or maintenance of chronic disease, or both” after “the Secretary)”, and

(2) by inserting “OR MAINTENANCE OF CHRONIC DISEASE” in the heading after “PREVENTIVE CARE”.

(d) Clarification of Treatment of Capitated Primary Care Payments as Amounts Paid for Medical Care.—Section 213(d) (relating to definitions) is amended by adding at the end the following new paragraph:
“(12) Treatment of capitated primary care payments.—Capitated primary care payments shall be treated as amounts paid for medical care.”.

(c) Special Rule for Individuals Eligible for Veterans or Indian Health Benefits.—Section 223(c)(1) (defining eligible individual) is amended by adding at the end the following new subparagraph:

“(C) Special rule for individuals eligible for veterans or Indian health benefits.—For purposes of subparagraph (A)(ii), an individual shall not be treated as covered under a health plan described in such subparagraph merely because the individual receives periodic hospital care or medical services under any law administered by the Secretary of Veterans Affairs or the Bureau of Indian Affairs.”.

(f) Certain Physician Fees To Be Treated as Medical Care.—

(1) In general.—Section 213(d), is amended by adding at the end the following new paragraph:

“(12) Pre-paid physician fees.—The term ‘medical care’ shall include amounts paid by patients to their primary physician in advance for the right to receive medical services on an as-needed basis.”.
(2) Effective Date.—The amendment made by this section shall apply to taxable years beginning after the date of the enactment of this Act.

(g) Effective Dates.—

(1) In General.—Except as provided in paragraph (2), the amendments made by this section shall apply to taxable years beginning after December 31, 2010.

(2) Capitated Primary Care Payments.—
The amendment made by subsection (d) shall apply to amounts paid before, on, or after the date of the enactment of this Act.

SEC. 122. EXCEPTION TO REQUIREMENT FOR EMPLOYERS TO MAKE COMPARABLE HEALTH SAVINGS ACCOUNT CONTRIBUTIONS.

(a) Greater Employer-Provided Contributions to HSAs for Chronically Ill Employees Treated as Meeting Comparability Requirements.—Subsection (b) of section 4980G (relating to failure of employer to make comparable health savings account contributions) is amended to read as follows:

“(b) Rules and Requirements.—

“(1) In general.—Except as provided in paragraph (2), rules and requirements similar to the
rules and requirements of section 4980E shall apply for purposes of this section.

“(2) TREATMENT OF EMPLOYER-PROVIDED CONTRIBUTIONS TO HSAS FOR CHRONICALLY ILL EMPLOYEES.—For purposes of this section—

“(A) IN GENERAL.—Any contribution by an employer to a health savings account of an employee who is (or the spouse or any dependent of the employee who is) a chronically ill individual in an amount which is greater than a contribution to a health savings account of a comparable participating employee who is not a chronically ill individual shall not fail to be considered a comparable contribution.

“(B) NONDISCRIMINATION REQUIREMENT.—Subparagraph (A) shall not apply unless the excess employer contributions described in subparagraph (A) are the same for all chronically ill individuals who are similarly situated.

“(C) CHRONICALLY ILL INDIVIDUAL.—For purposes of this paragraph, the term ‘chronically ill individual’ means any individual whose qualified medical expenses for any taxable year are more than 50 percent greater than the av-
verage qualified medical expenses of all employees of the employer for such year.”

(b) Effective Date.—The amendment made by this section shall apply to taxable years beginning after December 31, 2010.

Subtitle B—Health Plan Choice; Small Business Health Fairness; Tax Amendments

SEC. 131. COOPERATIVE GOVERNING OF INDIVIDUAL HEALTH INSURANCE COVERAGE.

(a) In General.—Title XXVII of the Public Health Service Act (42 U.S.C. 300gg et seq.) is amended by adding at the end the following new part:

“PART D—COOPERATIVE GOVERNING OF INDIVIDUAL HEALTH INSURANCE COVERAGE

“SEC. 2795. DEFINITIONS.

“In this part:

“(1) Primary State.—The term ‘primary State’ means, with respect to individual health insurance coverage offered by a health insurance issuer, the State designated by the issuer as the State whose covered laws shall govern the health insurance issuer in the sale of such coverage under this part.

An issuer, with respect to a particular policy, may only designate one such State as its primary State
with respect to all such coverage it offers. Such an issuer may not change the designated primary State with respect to individual health insurance coverage once the policy is issued, except that such a change may be made upon renewal of the policy. With respect to such designated State, the issuer is deemed to be doing business in that State.

“(2) SECONDARY STATE.—The term ‘secondary State’ means, with respect to individual health insurance coverage offered by a health insurance issuer, any State that is not the primary State. In the case of a health insurance issuer that is selling a policy in, or to a resident of, a secondary State, the issuer is deemed to be doing business in that secondary State.

“(3) HEALTH INSURANCE ISSUER.—The term ‘health insurance issuer’ has the meaning given such term in section 2791(b)(2), except that such an issuer must be licensed in the primary State and be qualified to sell individual health insurance coverage in that State.

“(4) INDIVIDUAL HEALTH INSURANCE COVERAGE.—The term ‘individual health insurance coverage’ means health insurance coverage offered in
the individual market, as defined in section 2791(e)(1).

“(5) **APPLICABLE STATE AUTHORITY.**—The term ‘applicable State authority’ means, with respect to a health insurance issuer in a State, the State insurance commissioner or official or officials designated by the State to enforce the requirements of this title for the State with respect to the issuer.

“(6) **HAZARDOUS FINANCIAL CONDITION.**—The term ‘hazardous financial condition’ means that, based on its present or reasonably anticipated financial condition, a health insurance issuer is unlikely to be able—

“(A) to meet obligations to policyholders with respect to known claims and reasonably anticipated claims; or

“(B) to pay other obligations in the normal course of business.

“(7) **COVERED LAWS.**—

“(A) **IN GENERAL.**—The term ‘covered laws’ means the laws, rules, regulations, agreements, and orders governing the insurance business pertaining to—

“(i) individual health insurance coverage issued by a health insurance issuer;
“(ii) the offer, sale, rating (including medical underwriting), renewal, and issuance of individual health insurance coverage to an individual;

“(iii) the provision to an individual in relation to individual health insurance coverage of health care and insurance related services;

“(iv) the provision to an individual in relation to individual health insurance coverage of management, operations, and investment activities of a health insurance issuer; and

“(v) the provision to an individual in relation to individual health insurance coverage of loss control and claims administration for a health insurance issuer with respect to liability for which the issuer provides insurance.

“(B) EXCEPTION.—Such term does not include any law, rule, regulation, agreement, or order governing the use of care or cost management techniques, including any requirement related to provider contracting, network access or
adequacy, health care data collection, or quality assurance.

“(8) **State.**—The term ‘State’ means the 50 States and includes the District of Columbia, Puerto Rico, the Virgin Islands, Guam, American Samoa, and the Northern Mariana Islands.

“(9) **Unfair claims settlement practices.**—The term ‘unfair claims settlement practices’ means only the following practices:

“(A) Knowingly misrepresenting to claimants and insured individuals relevant facts or policy provisions relating to coverage at issue.

“(B) Failing to acknowledge with reasonable promptness pertinent communications with respect to claims arising under policies.

“(C) Failing to adopt and implement reasonable standards for the prompt investigation and settlement of claims arising under policies.

“(D) Failing to effectuate prompt, fair, and equitable settlement of claims submitted in which liability has become reasonably clear.

“(E) Refusing to pay claims without conducting a reasonable investigation.

“(F) Failing to affirm or deny coverage of claims within a reasonable period of time after
having completed an investigation related to those claims.

“(G) A pattern or practice of compelling insured individuals or their beneficiaries to institute suits to recover amounts due under its policies by offering substantially less than the amounts ultimately recovered in suits brought by them.

“(H) A pattern or practice of attempting to settle or settling claims for less than the amount that a reasonable person would believe the insured individual or his or her beneficiary was entitled by reference to written or printed advertising material accompanying or made part of an application.

“(I) Attempting to settle or settling claims on the basis of an application that was materially altered without notice to, or knowledge or consent of, the insured.

“(J) Failing to provide forms necessary to present claims within 15 calendar days of a requests with reasonable explanations regarding their use.
“(K) Attempting to cancel a policy in less
time than that prescribed in the policy or by the
law of the primary State.

“(10) FRAUD AND ABUSE.—The term ‘fraud
and abuse’ means an act or omission committed by
a person who, knowingly and with intent to defraud,
commits, or conceals any material information con-
cerning, one or more of the following:

“(A) Presenting, causing to be presented
or preparing with knowledge or belief that it
will be presented to or by an insurer, a rein-
surer, broker or its agent, false information as
part of, in support of or concerning a fact ma-
terial to one or more of the following:

“(i) An application for the issuance or
renewal of an insurance policy or reinsur-
ance contract.

“(ii) The rating of an insurance policy
or reinsurance contract.

“(iii) A claim for payment or benefit
pursuant to an insurance policy or reinsur-
ance contract.

“(iv) Premiums paid on an insurance
policy or reinsurance contract.
“(v) Payments made in accordance
with the terms of an insurance policy or
reinsurance contract.

“(vi) A document filed with the com-
missioner or the chief insurance regulatory
official of another jurisdiction.

“(vii) The financial condition of an in-
surer or reinsurer.

“(viii) The formation, acquisition,
merger, reconsolidation, dissolution or
withdrawal from one or more lines of in-
surance or reinsurance in all or part of a
State by an insurer or reinsurer.

“(ix) The issuance of written evidence
of insurance.

“(x) The reinstatement of an insur-
ance policy.

“(B) Solicitation or acceptance of new or
renewal insurance risks on behalf of an insurer
reinsurer or other person engaged in the busi-
ness of insurance by a person who knows or
should know that the insurer or other person
responsible for the risk is insolvent at the time
of the transaction.
“(C) Transaction of the business of insurance in violation of laws requiring a license, certificate of authority or other legal authority for the transaction of the business of insurance.

“(D) Attempt to commit, aiding or abetting in the commission of, or conspiracy to commit the acts or omissions specified in this paragraph.

“SEC. 2796. APPLICATION OF LAW.

“(a) IN GENERAL.—The covered laws of the primary State shall apply to individual health insurance coverage offered by a health insurance issuer in the primary State and in any secondary State, but only if the coverage and issuer comply with the conditions of this section with respect to the offering of coverage in any secondary State.

“(b) EXEMPTIONS FROM COVERED LAWS IN A SECONDARY STATE.—Except as provided in this section, a health insurance issuer with respect to its offer, sale, rating (including medical underwriting), renewal, and issuance of individual health insurance coverage in any secondary State is exempt from any covered laws of the secondary State (and any rules, regulations, agreements, or orders sought or issued by such State under or related to such covered laws) to the extent that such laws would—
“(1) make unlawful, or regulate, directly or indirectly, the operation of the health insurance issuer operating in the secondary State, except that any secondary State may require such an issuer—

“(A) to pay, on a nondiscriminatory basis, applicable premium and other taxes (including high risk pool assessments) which are levied on insurers and surplus lines insurers, brokers, or policyholders under the laws of the State;

“(B) to register with and designate the State insurance commissioner as its agent solely for the purpose of receiving service of legal documents or process;

“(C) to submit to an examination of its financial condition by the State insurance commissioner in any State in which the issuer is doing business to determine the issuer’s financial condition, if—

“(i) the State insurance commissioner of the primary State has not done an examination within the period recommended by the National Association of Insurance Commissioners; and

“(ii) any such examination is conducted in accordance with the examiners’
handbook of the National Association of
Insurance Commissioners and is coordi-
nated to avoid unjustified duplication and
unjustified repetition;
“(D) to comply with a lawful order
issued—
“(i) in a delinquency proceeding com-
menced by the State insurance commis-
sioner if there has been a finding of finan-
cial impairment under subparagraph (C);
or
“(ii) in a voluntary dissolution pro-
ceeding;
“(E) to comply with an injunction issued
by a court of competent jurisdiction, upon a pe-
tition by the State insurance commissioner al-
leging that the issuer is in hazardous financial
condition;
“(F) to participate, on a nondiscriminatory
basis, in any insurance insolvency guaranty as-
sociation or similar association to which a
health insurance issuer in the State is required
to belong;
“(G) to comply with any State law regard-
ing fraud and abuse (as defined in section
2795(10)), except that if the State seeks an injunction regarding the conduct described in this subparagraph, such injunction must be obtained from a court of competent jurisdiction;

“(H) to comply with any State law regarding unfair claims settlement practices (as defined in section 2795(9)); or

“(I) to comply with the applicable requirements for independent review under section 2798 with respect to coverage offered in the State;

“(2) require any individual health insurance coverage issued by the issuer to be countersigned by an insurance agent or broker residing in that Secondary State; or

“(3) otherwise discriminate against the issuer issuing insurance in both the primary State and in any secondary State.

“(c) CLEAR AND CONSPICUOUS DISCLOSURE.—A health insurance issuer shall provide the following notice, in 12-point bold type, in any insurance coverage offered in a secondary State under this part by such a health insurance issuer and at renewal of the policy, with the blank spaces therein being appropriately filled with the name of the health insurance issuer, the name of primary
State, the name of the secondary State, the name of the secondary State, and the name of the secondary State, respectively, for the coverage concerned:

“Notice

“This policy is issued by ________ and is governed by the laws and regulations of the State of ________, and it has met all the laws of that State as determined by that State's Department of Insurance. This policy may be less expensive than others because it is not subject to all of the insurance laws and regulations of the State of ________, including coverage of some services or benefits mandated by the law of the State of ________. Additionally, this policy is not subject to all of the consumer protection laws or restrictions on rate changes of the State of ________. As with all insurance products, before purchasing this policy, you should carefully review the policy and determine what health care services the policy covers and what benefits it provides, including any exclusions, limitations, or conditions for such services or benefits.”
“(d) Prohibition on Certain Reclassifications and Premium Increases.—

“(1) In general.—For purposes of this section, a health insurance issuer that provides individual health insurance coverage to an individual under this part in a primary or secondary State may not upon renewal—

“(A) move or reclassify the individual insured under the health insurance coverage from the class such individual is in at the time of issue of the contract based on the health-status related factors of the individual; or

“(B) increase the premiums assessed the individual for such coverage based on a health status-related factor or change of a health status-related factor or the past or prospective claim experience of the insured individual.

“(2) Construction.—Nothing in paragraph (1) shall be construed to prohibit a health insurance issuer—

“(A) from terminating or discontinuing coverage or a class of coverage in accordance with subsections (b) and (e) of section 2742;
“(B) from raising premium rates for all policy holders within a class based on claims experience;

“(C) from changing premiums or offering discounted premiums to individuals who engage in wellness activities at intervals prescribed by the issuer, if such premium changes or incentives—

“(i) are disclosed to the consumer in the insurance contract;

“(ii) are based on specific wellness activities that are not applicable to all individuals; and

“(iii) are not obtainable by all individuals to whom coverage is offered;

“(D) from reinstating lapsed coverage; or

“(E) from retroactively adjusting the rates charged an insured individual if the initial rates were set based on material misrepresentation by the individual at the time of issue.

“(e) PRIOR OFFERING OF POLICY IN PRIMARY STATE.—A health insurance issuer may not offer for sale individual health insurance coverage in a secondary State unless that coverage is currently offered for sale in the primary State.
“(f) Licensing of Agents or Brokers for Health Insurance Issuers.—Any State may require that a person acting, or offering to act, as an agent or broker for a health insurance issuer with respect to the offering of individual health insurance coverage obtain a license from that State, with commissions or other compensation subject to the provisions of the laws of that State, except that a State may not impose any qualification or requirement which discriminates against a non-resident agent or broker.

“(g) Documents for Submission to State Insurance Commissioner.—Each health insurance issuer issuing individual health insurance coverage in both primary and secondary States shall submit—

“(1) to the insurance commissioner of each State in which it intends to offer such coverage, before it may offer individual health insurance coverage in such State—

“(A) a copy of the plan of operation or feasibility study or any similar statement of the policy being offered and its coverage (which shall include the name of its primary State and its principal place of business);

“(B) written notice of any change in its designation of its primary State; and
“(C) written notice from the issuer of the
issuer’s compliance with all the laws of the pri-
mary State; and
“(2) to the insurance commissioner of each sec-
ondary State in which it offers individual health in-
surance coverage, a copy of the issuer’s quarterly fi-
nancial statement submitted to the primary State,
which statement shall be certified by an independent
public accountant and contain a statement of opin-
ion on loss and loss adjustment expense reserves
made by—
“(A) a member of the American Academy
of Actuaries; or
“(B) a qualified loss reserve specialist.
“(h) POWER OF COURTS TO ENJOIN CONDUCT.—
Nothing in this section shall be construed to affect the
authority of any Federal or State court to enjoin—
“(1) the solicitation or sale of individual health
insurance coverage by a health insurance issuer to
any person or group who is not eligible for such in-
surance; or
“(2) the solicitation or sale of individual health
insurance coverage that violates the requirements of
the law of a secondary State which are described in
subparagraphs (A) through (H) of section 2796(b)(1).

“(i) Power of Secondary States To Take Administrative Action.—Nothing in this section shall be construed to affect the authority of any State to enjoin conduct in violation of that State’s laws described in section 2796(b)(1).

“(j) State Powers To Enforce State Laws.—

“(1) In general.—Subject to the provisions of subsection (b)(1)(G) (relating to injunctions) and paragraph (2), nothing in this section shall be construed to affect the authority of any State to make use of any of its powers to enforce the laws of such State with respect to which a health insurance issuer is not exempt under subsection (b).

“(2) Courts of Competent Jurisdiction.—
If a State seeks an injunction regarding the conduct described in paragraphs (1) and (2) of subsection (h), such injunction must be obtained from a Federal or State court of competent jurisdiction.

“(k) States’ Authority To Sue.—Nothing in this section shall affect the authority of any State to bring action in any Federal or State court.

“(l) Generally Applicable Laws.—Nothing in this section shall be construed to affect the applicability
of State laws generally applicable to persons or corporations.

“(m) GUARANTEED AVAILABILITY OF COVERAGE TO HIPAA ELIGIBLE INDIVIDUALS.—To the extent that a health insurance issuer is offering coverage in a primary State that does not accommodate residents of secondary States or does not provide a working mechanism for residents of a secondary State, and the issuer is offering coverage under this part in such secondary State which has not adopted a qualified high risk pool as its acceptable alternative mechanism (as defined in section 2744(c)(2)), the issuer shall, with respect to any individual health insurance coverage offered in a secondary State under this part, comply with the guaranteed availability requirements for eligible individuals in section 2741.

“SEC. 2797. PRIMARY STATE MUST MEET FEDERAL FLOOR BEFORE ISSUER MAY SELL INTO SECONDARY STATES.

“A health insurance issuer may not offer, sell, or issue individual health insurance coverage in a secondary State if the State insurance commissioner does not use a risk-based capital formula for the determination of capital and surplus requirements for all health insurance issuers.
SEC. 2798. INDEPENDENT EXTERNAL APPEALS PROCEDURES.

(a) Right to External Appeal.—A health insurance issuer may not offer, sell, or issue individual health insurance coverage in a secondary State under the provisions of this title unless—

(1) both the secondary State and the primary State have legislation or regulations in place establishing an independent review process for individuals who are covered by individual health insurance coverage, or

(2) in any case in which the requirements of subparagraph (A) are not met with respect to the either of such States, the issuer provides an independent review mechanism substantially identical (as determined by the applicable State authority of such State) to that prescribed in the ‘Health Carrier External Review Model Act’ of the National Association of Insurance Commissioners for all individuals who purchase insurance coverage under the terms of this part, except that, under such mechanism, the review is conducted by an independent medical reviewer, or a panel of such reviewers, with respect to whom the requirements of subsection (b) are met.
“(b) Qualifications of Independent Medical Reviewers.—In the case of any independent review mechanism referred to in subsection (a)(2)—

“(1) In general.—In referring a denial of a claim to an independent medical reviewer, or to any panel of such reviewers, to conduct independent medical review, the issuer shall ensure that—

“(A) each independent medical reviewer meets the qualifications described in paragraphs (2) and (3);

“(B) with respect to each review, each reviewer meets the requirements of paragraph (4) and the reviewer, or at least 1 reviewer on the panel, meets the requirements described in paragraph (5); and

“(C) compensation provided by the issuer to each reviewer is consistent with paragraph (6).

“(2) Licensure and expertise.—Each independent medical reviewer shall be a physician (allopathic or osteopathic) or health care professional who—

“(A) is appropriately credentialed or licensed in 1 or more States to deliver health care services; and
“(B) typically treats the condition, makes
the diagnosis, or provides the type of treatment
under review.

“(3) INDEPENDENCE.—

“(A) IN GENERAL.—Subject to subpara-
graph (B), each independent medical reviewer
in a case shall—

“(i) not be a related party (as defined
in paragraph (7));

“(ii) not have a material familial, fi-
nancial, or professional relationship with
such a party; and

“(iii) not otherwise have a conflict of
interest with such a party (as determined
under regulations).

“(B) EXCEPTION.—Nothing in subpara-
graph (A) shall be construed to—

“(i) prohibit an individual, solely on
the basis of affiliation with the issuer,
from serving as an independent medical re-
viewer if—

“(I) a non-affiliated individual is
not reasonably available;
“(II) the affiliated individual is not involved in the provision of items or services in the case under review;

“(III) the fact of such an affiliation is disclosed to the issuer and the enrollee (or authorized representative) and neither party objects; and

“(IV) the affiliated individual is not an employee of the issuer and does not provide services exclusively or primarily to or on behalf of the issuer;

“(ii) prohibit an individual who has staff privileges at the institution where the treatment involved takes place from serving as an independent medical reviewer merely on the basis of such affiliation if the affiliation is disclosed to the issuer and the enrollee (or authorized representative), and neither party objects; or

“(iii) prohibit receipt of compensation by an independent medical reviewer from an entity if the compensation is provided consistent with paragraph (6).

“(4) PRACTICING HEALTH CARE PROFESSIONAL IN SAME FIELD.—
“(A) IN GENERAL.—In a case involving

treatment, or the provision of items or serv-

ces—

“(i) by a physician, a reviewer shall be

a practicing physician (allopathic or osteo-

pathic) of the same or similar specialty, as

a physician who, acting within the appro-

priate scope of practice within the State in

which the service is provided or rendered,

typically treats the condition, makes the

diagnosis, or provides the type of treat-

ment under review; or

“(ii) by a non-physician health care

professional, the reviewer, or at least 1

member of the review panel, shall be a

practicing non-physician health care pro-

fessional of the same or similar specialty

as the non-physician health care profes-

sional who, acting within the appropriate

scope of practice within the State in which

the service is provided or rendered, typi-

cally treats the condition, makes the diag-

nosis, or provides the type of treatment

under review.
“(B) Practicing defined.—For purposes of this paragraph, the term ‘practicing’ means, with respect to an individual who is a physician or other health care professional, that the individual provides health care services to individual patients on average at least 2 days per week.

“(5) Pediatric expertise.—In the case of an external review relating to a child, a reviewer shall have expertise under paragraph (2) in pediatrics.

“(6) Limitations on reviewer compensation.—Compensation provided by the issuer to an independent medical reviewer in connection with a review under this section shall—

“(A) not exceed a reasonable level; and

“(B) not be contingent on the decision rendered by the reviewer.

“(7) Related party defined.—For purposes of this section, the term ‘related party’ means, with respect to a denial of a claim under a coverage relating to an enrollee, any of the following:

“(A) The issuer involved, or any fiduciary, officer, director, or employee of the issuer.

“(B) The enrollee (or authorized representative).
“(C) The health care professional that provides the items or services involved in the denial.

“(D) The institution at which the items or services (or treatment) involved in the denial are provided.

“(E) The manufacturer of any drug or other item that is included in the items or services involved in the denial.

“(F) Any other party determined under any regulations to have a substantial interest in the denial involved.

“(8) DEFINITIONS.—For purposes of this subsection:

“(A) ENROLLEE.—The term ‘enrollee’ means, with respect to health insurance coverage offered by a health insurance issuer, an individual enrolled with the issuer to receive such coverage.

“(B) HEALTH CARE PROFESSIONAL.—The term ‘health care professional’ means an individual who is licensed, accredited, or certified under State law to provide specified health care services and who is operating within the scope of such licensure, accreditation, or certification.
“SEC. 2799. ENFORCEMENT.

“(a) IN GENERAL.—Subject to subsection (b), with respect to specific individual health insurance coverage the primary State for such coverage has sole jurisdiction to enforce the primary State’s covered laws in the primary State and any secondary State.

“(b) SECONDARY STATE’S AUTHORITY.—Nothing in subsection (a) shall be construed to affect the authority of a secondary State to enforce its laws as set forth in the exception specified in section 2796(b)(1).

“(c) COURT INTERPRETATION.—In reviewing action initiated by the applicable secondary State authority, the court of competent jurisdiction shall apply the covered laws of the primary State.

“(d) NOTICE OF COMPLIANCE FAILURE.—In the case of individual health insurance coverage offered in a secondary State that fails to comply with the covered laws of the primary State, the applicable State authority of the secondary State may notify the applicable State authority of the primary State.”.

(b) EFFECTIVE DATE.—The amendment made by subsection (a) shall apply to individual health insurance coverage offered, issued, or sold after the date that is one year after the date of the enactment of this Act.

(e) GAO ONGOING STUDY AND REPORTS.—
(1) STUDY.—The Comptroller General of the United States shall conduct an ongoing study concerning the effect of the amendment made by subsection (a) on—

(A) the number of uninsured and under-insured;

(B) the availability and cost of health insurance policies for individuals with pre-existing medical conditions;

(C) the availability and cost of health insurance policies generally;

(D) the elimination or reduction of different types of benefits under health insurance policies offered in different States; and

(E) cases of fraud or abuse relating to health insurance coverage offered under such amendment and the resolution of such cases.

(2) ANNUAL REPORTS.—The Comptroller General shall submit to Congress an annual report, after the end of each of the 5 years following the effective date of the amendment made by subsection (a), on the ongoing study conducted under paragraph (1).

(d) SEVERABILITY.—If any provision of this subtitle or the application of such provision to any person or circumstance is held to be unconstitutional, the remainder
of this subtitle and the application of the provisions of such to any other person or circumstance shall not be af-

affected.

SEC. 132. SMALL BUSINESS HEALTH FAIRNESS.

(a) Rules Governing Association Health Plans.—

(1) In General.—Subtitle B of title I of the Employee Retirement Income Security Act of 1974 is amended by adding after part 7 the following new part:

“PART 8—RULES GOVERNING ASSOCIATION HEALTH PLANS

“SEC. 801. ASSOCIATION HEALTH PLANS.

“(a) In General.—For purposes of this part, the term ‘association health plan’ means a group health plan whose sponsor is (or is deemed under this part to be) de-
scribed in subsection (b).

“(b) Sponsorship.—The sponsor of a group health plan is described in this subsection if such sponsor—

“(1) is organized and maintained in good faith, with a constitution and bylaws specifically stating its purpose and providing for periodic meetings on at least an annual basis, as a bona fide trade associa-
tion, a bona fide industry association (including a rural electric cooperative association or a rural tele-
phone cooperative association), a bona fide professional association, or a bona fide chamber of commerce (or similar bona fide business association, including a corporation or similar organization that operates on a cooperative basis (within the meaning of section 1381 of the Internal Revenue Code of 1986)), for substantial purposes other than that of obtaining or providing medical care;

“(2) is established as a permanent entity which receives the active support of its members and requires for membership payment on a periodic basis of dues or payments necessary to maintain eligibility for membership in the sponsor; and

“(3) does not condition membership, such dues or payments, or coverage under the plan on the basis of health status-related factors with respect to the employees of its members (or affiliated members), or the dependents of such employees, and does not condition such dues or payments on the basis of group health plan participation.

Any sponsor consisting of an association of entities which meet the requirements of paragraphs (1), (2), and (3) shall be deemed to be a sponsor described in this subsection.
“SEC. 802. CERTIFICATION OF ASSOCIATION HEALTH PLANS.

“(a) In General.—The applicable authority shall prescribe by regulation a procedure under which, subject to subsection (b), the applicable authority shall certify association health plans which apply for certification as meeting the requirements of this part.

“(b) Standards.—Under the procedure prescribed pursuant to subsection (a), in the case of an association health plan that provides at least one benefit option which does not consist of health insurance coverage, the applicable authority shall certify such plan as meeting the requirements of this part only if the applicable authority is satisfied that the applicable requirements of this part are met (or, upon the date on which the plan is to commence operations, will be met) with respect to the plan.

“(c) Requirements Applicable to Certified Plans.—An association health plan with respect to which certification under this part is in effect shall meet the applicable requirements of this part, effective on the date of certification (or, if later, on the date on which the plan is to commence operations).

“(d) Requirements for Continued Certification.—The applicable authority may provide by regulation for continued certification of association health plans under this part.
“(e) Class Certification for Fully Insured Plans.—The applicable authority shall establish a class certification procedure for association health plans under which all benefits consist of health insurance coverage. Under such procedure, the applicable authority shall provide for the granting of certification under this part to the plans in each class of such association health plans upon appropriate filing under such procedure in connection with plans in such class and payment of the prescribed fee under section 807(a).

“(f) Certification of Self-Insured Association Health Plans.—An association health plan which offers one or more benefit options which do not consist of health insurance coverage may be certified under this part only if such plan consists of any of the following:

“(1) a plan which offered such coverage on the date of the enactment of this part,

“(2) a plan under which the sponsor does not restrict membership to one or more trades and businesses or industries and whose eligible participating employers represent a broad cross-section of trades and businesses or industries, or

“(3) a plan whose eligible participating employers represent one or more trades or businesses, or one or more industries, consisting of any of the fol-
lowing: agriculture; equipment and automobile dealerships; barbering and cosmetology; certified public accounting practices; child care; construction; dance, theatrical and orchestra productions; disinfecting and pest control; financial services; fishing; food service establishments; hospitals; labor organizations; logging; manufacturing (metals); mining; medical and dental practices; medical laboratories; professional consulting services; sanitary services; transportation (local and freight); warehousing; wholesaling/distributing; or any other trade or business or industry which has been indicated as having average or above-average risk or health claims experience by reason of State rate filings, denials of coverage, proposed premium rate levels, or other means demonstrated by such plan in accordance with regulations.

“SEC. 803. REQUIREMENTS RELATING TO SPONSORS AND BOARDS OF TRUSTEES.

“(a) SPONSOR.—The requirements of this subsection are met with respect to an association health plan if the sponsor has met (or is deemed under this part to have met) the requirements of section 801(b) for a continuous period of not less than 3 years ending with the date of the application for certification under this part.
“(b) BOARD OF TRUSTEES.—The requirements of this subsection are met with respect to an association health plan if the following requirements are met:

“(1) Fiscal control.—The plan is operated, pursuant to a trust agreement, by a board of trustees which has complete fiscal control over the plan and which is responsible for all operations of the plan.

“(2) Rules of operation and financial controls.—The board of trustees has in effect rules of operation and financial controls, based on a 3-year plan of operation, adequate to carry out the terms of the plan and to meet all requirements of this title applicable to the plan.

“(3) Rules governing relationship to participating employers and to contractors.—

“(A) Board membership.—

“(i) In general.—Except as provided in clauses (ii) and (iii), the members of the board of trustees are individuals selected from individuals who are the owners, officers, directors, or employees of the participating employers or who are partners in
the participating employers and actively participate in the business.

“(ii) Limitation.—

“(I) General rule.—Except as provided in subclauses (II) and (III), no such member is an owner, officer, director, or employee of, or partner in, a contract administrator or other service provider to the plan.

“(II) Limited exception for providers of services solely on behalf of the sponsor.—Officers or employees of a sponsor which is a service provider (other than a contract administrator) to the plan may be members of the board if they constitute not more than 25 percent of the membership of the board and they do not provide services to the plan other than on behalf of the sponsor.

“(III) Treatment of providers of medical care.—In the case of a sponsor which is an association whose membership consists primarily of providers of medical care,
subclause (I) shall not apply in the
case of any service provider described
in subclause (I) who is a provider of
medical care under the plan.

“(iii) CERTAIN PLANS EXCLUDED.—
Clause (i) shall not apply to an association
health plan which is in existence on the
date of the enactment of this part.

“(B) SOLE AUTHORITY.—The board has
sole authority under the plan to approve appli-
cations for participation in the plan and to con-
tract with a service provider to administer the
day-to-day affairs of the plan.

“(c) TREATMENT OF FRANCHISE NETWORKS.—In
the case of a group health plan which is established and
maintained by a franchiser for a franchise network con-
sisting of its franchisees—

“(1) the requirements of subsection (a) and sec-
tion 801(a) shall be deemed met if such require-
ments would otherwise be met if the franchiser were
deemed to be the sponsor referred to in section
801(b), such network were deemed to be an associ-
ation described in section 801(b), and each franchisee
were deemed to be a member (of the association and
the sponsor) referred to in section 801(b); and
“(2) the requirements of section 804(a)(1) shall be deemed met.

The Secretary may by regulation define for purposes of this subsection the terms ‘franchiser’, ‘franchise network’, and ‘franchisee’.

“SEC. 804. PARTICIPATION AND COVERAGE REQUIREMENTS.

“(a) COVERED EMPLOYERS AND INDIVIDUALS.—The requirements of this subsection are met with respect to an association health plan if, under the terms of the plan—

“(1) each participating employer must be—

“(A) a member of the sponsor,

“(B) the sponsor, or

“(C) an affiliated member of the sponsor with respect to which the requirements of subsection (b) are met,

except that, in the case of a sponsor which is a professional association or other individual-based association, if at least one of the officers, directors, or employees of an employer, or at least one of the individuals who are partners in an employer and who actively participates in the business, is a member or such an affiliated member of the sponsor, partici-
participating employers may also include such employer; and

“(2) all individuals commencing coverage under the plan after certification under this part must be—

“(A) active or retired owners (including self-employed individuals), officers, directors, or employees of, or partners in, participating employers; or

“(B) the beneficiaries of individuals described in subparagraph (A).

“(b) COVERAGE OF PREVIOUSLY UNINSURED EMPLOYEES.—In the case of an association health plan in existence on the date of the enactment of this part, an affiliated member of the sponsor of the plan may be offered coverage under the plan as a participating employer only if—

“(1) the affiliated member was an affiliated member on the date of certification under this part; or

“(2) during the 12-month period preceding the date of the offering of such coverage, the affiliated member has not maintained or contributed to a group health plan with respect to any of its employ-
ees who would otherwise be eligible to participate in
such association health plan.

“(c) Individual Market Unaffected.—The re-
quirements of this subsection are met with respect to an
association health plan if, under the terms of the plan,
no participating employer may provide health insurance
coverage in the individual market for any employee not
covered under the plan which is similar to the coverage
contemporaneously provided to employees of the employer
under the plan, if such exclusion of the employee from cov-
erage under the plan is based on a health status-related
factor with respect to the employee and such employee
would, but for such exclusion on such basis, be eligible
for coverage under the plan.

“(d) Prohibition of Discrimination Against
Employers and Employees Eligible To Particip-
pate.—The requirements of this subsection are met with
respect to an association health plan if—

“(1) under the terms of the plan, all employers
meeting the preceding requirements of this section
are eligible to qualify as participating employers for
all geographically available coverage options, unless,
in the case of any such employer, participation or
contribution requirements of the type referred to in
section 2711 of the Public Health Service Act are not met;

“(2) upon request, any employer eligible to participate is furnished information regarding all coverage options available under the plan; and

“(3) the applicable requirements of sections 701, 702, and 703 are met with respect to the plan.

“SEC. 805. OTHER REQUIREMENTS RELATING TO PLAN DOCUMENTS, CONTRIBUTION RATES, AND BENEFIT OPTIONS.

“(a) IN GENERAL.—The requirements of this section are met with respect to an association health plan if the following requirements are met:

“(1) CONTENTS OF GOVERNING INSTRUMENTS.—The instruments governing the plan include a written instrument, meeting the requirements of an instrument required under section 402(a)(1), which—

“(A) provides that the board of trustees serves as the named fiduciary required for plans under section 402(a)(1) and serves in the capacity of a plan administrator (referred to in section 3(16)(A));
“(B) provides that the sponsor of the plan is to serve as plan sponsor (referred to in section 3(16)(B)); and

“(C) incorporates the requirements of section 806.

“(2) Contribution rates must be nondiscriminatory.—

“(A) The contribution rates for any participating small employer do not vary on the basis of any health status-related factor in relation to employees of such employer or their beneficiaries and do not vary on the basis of the type of business or industry in which such employer is engaged.

“(B) Nothing in this title or any other provision of law shall be construed to preclude an association health plan, or a health insurance issuer offering health insurance coverage in connection with an association health plan, from—

“(i) setting contribution rates based on the claims experience of the plan; or

“(ii) varying contribution rates for small employers in a State to the extent that such rates could vary using the same
methodology employed in such State for regulating premium rates in the small group market with respect to health insurance coverage offered in connection with bona fide associations (within the meaning of section 2791(d)(3) of the Public Health Service Act),

subject to the requirements of section 702(b) relating to contribution rates.

“(3) Floor for number of covered individuals with respect to certain plans.—If any benefit option under the plan does not consist of health insurance coverage, the plan has as of the beginning of the plan year not fewer than 1,000 participants and beneficiaries.

“(4) Marketing requirements.—

“(A) In general.—If a benefit option which consists of health insurance coverage is offered under the plan, State-licensed insurance agents shall be used to distribute to small employers coverage which does not consist of health insurance coverage in a manner comparable to the manner in which such agents are used to distribute health insurance coverage.
“(B) State-licensed insurance agents.—For purposes of subparagraph (A), the term ‘State-licensed insurance agents’ means one or more agents who are licensed in a State and are subject to the laws of such State relating to licensure, qualification, testing, examination, and continuing education of persons authorized to offer, sell, or solicit health insurance coverage in such State.

“(5) Regulatory requirements.—Such other requirements as the applicable authority determines are necessary to carry out the purposes of this part, which shall be prescribed by the applicable authority by regulation.

“(b) Ability of association health plans to design benefit options.—Subject to section 514(d), nothing in this part or any provision of State law (as defined in section 514(c)(1)) shall be construed to preclude an association health plan, or a health insurance issuer offering health insurance coverage in connection with an association health plan, from exercising its sole discretion in selecting the specific items and services consisting of medical care to be included as benefits under such plan or coverage, except (subject to section 514) in the case of (1) any law to the extent that it is not preempted under
section 731(a)(1) with respect to matters governed by sec-
tion 711, 712, or 713, or (2) any law of the State with
which filing and approval of a policy type offered by the
plan was initially obtained to the extent that such law pro-
hibits an exclusion of a specific disease from such cov-
erage.

“SEC. 806. MAINTENANCE OF RESERVES AND PROVISIONS
FOR SOLVENCY FOR PLANS PROVIDING
HEALTH BENEFITS IN ADDITION TO HEALTH
INSURANCE COVERAGE.

“(a) IN GENERAL.—The requirements of this section
are met with respect to an association health plan if—
“(1) the benefits under the plan consist solely
of health insurance coverage; or
“(2) if the plan provides any additional benefit
options which do not consist of health insurance cov-
erage, the plan—
“(A) establishes and maintains reserves
with respect to such additional benefit options,
in amounts recommended by the qualified actu-
ary, consisting of—
“(i) a reserve sufficient for unearned
contributions;
“(ii) a reserve sufficient for benefit li-
abilities which have been incurred, which
have not been satisfied, and for which risk of loss has not yet been transferred, and for expected administrative costs with respect to such benefit liabilities;

“(iii) a reserve sufficient for any other obligations of the plan; and

“(iv) a reserve sufficient for a margin of error and other fluctuations, taking into account the specific circumstances of the plan; and

“(B) establishes and maintains aggregate and specific excess/stop loss insurance and solvency indemnification, with respect to such additional benefit options for which risk of loss has not yet been transferred, as follows:

“(i) The plan shall secure aggregate excess/stop loss insurance for the plan with an attachment point which is not greater than 125 percent of expected gross annual claims. The applicable authority may by regulation provide for upward adjustments in the amount of such percentage in specified circumstances in which the plan specifically provides for and maintains re-
serves in excess of the amounts required under subparagraph (A).

“(ii) The plan shall secure specific excess/stop loss insurance for the plan with an attachment point which is at least equal to an amount recommended by the plan’s qualified actuary. The applicable authority may by regulation provide for adjustments in the amount of such insurance in specified circumstances in which the plan specifically provides for and maintains reserves in excess of the amounts required under subparagraph (A).

“(iii) The plan shall secure indemnification insurance for any claims which the plan is unable to satisfy by reason of a plan termination.

Any person issuing to a plan insurance described in clause (i), (ii), or (iii) of subparagraph (B) shall notify the Secretary of any failure of premium payment meriting cancellation of the policy prior to undertaking such a cancellation. Any regulations prescribed by the applicable authority pursuant to clause (i) or (ii) of subparagraph (B) may allow for such adjustments in the required levels of excess/stop loss insurance as the qualified actuary may rec-
ommend, taking into account the specific circumstances
of the plan.

“(b) Minimum Surplus in Addition to Claims
Reserves.—In the case of any association health plan de-
scribed in subsection (a)(2), the requirements of this sub-
section are met if the plan establishes and maintains sur-
plus in an amount at least equal to—

“(1) $500,000, or

“(2) such greater amount (but not greater than
$2,000,000) as may be set forth in regulations pre-
scribed by the applicable authority, considering the
level of aggregate and specific excess/stop loss insur-
ance provided with respect to such plan and other
factors related to solvency risk, such as the plan’s
projected levels of participation or claims, the nature
of the plan’s liabilities, and the types of assets avail-
able to assure that such liabilities are met.

“(c) Additional Requirements.—In the case of
any association health plan described in subsection (a)(2),
the applicable authority may provide such additional re-
quirements relating to reserves, excess/stop loss insurance,
and indemnification insurance as the applicable authority
considers appropriate. Such requirements may be provided
by regulation with respect to any such plan or any class
of such plans.
“(d) Adjustments for Excess/Stop Loss Insurance.—The applicable authority may provide for adjustments to the levels of reserves otherwise required under subsections (a) and (b) with respect to any plan or class of plans to take into account excess/stop loss insurance provided with respect to such plan or plans.

“(e) Alternative Means of Compliance.—The applicable authority may permit an association health plan described in subsection (a)(2) to substitute, for all or part of the requirements of this section (except subsection (a)(2)(B)(iii)), such security, guarantee, hold-harmless arrangement, or other financial arrangement as the applicable authority determines to be adequate to enable the plan to fully meet all its financial obligations on a timely basis and is otherwise no less protective of the interests of participants and beneficiaries than the requirements for which it is substituted. The applicable authority may take into account, for purposes of this subsection, evidence provided by the plan or sponsor which demonstrates an assumption of liability with respect to the plan. Such evidence may be in the form of a contract of indemnification, lien, bonding, insurance, letter of credit, recourse under applicable terms of the plan in the form of assessments of participating employers, security, or other financial arrangement.
“(f) Measures To Ensure Continued Payment of Benefits by Certain Plans in Distress.—

“(1) Payments by certain plans to association health plan fund.—

“(A) In general.—In the case of an association health plan described in subsection (a)(2), the requirements of this subsection are met if the plan makes payments into the Association Health Plan Fund under this subparagraph when they are due. Such payments shall consist of annual payments in the amount of $5,000, and, in addition to such annual payments, such supplemental payments as the Secretary may determine to be necessary under paragraph (2). Payments under this paragraph are payable to the Fund at the time determined by the Secretary. Initial payments are due in advance of certification under this part. Payments shall continue to accrue until a plan’s assets are distributed pursuant to a termination procedure.

“(B) Penalties for failure to make payments.—If any payment is not made by a plan when it is due, a late payment charge of not more than 100 percent of the payment
which was not timely paid shall be payable by
the plan to the Fund.

“(C) CONTINUED DUTY OF THE SEC-
RETARY.—The Secretary shall not cease to
carry out the provisions of paragraph (2) on ac-
count of the failure of a plan to pay any pay-
ment when due.

“(2) PAYMENTS BY SECRETARY TO CONTINUE
EXCESS/STOP LOSS INSURANCE COVERAGE AND IN-
DEMNIFICATION INSURANCE COVERAGE FOR CER-
TAIN PLANS.—In any case in which the applicable
authority determines that there is, or that there is
reason to believe that there will be: (A) a failure to
take necessary corrective actions under section
809(a) with respect to an association health plan de-
scribed in subsection (a)(2); or (B) a termination of
such a plan under section 809(b) or 810(b)(8) (and,
if the applicable authority is not the Secretary, cer-
tifies such determination to the Secretary), the Sec-
retary shall determine the amounts necessary to
make payments to an insurer (designated by the
Secretary) to maintain in force excess/stop loss in-
surance coverage or indemnification insurance cov-
erage for such plan, if the Secretary determines that
there is a reasonable expectation that, without such
payments, claims would not be satisfied by reason of termination of such coverage. The Secretary shall, to the extent provided in advance in appropriation Acts, pay such amounts so determined to the insurer designated by the Secretary.

“(3) ASSOCIATION HEALTH PLAN FUND.—

“(A) In general.—There is established on the books of the Treasury a fund to be known as the ‘Association Health Plan Fund’. The Fund shall be available for making payments pursuant to paragraph (2). The Fund shall be credited with payments received pursuant to paragraph (1)(A), penalties received pursuant to paragraph (1)(B); and earnings on investments of amounts of the Fund under subparagraph (B).

“(B) Investment.—Whenever the Secretary determines that the moneys of the fund are in excess of current needs, the Secretary may request the investment of such amounts as the Secretary determines advisable by the Secretary of the Treasury in obligations issued or guaranteed by the United States.

“(g) Excess/Stop Loss Insurance.—For purposes of this section—
“(1) AGGREGATE EXCESS/STOP LOSS INSURANCE.—The term ‘aggregate excess/stop loss insurance’ means, in connection with an association health plan, a contract—

“(A) under which an insurer (meeting such minimum standards as the applicable authority may prescribe by regulation) provides for payment to the plan with respect to aggregate claims under the plan in excess of an amount or amounts specified in such contract;

“(B) which is guaranteed renewable; and

“(C) which allows for payment of premiums by any third party on behalf of the insured plan.

“(2) SPECIFIC EXCESS/STOP LOSS INSURANCE.—The term ‘specific excess/stop loss insurance’ means, in connection with an association health plan, a contract—

“(A) under which an insurer (meeting such minimum standards as the applicable authority may prescribe by regulation) provides for payment to the plan with respect to claims under the plan in connection with a covered individual in excess of an amount or amounts specified in
such contract in connection with such covered
individual;
  “(B) which is guaranteed renewable; and
  “(C) which allows for payment of pre-
  miums by any third party on behalf of the in-
  sured plan.

“(h) INDEMNIFICATION INSURANCE.—For purposes
of this section, the term ‘indemnification insurance’
means, in connection with an association health plan, a
contract—

“(1) under which an insurer (meeting such min-
imum standards as the applicable authority may pre-
scribe by regulation) provides for payment to the
plan with respect to claims under the plan which the
plan is unable to satisfy by reason of a termination
pursuant to section 809(b) (relating to mandatory
termination);

“(2) which is guaranteed renewable and
noncancellable for any reason (except as the applica-
ble authority may prescribe by regulation); and

“(3) which allows for payment of premiums by
any third party on behalf of the insured plan.

“(i) RESERVES.—For purposes of this section, the
term ‘reserves’ means, in connection with an association
health plan, plan assets which meet the fiduciary stand-
ards under part 4 and such additional requirements re-
garding liquidity as the applicable authority may prescribe
by regulation.

“(j) SOLVENCY STANDARDS WORKING GROUP.—

“(1) IN GENERAL.—Within 90 days after the
date of the enactment of this part, the applicable au-
thority shall establish a Solvency Standards Working
Group. In prescribing the initial regulations under
this section, the applicable authority shall take into
account the recommendations of such Working
Group.

“(2) MEMBERSHIP.—The Working Group shall
consist of not more than 15 members appointed by
the applicable authority. The applicable authority
shall include among persons invited to membership
on the Working Group at least one of each of the
following:

“(A) a representative of the National Asso-
ciation of Insurance Commissioners;

“(B) a representative of the American
Academy of Actuaries;

“(C) a representative of the State govern-
ments, or their interests;

“(D) a representative of existing self-ins-
sured arrangements, or their interests;
“(E) a representative of associations of the type referred to in section 801(b)(1), or their interests; and

“(F) a representative of multiemployer plans that are group health plans, or their interests.

“SEC. 807. REQUIREMENTS FOR APPLICATION AND RELATED REQUIREMENTS.

“(a) Filing Fee.—Under the procedure prescribed pursuant to section 802(a), an association health plan shall pay to the applicable authority at the time of filing an application for certification under this part a filing fee in the amount of $5,000, which shall be available in the case of the Secretary, to the extent provided in appropriation Acts, for the sole purpose of administering the certification procedures applicable with respect to association health plans.

“(b) Information To Be Included in Application for Certification.—An application for certification under this part meets the requirements of this section only if it includes, in a manner and form which shall be prescribed by the applicable authority by regulation, at least the following information:

“(1) Identifying Information.—The names and addresses of—
“(A) the sponsor; and

“(B) the members of the board of trustees

of the plan.

“(2) STATES IN WHICH PLAN INTENDS TO DO

BUSINESS.—The States in which participants and

beneficiaries under the plan are to be located and

the number of them expected to be located in each

such State.

“(3) BONDING REQUIREMENTS.—Evidence pro-

vided by the board of trustees that the bonding re-

quirements of section 412 will be met as of the date

of the application or (if later) commencement of op-

erations.

“(4) PLAN DOCUMENTS.—A copy of the docu-

ments governing the plan (including any bylaws and

trust agreements), the summary plan description,

and other material describing the benefits that will

be provided to participants and beneficiaries under

the plan.

“(5) AGREEMENTS WITH SERVICE PRO-

VIDERS.—A copy of any agreements between the

plan and contract administrators and other service

providers.

“(6) FUNDING REPORT.—In the case of asso-

ciation health plans providing benefits options in ad-
dition to health insurance coverage, a report setting forth information with respect to such additional benefit options determined as of a date within the 120-day period ending with the date of the application, including the following:

“(A) RESERVES.—A statement, certified by the board of trustees of the plan, and a statement of actuarial opinion, signed by a qualified actuary, that all applicable requirements of section 806 are or will be met in accordance with regulations which the applicable authority shall prescribe.

“(B) ADEQUACY OF CONTRIBUTION RATES.—A statement of actuarial opinion, signed by a qualified actuary, which sets forth a description of the extent to which contribution rates are adequate to provide for the payment of all obligations and the maintenance of required reserves under the plan for the 12-month period beginning with such date within such 120-day period, taking into account the expected coverage and experience of the plan. If the contribution rates are not fully adequate, the statement of actuarial opinion shall indicate
the extent to which the rates are inadequate
and the changes needed to ensure adequacy.

“(C) Current and projected value of
assets and liabilities.—A statement of ac-
tuarial opinion signed by a qualified actuary,
which sets forth the current value of the assets
and liabilities accumulated under the plan and
a projection of the assets, liabilities, income,
and expenses of the plan for the 12-month pe-
riod referred to in subparagraph (B). The in-
come statement shall identify separately the
plan’s administrative expenses and claims.

“(D) Costs of coverage to be
charged and other expenses.—A state-
ment of the costs of coverage to be charged, in-
cluding an itemization of amounts for adminis-
tration, reserves, and other expenses associated
with the operation of the plan.

“(E) Other information.—Any other
information as may be determined by the appli-
cable authority, by regulation, as necessary to
carry out the purposes of this part.

“(e) Filing Notice of Certification With
States.—A certification granted under this part to an
association health plan shall not be effective unless written
notice of such certification is filed with the applicable State authority of each State in which at least 25 percent of the participants and beneficiaries under the plan are located. For purposes of this subsection, an individual shall be considered to be located in the State in which a known address of such individual is located or in which such individual is employed.

“(d) Notice of Material Changes.—In the case of any association health plan certified under this part, descriptions of material changes in any information which was required to be submitted with the application for the certification under this part shall be filed in such form and manner as shall be prescribed by the applicable authority by regulation. The applicable authority may require by regulation prior notice of material changes with respect to specified matters which might serve as the basis for suspension or revocation of the certification.

“(e) Reporting Requirements for Certain Association Health Plans.—An association health plan certified under this part which provides benefit options in addition to health insurance coverage for such plan year shall meet the requirements of section 103 by filing an annual report under such section which shall include information described in subsection (b)(6) with respect to the plan year and, notwithstanding section 104(a)(1)(A), shall
be filed with the applicable authority not later than 90
days after the close of the plan year (or on such later date
as may be prescribed by the applicable authority). The ap-
plicable authority may require by regulation such interim
reports as it considers appropriate.

“(f) ENGAGEMENT OF QUALIFIED ACTUARY.—The
board of trustees of each association health plan which
provides benefits options in addition to health insurance
coverage and which is applying for certification under this
part or is certified under this part shall engage, on behalf
of all participants and beneficiaries, a qualified actuary
who shall be responsible for the preparation of the mate-
rials comprising information necessary to be submitted by
a qualified actuary under this part. The qualified actuary
shall utilize such assumptions and techniques as are nec-
essary to enable such actuary to form an opinion as to
whether the contents of the matters reported under this
part—

“(1) are in the aggregate reasonably related to
the experience of the plan and to reasonable expecta-
tions; and

“(2) represent such actuary’s best estimate of
anticipated experience under the plan.

The opinion by the qualified actuary shall be made with
respect to, and shall be made a part of, the annual report.
“SEC. 808. NOTICE REQUIREMENTS FOR VOLUNTARY TERMINATION.

“Except as provided in section 809(b), an association health plan which is or has been certified under this part may terminate (upon or at any time after cessation of accruals in benefit liabilities) only if the board of trustees, not less than 60 days before the proposed termination date—

“(1) provides to the participants and beneficiaries a written notice of intent to terminate stating that such termination is intended and the proposed termination date;

“(2) develops a plan for winding up the affairs of the plan in connection with such termination in a manner which will result in timely payment of all benefits for which the plan is obligated; and

“(3) submits such plan in writing to the applicable authority.

Actions required under this section shall be taken in such form and manner as may be prescribed by the applicable authority by regulation.

“SEC. 809. CORRECTIVE ACTIONS AND MANDATORY TERMINATION.

“(a) ACTIONS TO AVOID DEPLETION OF RESERVES.—An association health plan which is certified under this part and which provides benefits other than
health insurance coverage shall continue to meet the re-
quirements of section 806, irrespective of whether such
certification continues in effect. The board of trustees of
such plan shall determine quarterly whether the require-
ments of section 806 are met. In any case in which the
board determines that there is reason to believe that there
is or will be a failure to meet such requirements, or the
applicable authority makes such a determination and so
notifies the board, the board shall immediately notify the
qualified actuary engaged by the plan, and such actuary
shall, not later than the end of the next following month,
make such recommendations to the board for corrective
action as the actuary determines necessary to ensure com-
pliance with section 806. Not later than 30 days after re-
ceiving from the actuary recommendations for corrective
actions, the board shall notify the applicable authority (in
such form and manner as the applicable authority may
prescribe by regulation) of such recommendations of the
actuary for corrective action, together with a description
of the actions (if any) that the board has taken or plans
to take in response to such recommendations. The board
shall thereafter report to the applicable authority, in such
form and frequency as the applicable authority may speci-
fy to the board, regarding corrective action taken by the
board until the requirements of section 806 are met.
“(b) MANDATORY TERMINATION.—In any case in which—

“(1) the applicable authority has been notified under subsection (a) (or by an issuer of excess/stop loss insurance or indemnity insurance pursuant to section 806(a)) of a failure of an association health plan which is or has been certified under this part and is described in section 806(a)(2) to meet the requirements of section 806 and has not been notified by the board of trustees of the plan that corrective action has restored compliance with such requirements; and

“(2) the applicable authority determines that there is a reasonable expectation that the plan will continue to fail to meet the requirements of section 806,

the board of trustees of the plan shall, at the direction of the applicable authority, terminate the plan and, in the course of the termination, take such actions as the applicable authority may require, including satisfying any claims referred to in section 806(a)(2)(B)(iii) and recovering for the plan any liability under subsection (a)(2)(B)(iii) or (e) of section 806, as necessary to ensure that the affairs of the plan will be, to the maximum extent
possible, wound up in a manner which will result in timely
provision of all benefits for which the plan is obligated.

“SEC. 810. TRUSTEESHIP BY THE SECRETARY OF INSOL-
VENT ASSOCIATION HEALTH PLANS PROVIDING HEALTH BENEFITS IN ADDITION TO
HEALTH INSURANCE COVERAGE.

“(a) APPOINTMENT OF SECRETARY AS TRUSTEE FOR
INSOLVENT PLANS.—Whenever the Secretary determines
that an association health plan which is or has been cer-
tified under this part and which is described in section
806(a)(2) will be unable to provide benefits when due or
is otherwise in a financially hazardous condition, as shall
be defined by the Secretary by regulation, the Secretary
shall, upon notice to the plan, apply to the appropriate
United States district court for appointment of the Sec-
retary as trustee to administer the plan for the duration
of the insolvency. The plan may appear as a party and
other interested persons may intervene in the proceedings
at the discretion of the court. The court shall appoint such
Secretary trustee if the court determines that the trustee-
ship is necessary to protect the interests of the partici-
pants and beneficiaries or providers of medical care or to
avoid any unreasonable deterioration of the financial con-
dition of the plan. The trusteeship of such Secretary shall
continue until the conditions described in the first sen-
tence of this subsection are remedied or the plan is termi-
nated.

“(b) Powers as Trustee.—The Secretary, upon
appointment as trustee under subsection (a), shall have
the power—

“(1) to do any act authorized by the plan, this
title, or other applicable provisions of law to be done
by the plan administrator or any trustee of the plan;

“(2) to require the transfer of all (or any part)
of the assets and records of the plan to the Sec-
retary as trustee;

“(3) to invest any assets of the plan which the
Secretary holds in accordance with the provisions of
the plan, regulations prescribed by the Secretary,
and applicable provisions of law;

“(4) to require the sponsor, the plan adminis-
trator, any participating employer, and any employee
organization representing plan participants to fur-
nish any information with respect to the plan which
the Secretary as trustee may reasonably need in
order to administer the plan;

“(5) to collect for the plan any amounts due the
plan and to recover reasonable expenses of the trust-
eeship;
“(6) to commence, prosecute, or defend on behalf of the plan any suit or proceeding involving the plan;

“(7) to issue, publish, or file such notices, statements, and reports as may be required by the Secretary by regulation or required by any order of the court;

“(8) to terminate the plan (or provide for its termination in accordance with section 809(b)) and liquidate the plan assets, to restore the plan to the responsibility of the sponsor, or to continue the trusteeship;

“(9) to provide for the enrollment of plan participants and beneficiaries under appropriate coverage options; and

“(10) to do such other acts as may be necessary to comply with this title or any order of the court and to protect the interests of plan participants and beneficiaries and providers of medical care.

“(c) NOTICE OF APPOINTMENT.—As soon as practicable after the Secretary's appointment as trustee, the Secretary shall give notice of such appointment to—

“(1) the sponsor and plan administrator;

“(2) each participant;
“(3) each participating employer; and

“(4) if applicable, each employee organization

which, for purposes of collective bargaining, rep-

resents plan participants.

“(d) ADDITIONAL DUTIES.—Except to the extent in-

consistent with the provisions of this title, or as may be

otherwise ordered by the court, the Secretary, upon ap-

pointment as trustee under this section, shall be subject

to the same duties as those of a trustee under section 704

of title 11, United States Code, and shall have the duties

of a fiduciary for purposes of this title.

“(e) OTHER PROCEEDINGS.—An application by the

Secretary under this subsection may be filed notwith-

standing the pendency in the same or any other court of

any bankruptcy, mortgage foreclosure, or equity receiver-

ship proceeding, or any proceeding to reorganize, conserve,

or liquidate such plan or its property, or any proceeding

to enforce a lien against property of the plan.

“(f) JURISDICTION OF COURT.—

“(1) IN GENERAL.—Upon the filing of an appli-

cation for the appointment as trustee or the issuance

of a decree under this section, the court to which the

application is made shall have exclusive jurisdiction

of the plan involved and its property wherever lo-

cated with the powers, to the extent consistent with
the purposes of this section, of a court of the United
States having jurisdiction over cases under chapter
11 of title 11, United States Code. Pending an adju-
dication under this section such court shall stay, and
upon appointment by it of the Secretary as trustee,
such court shall continue the stay of, any pending
mortgage foreclosure, equity receivership, or other
proceeding to reorganize, conserve, or liquidate the
plan, the sponsor, or property of such plan or spon-
sor, and any other suit against any receiver, conserv-
vator, or trustee of the plan, the sponsor, or prop-
erty of the plan or sponsor. Pending such adjudica-
tion and upon the appointment by it of the Sec-
retary as trustee, the court may stay any proceeding
to enforce a lien against property of the plan or the
sponsor or any other suit against the plan or the
sponsor.

“(2) VENUE.—An action under this section
may be brought in the judicial district where the
sponsor or the plan administrator resides or does
business or where any asset of the plan is situated.
A district court in which such action is brought may
issue process with respect to such action in any
other judicial district.
“(g) PERSONNEL.—In accordance with regulations which shall be prescribed by the Secretary, the Secretary shall appoint, retain, and compensate accountants, actuaries, and other professional service personnel as may be necessary in connection with the Secretary’s service as trustee under this section.

“SEC. 811. STATE ASSESSMENT AUTHORITY.

“(a) IN GENERAL.—Notwithstanding section 514, a State may impose by law a contribution tax on an association health plan described in section 806(a)(2), if the plan commenced operations in such State after the date of the enactment of this part.

“(b) CONTRIBUTION TAX.—For purposes of this section, the term ‘contribution tax’ imposed by a State on an association health plan means any tax imposed by such State if—

“(1) such tax is computed by applying a rate to the amount of premiums or contributions, with respect to individuals covered under the plan who are residents of such State, which are received by the plan from participating employers located in such State or from such individuals;

“(2) the rate of such tax does not exceed the rate of any tax imposed by such State on premiums or contributions received by insurers or health main-
tenance organizations for health insurance coverage
offered in such State in connection with a group
health plan;

“(3) such tax is otherwise nondiscriminatory; and

“(4) the amount of any such tax assessed on
the plan is reduced by the amount of any tax or as-
assessment otherwise imposed by the State on pre-
miums, contributions, or both received by insurers or
health maintenance organizations for health insur-
ance coverage, aggregate excess/stop loss insurance
(as defined in section 806(g)(1)), specific excess/stop
loss insurance (as defined in section 806(g)(2)),
other insurance related to the provision of medical
care under the plan, or any combination thereof pro-
vided by such insurers or health maintenance organi-
zations in such State in connection with such plan.

“SEC. 812. DEFINITIONS AND RULES OF CONSTRUCTION.

“(a) DEFINITIONS.—For purposes of this part—

“(1) GROUP HEALTH PLAN.—The term ‘group
health plan’ has the meaning provided in section
733(a)(1) (after applying subsection (b) of this sec-
tion).

“(2) MEDICAL CARE.—The term ‘medical care’
has the meaning provided in section 733(a)(2).
“(3) Health insurance coverage.—The term ‘health insurance coverage’ has the meaning provided in section 733(b)(1).

“(4) Health insurance issuer.—The term ‘health insurance issuer’ has the meaning provided in section 733(b)(2).

“(5) Applicable authority.—The term ‘applicable authority’ means the Secretary, except that, in connection with any exercise of the Secretary’s authority regarding which the Secretary is required under section 506(d) to consult with a State, such term means the Secretary, in consultation with such State.

“(6) Health status-related factor.—The term ‘health status-related factor’ has the meaning provided in section 733(d)(2).

“(7) Individual market.—

“(A) In general.—The term ‘individual market’ means the market for health insurance coverage offered to individuals other than in connection with a group health plan.

“(B) Treatment of very small groups.—

“(i) In general.—Subject to clause (ii), such term includes coverage offered in
connection with a group health plan that has fewer than 2 participants as current employees or participants described in section 732(d)(3) on the first day of the plan year.

“(ii) STATE EXCEPTION.—Clause (i) shall not apply in the case of health insurance coverage offered in a State if such State regulates the coverage described in such clause in the same manner and to the same extent as coverage in the small group market (as defined in section 2791(e)(5) of the Public Health Service Act) is regulated by such State.

“(8) PARTICIPATING EMPLOYER.—The term ‘participating employer’ means, in connection with an association health plan, any employer, if any individual who is an employee of such employer, a partner in such employer, or a self-employed individual who is such employer (or any dependent, as defined under the terms of the plan, of such individual) is or was covered under such plan in connection with the status of such individual as such an employee, partner, or self-employed individual in relation to the plan.
“(9) Applicable state authority.—The term ‘applicable State authority’ means, with respect to a health insurance issuer in a State, the State insurance commissioner or official or officials designated by the State to enforce the requirements of title XXVII of the Public Health Service Act for the State involved with respect to such issuer.

“(10) Qualified actuary.—The term ‘qualified actuary’ means an individual who is a member of the American Academy of Actuaries.

“(11) Affiliated member.—The term ‘affiliated member’ means, in connection with a sponsor—

“(A) a person who is otherwise eligible to be a member of the sponsor but who elects an affiliated status with the sponsor,

“(B) in the case of a sponsor with members which consist of associations, a person who is a member of any such association and elects an affiliated status with the sponsor, or

“(C) in the case of an association health plan in existence on the date of the enactment of this part, a person eligible to be a member of the sponsor or one of its member associations.
“(12) LARGE EMPLOYER.—The term ‘large employer’ means, in connection with a group health plan with respect to a plan year, an employer who employed an average of at least 51 employees on business days during the preceding calendar year and who employs at least 2 employees on the first day of the plan year.

“(13) SMALL EMPLOYER.—The term ‘small employer’ means, in connection with a group health plan with respect to a plan year, an employer who is not a large employer.

“(b) RULES OF CONSTRUCTION.—

“(1) EMPLOYERS AND EMPLOYEES.—For purposes of determining whether a plan, fund, or program is an employee welfare benefit plan which is an association health plan, and for purposes of applying this title in connection with such plan, fund, or program so determined to be such an employee welfare benefit plan—

“(A) in the case of a partnership, the term ‘employer’ (as defined in section 3(5)) includes the partnership in relation to the partners, and the term ‘employee’ (as defined in section 3(6)) includes any partner in relation to the partnership; and
“(B) in the case of a self-employed individual, the term ‘employer’ (as defined in section 3(5)) and the term ‘employee’ (as defined in section 3(6)) shall include such individual.

“(2) PLANS, FUNDS, AND PROGRAMS TREATED AS EMPLOYEE WELFARE BENEFIT PLANS.—In the case of any plan, fund, or program which was established or is maintained for the purpose of providing medical care (through the purchase of insurance or otherwise) for employees (or their dependents) covered thereunder and which demonstrates to the Secretary that all requirements for certification under this part would be met with respect to such plan, fund, or program if such plan, fund, or program were a group health plan, such plan, fund, or program shall be treated for purposes of this title as an employee welfare benefit plan on and after the date of such demonstration.”.

(2) CONFORMING AMENDMENTS TO PREEMPTION RULES.—

(A) Section 514(b)(6) of such Act (29 U.S.C. 1144(b)(6)) is amended by adding at the end the following new subparagraph:

“(E) The preceding subparagraphs of this paragraph do not apply with respect to any State law in the case...
of an association health plan which is certified under part 8.”.

(B) Section 514 of such Act (29 U.S.C. 1144) is amended—

(i) in subsection (b)(4), by striking “Subsection (a)” and inserting “Subsections (a) and (d)”; 

(ii) in subsection (b)(5), by striking “subsection (a)” in subparagraph (A) and inserting “subsection (a) of this section and subsections (a)(2)(B) and (b) of section 805”, and by striking “subsection (a)” in subparagraph (B) and inserting “subsection (a) of this section or subsection (a)(2)(B) or (b) of section 805”;

(iii) by redesignating subsection (d) as subsection (e); and

(iv) by inserting after subsection (e) the following new subsection:

“(d)(1) Except as provided in subsection (b)(4), the provisions of this title shall supersede any and all State laws insofar as they may now or hereafter preclude, or have the effect of precluding, a health insurance issuer from offering health insurance coverage in connection with
an association health plan which is certified under part 8.

“(2) Except as provided in paragraphs (4) and (5) of subsection (b) of this section—

“(A) In any case in which health insurance coverage of any policy type is offered under an association health plan certified under part 8 to a participating employer operating in such State, the provisions of this title shall supersede any and all laws of such State insofar as they may preclude a health insurance issuer from offering health insurance coverage of the same policy type to other employers operating in the State which are eligible for coverage under such association health plan, whether or not such other employers are participating employers in such plan.

“(B) In any case in which health insurance coverage of any policy type is offered in a State under an association health plan certified under part 8 and the filing, with the applicable State authority (as defined in section 812(a)(9)), of the policy form in connection with such policy type is approved by such State authority, the provisions of this title shall supersede any and all laws of any other State in which health insurance coverage of such type is offered, in-
sofar as they may preclude, upon the filing in the
same form and manner of such policy form with the
applicable State authority in such other State, the
approval of the filing in such other State.

“(3) Nothing in subsection (b)(6)(E) or the preceding
provisions of this subsection shall be construed, with re-
spect to health insurance issuers or health insurance cov-
erage, to supersede or impair the law of any State—

“(A) providing solvency standards or similar
standards regarding the adequacy of insurer capital,
surplus, reserves, or contributions, or

“(B) relating to prompt payment of claims.

“(4) For additional provisions relating to association
health plans, see subsections (a)(2)(B) and (b) of section
805.

“(5) For purposes of this subsection, the term ‘asso-
ciation health plan’ has the meaning provided in section
801(a), and the terms ‘health insurance coverage’, ‘par-
ticipating employer’, and ‘health insurance issuer’ have
the meanings provided such terms in section 812, respec-
tively.’’.

(C) Section 514(b)(6)(A) of such Act (29
U.S.C. 1144(b)(6)(A)) is amended—

(i) in clause (i)(II), by striking “and”
at the end;
(ii) in clause (ii), by inserting “and which does not provide medical care (within the meaning of section 733(a)(2)),” after “arrangement,”, and by striking “title.” and inserting “title, and”; and

(iii) by adding at the end the following new clause:

“(iii) subject to subparagraph (E), in the case of any other employee welfare benefit plan which is a multiple employer welfare arrangement and which provides medical care (within the meaning of section 733(a)(2)), any law of any State which regulates insurance may apply.”.

(D) Section 514(e) of such Act (as redesignated by subparagraph (B)(iii)) is amended—

(i) by striking “Nothing” and inserting “(1) Except as provided in paragraph (2), nothing”; and

(ii) by adding at the end the following new paragraph:

“(2) Nothing in any other provision of law enacted on or after the date of the enactment of part 8 shall be construed to alter, amend, modify, invalidate, impair, or supersede any provision of this title, except by specific cross-reference to the affected section.”.
(3) Plan Sponsor.—Section 3(16)(B) of such Act (29 U.S.C. 102(16)(B)) is amended by adding at the end the following new sentence: “Such term also includes a person serving as the sponsor of an association health plan under part 8.”

(4) Disclosure of Solvency Protections Related to Self-Insured and Fully Insured Options under Association Health Plans.—Section 102(b) of such Act (29 U.S.C. 102(b)) is amended by adding at the end the following: “An association health plan shall include in its summary plan description, in connection with each benefit option, a description of the form of solvency or guarantee fund protection secured pursuant to this Act or applicable State law, if any.”

(5) Savings Clause.—Section 731(c) of such Act is amended by inserting “or part 8” after “this part”.

(6) Report to the Congress Regarding Certification of Self-Insured Association Health Plans.—Not later than January 1, 2012, the Secretary of Labor shall report to the Committee on Education and the Workforce of the House of Representatives and the Committee on Health, Education, Labor, and Pensions of the Senate the effect
association health plans have had, if any, on reducing the number of uninsured individuals.

(7) CLERICAL AMENDMENT.—The table of contents in section 1 of the Employee Retirement Income Security Act of 1974 is amended by inserting after the item relating to section 734 the following new items:

"PART 8—RULES GOVERNING ASSOCIATION HEALTH PLANS"

``801. Association health plans.
``802. Certification of association health plans.
``803. Requirements relating to sponsors and boards of trustees.
``804. Participation and coverage requirements.
``805. Other requirements relating to plan documents, contribution rates, and benefit options.
``806. Maintenance of reserves and provisions for solvency for plans providing health benefits in addition to health insurance coverage.
``807. Requirements for application and related requirements.
``808. Notice requirements for voluntary termination.
``809. Corrective actions and mandatory termination.
``810. Trusteeship by the Secretary of insolvent association health plans providing health benefits in addition to health insurance coverage.
``811. State assessment authority.
``812. Definitions and rules of construction."

(b) CLARIFICATION OF TREATMENT OF SINGLE EMPLOYER ARRANGEMENTS.—Section 3(40)(B) of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1002(40)(B)) is amended—

(1) in clause (i), by inserting after "control group," the following: "except that, in any case in which the benefit referred to in subparagraph (A) consists of medical care (as defined in section 812(a)(2)), two or more trades or businesses, whether or not incorporated, shall be deemed a single em-
ployer for any plan year of such plan, or any fiscal
year of such other arrangement, if such trades or
businesses are within the same control group during
such year or at any time during the preceding 1-year
period,”;

(2) in clause (iii), by striking “(iii) the deter-
mination” and inserting the following:

“(iii)(I) in any case in which the benefit re-
ferred to in subparagraph (A) consists of medical
care (as defined in section 812(a)(2)), the deter-
mination of whether a trade or business is under
‘common control’ with another trade or business
shall be determined under regulations of the Sec-
retary applying principles consistent and coextensive
with the principles applied in determining whether
employees of two or more trades or businesses are
treated as employed by a single employer under sec-
section 4001(b), except that, for purposes of this para-
graph, an interest of greater than 25 percent may
not be required as the minimum interest necessary
for common control, or

“(II) in any other case, the determination”;

(3) by redesignating clauses (iv) and (v) as
clauses (v) and (vi), respectively; and
(4) by inserting after clause (iii) the following new clause:

“(iv) in any case in which the benefit referred to in subparagraph (A) consists of medical care (as defined in section 812(a)(2)), in determining, after the application of clause (i), whether benefits are provided to employees of two or more employers, the arrangement shall be treated as having only one participating employer if, after the application of clause (i), the number of individuals who are employees and former employees of any one participating employer and who are covered under the arrangement is greater than 75 percent of the aggregate number of all individuals who are employees or former employees of participating employers and who are covered under the arrangement,”.

(c) Enforcement Provisions Relating to Association Health Plans.—

(1) Criminal penalties for certain willful misrepresentations.—Section 501 of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1131) is amended—

(A) by inserting “(a)” after “Sec. 501.”; and
(B) by adding at the end the following new subsection:

“(b) Any person who willfully falsely represents, to any employee, any employee’s beneficiary, any employer, the Secretary, or any State, a plan or other arrangement established or maintained for the purpose of offering or providing any benefit described in section 3(1) to employees or their beneficiaries as—

“(1) being an association health plan which has been certified under part 8;

“(2) having been established or maintained under or pursuant to one or more collective bargaining agreements which are reached pursuant to collective bargaining described in section 8(d) of the National Labor Relations Act (29 U.S.C. 158(d)) or paragraph Fourth of section 2 of the Railway Labor Act (45 U.S.C. 152, paragraph Fourth) or which are reached pursuant to labor-management negotiations under similar provisions of State public employee relations laws; or

“(3) being a plan or arrangement described in section 3(40)(A)(i), shall, upon conviction, be imprisoned not more than 5 years, be fined under title 18, United States Code, or both.”.
(2) Cease activities orders.—Section 502 of such Act (29 U.S.C. 1132) is amended by adding at the end the following new subsection:

“(n) Association health plan cease and desist orders.—

“(1) In general.—Subject to paragraph (2), upon application by the Secretary showing the operation, promotion, or marketing of an association health plan (or similar arrangement providing benefits consisting of medical care (as defined in section 733(a)(2))) that—

“(A) is not certified under part 8, is subject under section 514(b)(6) to the insurance laws of any State in which the plan or arrangement offers or provides benefits, and is not licensed, registered, or otherwise approved under the insurance laws of such State; or

“(B) is an association health plan certified under part 8 and is not operating in accordance with the requirements under part 8 for such certification,

a district court of the United States shall enter an order requiring that the plan or arrangement cease activities.
“(2) EXCEPTION.—Paragraph (1) shall not apply in the case of an association health plan or other arrangement if the plan or arrangement shows that—

“(A) all benefits under it referred to in paragraph (1) consist of health insurance coverage; and

“(B) with respect to each State in which the plan or arrangement offers or provides benefits, the plan or arrangement is operating in accordance with applicable State laws that are not superseded under section 514.

“(3) ADDITIONAL EQUITABLE RELIEF.—The court may grant such additional equitable relief, including any relief available under this title, as it deems necessary to protect the interests of the public and of persons having claims for benefits against the plan.”.

(3) RESPONSIBILITY FOR CLAIMS PROCEDURE.—Section 503 of such Act (29 U.S.C. 1133) is amended by inserting “(a) IN GENERAL.—” before “In accordance”, and by adding at the end the following new subsection:

“(b) ASSOCIATION HEALTH PLANS.—The terms of each association health plan which is or has been certified
under part 8 shall require the board of trustees or the
named fiduciary (as applicable) to ensure that the require-
ments of this section are met in connection with claims
filed under the plan.”

(d) COOPERATION BETWEEN FEDERAL AND STATE
AUTHORITIES.—Section 506 of the Employee Retirement
Income Security Act of 1974 (29 U.S.C. 1136) is amended
by adding at the end the following new subsection:

“(d) CONSULTATION WITH STATES WITH RESPECT
to Association Health Plans.—

“(1) AGREEMENTS WITH STATES.—The Sec-
retary shall consult with the State recognized under
paragraph (2) with respect to an association health
plan regarding the exercise of—

“(A) the Secretary’s authority under sec-
tions 502 and 504 to enforce the requirements
for certification under part 8; and

“(B) the Secretary’s authority to certify
association health plans under part 8 in accord-
ance with regulations of the Secretary applica-
table to certification under part 8.

“(2) RECOGNITION OF PRIMARY DOMICILE
STATE.—In carrying out paragraph (1), the Sec-
retary shall ensure that only one State will be recog-
nized, with respect to any particular association
health plan, as the State with which consultation is required. In carrying out this paragraph—

“(A) in the case of a plan which provides health insurance coverage (as defined in section 812(a)(3)), such State shall be the State with which filing and approval of a policy type offered by the plan was initially obtained, and

“(B) in any other case, the Secretary shall take into account the places of residence of the participants and beneficiaries under the plan and the State in which the trust is maintained.”.

(e) Effective Date and Transitional and Other Rules.—

(1) Effective Date.—The amendments made by this section shall take effect 1 year after the date of the enactment of this Act. The Secretary of Labor shall first issue all regulations necessary to carry out such amendments within 1 year after the date of the enactment of this Act.

(2) Treatment of Certain Existing Health Benefits Programs.—

(A) In General.—In any case in which, as of the date of the enactment of this Act, an arrangement is maintained in a State for the
purpose of providing benefits consisting of med-
ical care for the employees and beneficiaries of
its participating employers, at least 200 partici-
pating employers make contributions to such
arrangement, such arrangement has been in ex-
istence for at least 10 years, and such arrange-
ment is licensed under the laws of one or more
States to provide such benefits to its partici-
pating employers, upon the filing with the ap-
plicable authority (as defined in section
812(a)(5) of the Employee Retirement Income
Security Act of 1974 (as amended by this sub-
title)) by the arrangement of an application for
certification of the arrangement under part 8 of
subtitle B of title I of such Act—

(i) such arrangement shall be deemed
to be a group health plan for purposes of
title I of such Act;

(ii) the requirements of sections
801(a) and 803(a) of the Employee Retire-
ment Income Security Act of 1974 shall be
deemed met with respect to such arrange-
ment;

(iii) the requirements of section
803(b) of such Act shall be deemed met, if
the arrangement is operated by a board of directors which—

(I) is elected by the participating employers, with each employer having one vote; and

(II) has complete fiscal control over the arrangement and which is responsible for all operations of the arrangement;

(iv) the requirements of section 804(a) of such Act shall be deemed met with respect to such arrangement; and

(v) the arrangement may be certified by any applicable authority with respect to its operations in any State only if it operates in such State on the date of certification.

The provisions of this subparagraph shall cease to apply with respect to any such arrangement at such time after the date of the enactment of this Act as the applicable requirements of this subparagraph are not met with respect to such arrangement.

(B) DEFINITIONS.—For purposes of this paragraph, the terms “group health plan”,

“medical care”, and “participating employer” shall have the meanings provided in section 812 of the Employee Retirement Income Security Act of 1974, except that the reference in paragraph (7) of such section to an “association health plan” shall be deemed a reference to an arrangement referred to in this paragraph.

SEC. 133. REPEAL OF CERTAIN TAX EXEMPTIONS FOR HEALTH INSURANCE PAYMENTS.

(a) FICA DEFINITION OF WAGES.—Paragraphs (2) and (4) of sections 3121(a)of the Internal Revenue Code of 1986 (relating to tax on employers and employees) are hereby repealed.

(b) CONFORMING AMENDMENTS.—Section 3401 of the Internal Revenue Code of 1986 (relating to the collection of wages at source) is amended by striking paragraph (20) and redesignating paragraphs (21), (22), and (23)as paragraphs (20), (21), and (22), respectively.

(c) APPLICABLE DATE.—The amendments made by this section shall apply to taxable years beginning after December 31, 2010.
Subtitle C—Health Care Services Commission

PART I—ESTABLISHMENT AND GENERAL DUTIES

SEC. 141. ESTABLISHMENT.

(a) In General.—There is hereby established a Health Care Services Commission (in this subtitle referred to as the “Commission”) to be composed of five commissioners (in this subtitle referred to as the “Commissioners”) to be appointed by the President by and with the advice and consent of the Senate. Not more than three of such commissioners shall be members of the same political party, and in making appointments members of different political parties shall be appointed alternately as nearly as may be practicable. No commissioner shall engage in any other business, vocation, or employment than that of serving as commissioner. Each commissioner shall hold office for a term of five years and until his successor is appointed and has qualified, except that he shall not so continue to serve beyond the expiration of the next session of Congress subsequent to the expiration of said fixed term of office, and except (1) any commissioner appointed to fill a vacancy occurring prior to the expiration of the term for which his predecessor was appointed shall be appointed for the remainder of such term, and (2) the terms of office of the commissioners first taking office after the
enactment of this subtitle shall expire as designated by
the President at the time of nomination, one at the end
of one year, one at the end of two years, one at the end
of three years, one at the end of four years, and one at
the end of five years, after the date of the enactment of
this Act.

(b) PURPOSE.—The purpose of the Commission is to
enhance the quality, appropriateness, and effectiveness of
health care services, and access to such services, through
the establishment of a broad base of scientific research
and through the promotion of improvements in clinical
practice and in the organization, financing, and delivery
of health care services.

(c) APPOINTMENT OF CHAIRMAN.—The President
shall, from among the Commissioners appointed under
subsection (a), designate an individual to serve as the
Chairman of the Commission.

SEC. 142. GENERAL AUTHORITIES AND DUTIES.

(a) IN GENERAL.—In carrying out section 141(b),
the Commissioners shall conduct and support research,
demonstration projects, evaluations, training, guideline de-
velopment, and the dissemination of information, on
health care services and on systems for the delivery of
such services, including activities with respect to—
(1) the effectiveness, efficiency, and quality of health care services;

(2) subject to subsection (b), the outcomes of health care services and procedures;

(3) clinical practice, including primary care and practice-oriented research;

(4) health care technologies, facilities, and equipment;

(5) health care costs, productivity, and market forces;

(6) health promotion and disease prevention;

(7) health statistics and epidemiology; and

(8) medical liability.

(b) Requirements With Respect to Rural Areas and Underserved Populations.—In carrying out subsection (a), the Commissioners shall undertake and support research, demonstration projects, and evaluations with respect to—

(1) the delivery of health care services in rural areas (including frontier areas); and

(2) the health of low-income groups, minority groups, and the elderly.

SEC. 143. DISSEMINATION.

(a) In General.—The Commissioners shall—
(1) promptly publish, make available, and otherwise disseminate, in a form understandable and on as broad a basis as practicable so as to maximize its use, the results of research, demonstration projects, and evaluations conducted or supported under this subtitle and the guidelines, standards, and review criteria developed under this subtitle;

(2) promptly make available to the public data developed in such research, demonstration projects, and evaluations; and

(3) as appropriate, provide technical assistance to State and local government and health agencies and conduct liaison activities to such agencies to foster dissemination.

(b) Prohibition Against Restrictions.—Except as provided in subsection (c), the Commissioners may not restrict the publication or dissemination of data from, or the results of, projects conducted or supported under this subtitle.

(c) Limitation on Use of Certain Information.—No information, if an establishment or person supplying the information or described in it is identifiable, obtained in the course of activities undertaken or supported under this subtitle may be used for any purpose other than the purpose for which it was supplied unless
such establishment or person has consented (as deter-
mined under regulations of the Secretary) to its use for
such other purpose. Such information may not be pub-
lished or released in other form if the person who supplied
the information or who is described in it is identifiable
unless such person has consented (as determined under
regulations of the Secretary) to its publication or release
in other form.

(d) CERTAIN INTERAGENCY AGREEMENT.—The
Commissioners and the Director of the National Library
of Medicine shall enter into an agreement providing for
the implementation of subsection (a)(1).

PART II—FORUM FOR QUALITY AND
EFFECTIVENESS IN HEALTH CARE

SEC. 151. ESTABLISHMENT OF OFFICE.

There is established within the Commission an office
to be known as the Office of the Forum for Quality and
Effectiveness in Health Care. The office shall be headed
by a director (referred to in this subtitle as the “Direc-
tor”), who shall be appointed by the Commissioners.

SEC. 152. MEMBERSHIP.

(a) IN GENERAL.—The Office of the Forum for Qual-
ity and Effectiveness in Health Care shall be composed
of 15 individuals nominated by private sector health care
organizations and appointed by the Commission and shall include representation from at least the following:

(1) Health insurance industry.
(2) Health care provider groups.
(3) Non-profit organizations.
(4) Rural health organizations.

(b) Terms.—

(1) In general.—Except as provided in subparagraph (B), members of the Office of the Forum for Quality and Effectiveness in Health Care shall serve for a term of 5 years.

(2) Staggered rotation.—Of the members first appointed to the Office of the Forum for Quality and Effectiveness in Health Care, the Commission shall appoint 5 members to serve for a term of 2 years, 5 members to serve for a term of 3 years, and 5 members to serve for a term of 4 years.

(c) Treatment of other employment.—Each member of the Office of the Forum for Quality and Effectiveness in Health Care shall serve the Office independently from any other position of employment.

SEC. 153. DUTIES.

(a) Establishment of forum program.—The Commissioners, acting through the Director, shall establish a program to be known as the Forum for Quality and
Effectiveness in Health Care. For the purpose of promoting transparency in price, quality, appropriateness, and effectiveness of health care, the Director, using the process set forth in section 154, shall arrange for the development and periodic review and updating of standards of quality, performance measures, and medical review criteria through which health care providers and other appropriate entities may assess or review the provision of health care and assure the quality of such care.

(b) Certain Requirements.—Guidelines, standards, performance measures, and review criteria under subsection (a) shall—

(1) be based on the best available research and professional judgment regarding the effectiveness and appropriateness of health care services and procedures; and

(2) be presented in formats appropriate for use by physicians, health care practitioners, providers, medical educators, and medical review organizations and in formats appropriate for use by consumers of health care.

(c) Authority for Contracts.—In carrying out this part, the Director may enter into contracts with public or nonprofit private entities.
(d) Public Disclosure of Recommendations.—
For each fiscal year beginning with 2010, the Director
shall make publicly available the following:

(1) quarterly reports for public comment that
include proposed recommendations for guidelines,
standards, performance measures, and review cri-
teria under subsection (a) and any updates to such
guidelines, standards, performance measures, and
review criteria; and

(2) after consideration of such comments, a
final report that contains final recommendations for
such guidelines, standards, performance measures,
review criteria, and updates.

(e) Date Certain for Initial Guidelines and
Standards.—The Commissioners, by not later than Jan-
uary 1, 2012, shall assure the development of an initial
set of guidelines, standards, performance measures, and
review criteria under subsection (a).

SEC. 154. ADOPTION AND ENFORCEMENT OF GUIDELINES
AND STANDARDS.

(a) Adoption of Recommendations of Forum
for Quality and Effectiveness in Health Care.—
For each fiscal year, the Commissioners shall adopt the
recommendations made for such year in the final report
under subsection (d)(2) of section 153 for guidelines,
standards, performance measures, and review criteria described in subsection (a) of such section.

(b) Enforcement Authority.—The Commissioners, in consultation with the Secretary of Health and Human Services, have the authority to make recommendations to the Secretary to enforce compliance of health care providers with the guidelines, standards, performance measures, and review criteria adopted under subsection (a). Such recommendations may include the following, with respect to a health care provider who is not in compliance with such guidelines, standards, measures, and criteria:

(1) Exclusion from participation in Federal health care programs (as defined in section 1128B(f) of the Social Security Act).

(2) Imposition of a civil money penalty on such provider.

SEC. 155. ADDITIONAL REQUIREMENTS.

(a) Program Agenda.—The Commissioners shall provide for an agenda for the development of the guidelines, standards, performance measures, and review criteria described in section 153(a), including with respect to the standards, performance measures, and review criteria, identifying specific aspects of health care for which the standards, performance measures, and review criteria
are to be developed and those that are to be given priority in the development of the standards, performance measures, and review criteria.

PART III—GENERAL PROVISIONS

SEC. 161. CERTAIN ADMINISTRATIVE AUTHORITIES.

The Commissioners, in carrying out this subtitle, may accept voluntary and uncompensated services.

SEC. 162. FUNDING.

For the purpose of carrying out this subtitle, there are authorized to be appropriated such sums as may be necessary for fiscal years 2011 through 2015.

SEC. 163. DEFINITIONS.

For purposes of this subtitle:

(1) The term “Commissioners” means the Commissioners of the Health Care Services Commission.

(2) The term “Commission” means the Health Care Services Commission.

(3) The term “Director” means the Director of the Office of the Forum for Quality and Effectiveness in Health Care.

(4) The term “Secretary” means the Secretary of Health and Human Services.
PART IV—TERMINATIONS AND TRANSITION

SEC. 171. TERMINATION OF AGENCY FOR HEALTHCARE RESEARCH AND QUALITY.

As of the date of the enactment of this Act, the Agency for Healthcare Research and Quality is terminated, and title IX of the Public Health Service Act is repealed.

SEC. 172. TRANSITION.

All orders, grants, contracts, privileges, and other determinations or actions of the Agency for Healthcare Research and Quality that are effective as of the date before the date of the enactment of this Act, shall be transferred to the Secretary and shall continue in effect according to their terms unless changed pursuant to law.

PART V—INDEPENDENT HEALTH RECORD TRUST

SEC. 181. SHORT TITLE OF PART.

This part may be cited as the “Independent Health Record Trust Act of 2008”.

SEC. 182. PURPOSE.

It is the purpose of this part to provide for the establishment of a nationwide health information technology network that—

(1) improves health care quality, reduces medical errors, increases the efficiency of care, and advances the delivery of appropriate, evidence-based health care services;
(2) promotes wellness, disease prevention, and the management of chronic illnesses by increasing the availability and transparency of information related to the health care needs of an individual;

(3) ensures that appropriate information necessary to make medical decisions is available in a usable form at the time and in the location that the medical service involved is provided;

(4) produces greater value for health care expenditures by reducing health care costs that result from inefficiency, medical errors, inappropriate care, and incomplete information;

(5) promotes a more effective marketplace, greater competition, greater systems analysis, increased choice, enhanced quality, and improved outcomes in health care services;

(6) improves the coordination of information and the provision of such services through an effective infrastructure for the secure and authorized exchange and use of health information; and

(7) ensures that the health information privacy, security, and confidentiality of individually identifiable health information is protected.

SEC. 183. DEFINITIONS.

In this part:
(1) Access.—The term “access” means, with respect to an electronic health record, entering information into such account as well as retrieving information from such account.

(2) Account.—The term “account” means an electronic health record of an individual contained in an independent health record trust.

(3) Affirmative Consent.—The term “affirmative consent” means, with respect to an electronic health record of an individual contained in an IHRT, express consent given by the individual for the use of such record in response to a clear and conspicuous request for such consent or at the individual’s own initiative.

(4) Authorized EHR Data User.—The term “authorized EHR data user” means, with respect to an electronic health record of an IHRT participant contained as part of an IHRT, any entity (other than the participant) authorized (in the form of affirmative consent) by the participant to access the electronic health record.

(5) Confidentiality.—The term “confidentiality” means, with respect to individually identifiable health information of an individual, the obliga-
tion of those who receive such information to respect
the health information privacy of the individual.

(6) **Electronic health record.**—The term
“electronic health record” means a longitudinal col-
lection of information concerning a single individual,
including medical records and personal health infor-
formation, that is stored electronically.

(7) **Health information privacy.**—The
term “health information privacy” means, with re-
spect to individually identifiable health information
of an individual, the right of such individual to con-
trol the acquisition, uses, or disclosures of such in-
formation.

(8) **Health plan.**—The term “health plan”
means a group health plan (as defined in section
2208(1) of the Public Health Service Act (42 U.S.C.
300bb–8(1))) as well as a plan that offers health in-
surance coverage in the individual market.

(9) **HIPAA privacy regulations.**—The term
“HIPAA privacy regulations” means the regulations
promulgated under section 264(c) of the Health In-
surance Portability and Accountability Act of 1996

(10) **Independent health record trust; IHRT.**—The terms “independent health record trust”
and “IHRT” mean a legal arrangement under the administration of an IHRT operator that meets the requirements of this part with respect to electronic health records of individuals participating in the trust or IHRT.

(11) IHRT OPERATOR.—The term “IHRT operator” means, with respect to an IHRT, the organization that is responsible for the administration and operation of the IHRT in accordance with this part.

(12) IHRT PARTICIPANT.—The term “IHRT participant” means, with respect to an IHRT, an individual who has a participation agreement in effect with respect to the maintenance of the individual’s electronic health record by the IHRT.

(13) INDIVIDUALLY IDENTIFIABLE HEALTH INFORMATION.—The term “individually identifiable health information” has the meaning given such term in section 1171(6) of the Social Security Act (42 U.S.C. 1320d(6)).

(14) SECURITY.—The term “security” means, with respect to individually identifiable health information of an individual, the physical, technological, or administrative safeguards or tools used to protect such information from unwarranted access or disclosure.
SEC. 184. ESTABLISHMENT, CERTIFICATION, AND MEMBERSHIP OF INDEPENDENT HEALTH RECORD TRUSTS.

(a) Establishment.—Not later than one year after the date of the enactment of this Act, the Federal Trade Commission, in consultation with the National Committee on Vital and Health Statistics, shall prescribe standards for the establishment, certification, operation, and interoperability of IHRTs to carry out the purposes described in section 182 in accordance with the provisions of this part.

(b) Certification.—

(1) Certification by FTC.—The Federal Trade Commission shall provide for the certification of IHRTs. No IHRT may be certified unless the IHRT is determined to meet the standards for certification established under subsection (a).

(2) Decertification.—The Federal Trade Commission shall establish a process for the revocation of certification of an IHRT under this section in the case that the IHRT violates the standards established under subsection (a).

(c) Membership.—

(1) In general.—To be eligible to be a participant in an IHRT, an individual shall—
(A) submit to the IHRT information as required by the IHRT to establish an electronic health record with the IHRT; and

(B) enter into a privacy protection agreement described in section 186(b)(1) with the IHRT.

The process to determine eligibility of an individual under this subsection shall allow for the establishment by such individual of an electronic health record as expeditiously as possible if such individual is determined so eligible.

(2) NO LIMITATION ON MEMBERSHIP.—Nothing in this subsection shall be construed to permit an IHRT to restrict membership, including on the basis of health condition.

SEC. 185. DUTIES OF IHRT TO IHRT PARTICIPANTS.

(a) FIDUCIARY DUTY OF IHRT; PENALTIES FOR VIOLATIONS OF FIDUCIARY DUTY.—

(1) FIDUCIARY DUTY.—With respect to the electronic health record of an IHRT participant maintained by an IHRT, the IHRT shall have a fiduciary duty to act for the benefit and in the interests of such participant and of the IHRT as a whole. Such duty shall include obtaining the affirmative consent of such participant prior to the release of in-
information in such participant’s electronic health record in accordance with the requirements of this part.

(2) Penalties.—If the IHRT knowingly or recklessly breaches the fiduciary duty described in paragraph (1), the IHRT shall be subject to the following penalties:

(A) Loss of certification of the IHRT.

(B) A fine that is not in excess of $50,000.

(C) A term of imprisonment for the individuals involved of not more than 5 years.

(b) Electronic Health Record Deemed To Be Held In Trust By IHRT.—With respect to an individual, an electronic health record maintained by an IHRT shall be deemed to be held in trust by the IHRT for the benefit of the individual and the IHRT shall have no legal or equitable interest in such electronic health record.

SEC. 186. AVAILABILITY AND USE OF INFORMATION FROM RECORDS IN IHRT CONSISTENT WITH PRIVACY PROTECTIONS AND AGREEMENTS.

(a) Protected Electronic Health Records Use And Access.—

(1) General rights regarding uses of information.—
(A) IN GENERAL.—With respect to the electronic health record of an IHRT participant maintained by an IHRT, subject to paragraph (2)(C), primary uses and secondary uses (described in subparagraphs (B) and (C), respectively) of information within such record (other than by such participant) shall be permitted only upon the authorization of such use, prior to such use, by such participant.

(B) PRIMARY USES.—For purposes of subparagraph (A) and with respect to an electronic health record of an individual, a primary use is a use for purposes of the individual’s self-care or care by health care professionals.

(C) SECONDARY USES.—For purposes of subparagraph (B) and with respect to an electronic health record of an individual, a secondary use is any use not described in subparagraph (B) and includes a use for purposes of public health research or other related activities. Additional authorization is required for a secondary use extending beyond the original purpose of the secondary use authorized by the IHRT participant involved. Nothing in this paragraph shall be construed as requiring au-
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authorization for every secondary use that is within the authorized original purpose.

(2) Rules for primary use of records for health care purposes.—With respect to the electronic health record of an IHRT participant (or specified parts of such electronic health record) maintained by an IHRT standards for access to such record shall provide for the following:

(A) Access by IHRT participants to their electronic health records.—

(i) Ownership.—The participant maintains ownership over the entire electronic health record (and all portions of such record) and shall have the right to electronically access and review the contents of the entire record (and any portion of such record) at any time, in accordance with this subparagraph.

(ii) Addition of personal information.—The participant may add personal health information to the health record of that participant, except that such participant shall not alter information that is entered into the electronic health record by any authorized EHR data user. Such
participant shall have the right to propose
an amendment to information that is en-
tered by an authorized EHR data user
pursuant to standards prescribed by the
Federal Trade Commission for purposes of
amending such information.

(iii) IDENTIFICATION OF INFORMATION ENTERED BY PARTICIPANT.—Any ad-
ditions or amendments made by the partic-
ipant to the health record shall be identi-
fied and disclosed within such record as
being made by such participant.

(B) ACCESS BY ENTITIES OTHER THAN IHRT PARTICIPANT.—

(i) AUTHORIZED ACCESS ONLY.—Ex-
ccept as provided under subparagraph (C)
and paragraph (4), access to the electronic
health record (or any portion of the
record)—

(I) may be made only by author-
ized EHR data users and only to such
portions of the record as specified by
the participant; and

(II) may be limited by the partic-
ipant for purposes of entering infor-
information into such record, retrieving information from such record, or both.

(ii) Identification of entity that enters information.—Any information that is added by an authorized EHR data user to the health record shall be identified and disclosed within such record as being made by such user.

(iii) Satisfaction of HIPAA privacy regulations.—In the case of a record of a covered entity (as defined for purposes of HIPAA privacy regulations), with respect to an individual, if such individual is an IHRT participant with an independent health record trust and such covered entity is an authorized EHR data user, the requirement under the HIPAA privacy regulations for such entity to provide the record to the participant shall be deemed met if such entity, without charge to the IHRT or the participant—

(I) forwards to the trust an appropriately formatted electronic copy of the record (and updates to such records) for inclusion in the electronic
health record of the participant maintained by the trust;

(II) enters such record into the electronic health record of the participant so maintained; or

(III) otherwise makes such record available for electronic access by the IHRT or the individual in a manner that permits such record to be included in the account of the individual contained in the IHRT.

(iv) Notification of Sensitive Information.—Any information, with respect to the participant, that is sensitive information, as specified by the Federal Trade Commission, shall not be forwarded or entered by an authorized EHR data user into the electronic health record of the participant maintained by the trust unless the user certifies that the participant has been notified of such information.

(C) Deemed Authorization for Access for Emergency Health Care.—

(i) Findings.—Congress finds that—
(I) given the size and nature of visits to emergency departments in the United States, readily available health information could make the difference between life and death; and

(II) because of the case mix and volume of patients treated, emergency departments are well positioned to provide information for public health surveillance, community risk assessment, research, education, training, quality improvement, and other uses.

(ii) USE OF INFORMATION.—With respect to the electronic health record of an IHRT participant (or specified parts of such electronic health record) maintained by an IHRT, the participant shall be deemed as providing authorization (in the form of affirmative consent) for health care providers to access, in connection with providing emergency care services to the participant, a limited, authenticated information set concerning the participant for emergency response purposes, unless the participant specifies that such information
set (or any portion of such information set) may not be so accessed. Such limited information set may include information—

(I) patient identification data, as determined appropriate by the participant;

(II) provider identification that includes the use of unique provider identifiers;

(III) payment information;

(IV) information related to the individual’s vitals, allergies, and medication history;

(V) information related to existing chronic problems and active clinical conditions of the participant; and

(VI) information concerning physical examinations, procedures, results, and diagnosis data.

(3) Rules for secondary uses of records for research and other purposes.—

(A) In General.—With respect to the electronic health record of an IHRT participant (or specified parts of such electronic health record) maintained by an IHRT, the IHRT
may sell such record (or specified parts of such record) only if—

(i) the transfer is authorized by the participant pursuant to an agreement between the participant and the IHRT and is in accordance with the privacy protection agreement described in subsection (b)(1) entered into between such participant and such IHRT;

(ii) such agreement includes parameters with respect to the disclosure of information involved and a process for the authorization of the further disclosure of information in such record;

(iii) the information involved is to be used for research or other activities only as provided for in the agreement;

(iv) the recipient of the information provides assurances that the information will not be further transferred or reused in violation of such agreement; and

(v) the transfer otherwise meets the requirements and standards prescribed by the Federal Trade Commission.
(B) Treatment of Public Health Reporting.—Nothing in this paragraph shall be construed as prohibiting or limiting the use of health care information of an individual, including an individual who is an IHRT participant, for public health reporting (or other research) purposes prior to the inclusion of such information in an electronic health record maintained by an IHRT.

(4) Law Enforcement Clarification.—Nothing in this part shall prevent an IHRT from disclosing information contained in an electronic health record maintained by the IHRT when required for purposes of a lawful investigation or official proceeding inquiring into a violation of, or failure to comply with, any criminal or civil statute or any regulation, rule, or order issued pursuant to such a statute.

(5) Rule of Construction.—Nothing in this section shall be construed to require a health care provider that does not utilize electronic methods or appropriate levels of health information technology on the date of the enactment of this Act to adopt such electronic methods or technology as a requirement for participation or compliance under this part.
(b) Privacy Protection Agreement; Treatment of State Privacy and Security Laws.—

(1) Privacy protection agreement.—A privacy protection agreement described in this subsection is an agreement, with respect to an electronic health record of an IHRT participant to be maintained by an independent health record trust, between the participant and the trust—

(A) that is consistent with the standards described in subsection (a)(2);

(B) under which the participant specifies the portions of the record that may be accessed, under what circumstances such portions may be accessed, any authorizations for indicated authorized EHR data users to access information contained in the record, and the purposes for which the information (or portions of the information) in the record may be used;

(C) which provides a process for the authorization of the transfer of information contained in the record to a third party, including for the sale of such information for purposes of research, by an authorized EHR data user and reuse of such information by such third party, including a provision requiring that such trans-
fer and reuse is not in violation of any privacy
or transfer restrictions placed by the partici-

pant on the independent health record of such
participant; and

(D) under which the trust provides assur-
ances that the trust will not transfer, disclose,
or provide access to the record (or any portion
of the record) in violation of the parameters es-

established in the agreement or to any person or
entity who has not agreed to use and transfer
such record (or portion of such record) in ac-

cordance with such agreement.

(2) TREATMENT OF STATE LAWS.—

(A) IN GENERAL.—Except as provided
under subparagraph (B), the provisions of a
privacy protection agreement entered into be-

tween an IHRT and an IHRT participant shall
preempt any provision of State law (or any
State regulation) relating to the privacy and
confidentiality of individually identifiable health
information or to the security of such health in-

formation.

(B) EXCEPTION FOR PRIVILEGED INFOR-

MATION.—The provisions of a privacy protec-

tion agreement shall not preempt any provision
of State law (or any State regulation) that recognizes privileged communications between physicians, health care practitioners, and patients of such physicians or health care practitioners, respectively.

(C) STATE DEFINED.—For purposes of this section, the term “State” has the meaning given such term when used in title XI of the Social Security Act, as provided under section 1101(a) of such Act (42 U.S.C. 1301(a)).

SEC. 187. VOLUNTARY NATURE OF TRUST PARTICIPATION AND INFORMATION SHARING.

(a) IN GENERAL.—Participation in an independent health record trust, or authorizing access to information from such a trust, is voluntary. No employer, health insurance issuer, group health plan, health care provider, or other person may require, as a condition of employment, issuance of a health insurance policy, coverage under a group health plan, the provision of health care services, payment for such services, or otherwise, that an individual participate in, or authorize access to information from, an independent health record trust.

(b) ENFORCEMENT.—The penalties provided for in subsection (a) of section 1177 of the Social Security Act (42 U.S.C. 1320d–6) shall apply to a violation of sub-
section (a) in the same manner as such penalties apply
to a person in violation of subsection (a) of such section.

SEC. 188. FINANCING OF ACTIVITIES.

(a) IN GENERAL.—Except as provided in subsection
(b), an IHRT may generate revenue to pay for the oper-
ations of the IHRT through—

(1) charging IHRT participants account fees
for use of the trust;

(2) charging authorized EHR data users for ac-
accessing electronic health records maintained in the
trust;

(3) the sale of information contained in the
trust (as provided for in section 186(a)(3)(A)); and

(4) any other activity determined appropriate
by the Federal Trade Commission.

(b) PROHIBITION AGAINST ACCESS FEES FOR
HEALTH CARE PROVIDERS.—For purposes of providing
incentives to health care providers to access information
maintained in an IHRT, as authorized by the IHRT par-
ticipants involved, the IHRT may not charge a fee for
services specified by the IHRT. Such services shall include
the transmittal of information from a health care provider
to be included in an independent electronic health record
maintained by the IHRT (or permitting such provider to
input such information into the record), including the
transmission of or access to information described in section 186(a)(2)(C)(ii) by appropriate emergency responders.

(c) Required Disclosures.—The sources and amounts of revenue derived under subsection (a) for the operations of an IHRT shall be fully disclosed to each IHRT participant of such IHRT and to the public.

(d) Treatment of Income.—For purposes of the Internal Revenue Code of 1986, any revenue described in subsection (a) shall not be included in gross income of any IHRT, IHRT participant, or authorized EHR data user.

SEC. 189. REGULATORY OVERSIGHT.

(a) In General.—In carrying out this part, the Federal Trade Commission shall promulgate regulations for independent health record trusts.

(b) Establishment of Interagency Steering Committee.—

(1) In General.—The Secretary of Health and Human Services shall establish an Interagency Steering Committee in accordance with this subsection.

(2) Chairperson.—The Secretary of Health and Human Services shall serve as the chairperson of the Interagency Steering Committee.
(3) **MEMBERSHIP.**—The members of the Interagency Steering Committee shall consist of the Attorney General, the Chairperson of the Federal Trade Commission, the Chairperson for the National Committee for Vital and Health Statistics, a representative of the Federal Reserve, and other Federal officials determined appropriate by the Secretary of Health and Human Services.

(4) **DUTIES.**—The Interagency Steering Committee shall coordinate the implementation of this part, including the implementation of policies described in subsection (d) based upon the recommendations provided under such subsection, and regulations promulgated under this part.

(c) **FEDERAL ADVISORY COMMITTEE.**—

(1) **IN GENERAL.**—The National Committee for Vital and Health Statistics shall serve as an advisory committee for the IHRTs. The membership of such advisory committee shall include a representative from the Federal Trade Commission and the chairperson of the Interagency Steering Committee. Not less than 60 percent of such membership shall consist of representatives of nongovernment entities, at least one of whom shall be a representative from an organization representing health care consumers.
(2) Duties.—The National Committee for Vital and Health Statistics shall issue periodic reports and review policies concerning IHRTs based on each of the following factors:

(A) Privacy and security policies.

(B) Economic progress.

(C) Interoperability standards.

(d) Policies Recommended by Federal Trade Commission.—The Federal Trade Commission, in consultation with the National Committee for Vital and Health Statistics, shall recommend policies to—

(1) provide assistance to encourage the growth of independent health record trusts;

(2) track economic progress as it pertains to operators of independent health records trusts and individuals receiving nontaxable income with respect to accounts;

(3) conduct public education activities regarding the creation and usage of the independent health records trusts;

(4) establish standards for the interoperability of health information technology to ensure that information contained in such record may be shared between the trust involved, the participant, and authorized EHR data users, including for the stand-
ardized collection and transmission of individual
health records (or portions of such records) to au-
thorized EHR data users through a common inter-
face and for the portability of such records among
independent health record trusts; and

(5) carry out any other activities determined
appropriate by the Federal Trade Commission.

(c) REGULATIONS PROMULGATED BY FEDERAL
TRADE COMMISSION.—The Federal Trade Commission
shall promulgate regulations based on, at a minimum, the
following factors:

(1) Requiring that an IHRT participant, who
has an electronic health record that is maintained by
an IHRT, be notified of a security breech with re-
pect to such record, and any corrective action taken
on behalf of the participant.

(2) Requiring that information sent to, or re-
ceived from, an IHRT that has been designated as
high-risk should be authenticated through the use of
methods such as the periodic changing of passwords,
the use of biometrics, the use of tokens or other
technology as determined appropriate by the council.

(3) Requiring a delay in releasing sensitive
health care test results and other similar informa-
tion to patients directly in order to give physicians
time to contact the patient.

(4) Recommendations for entities operating
IHRTs, including requiring analysis of the potential
risk of health transaction security breeches based on
set criteria.

(5) The conduct of audits of IHRTs to ensure
that they are in compliance with the requirements
and standards established under this part.

(6) Disclosure to IHRT participants of the
means by which such trusts are financed, including
revenue from the sale of patient data.

(7) Prevention of certification of an entity seek-
ing independent heath record trust certification
based on—

(A) the potential for conflicts between the
interests of such entity and the security of the
health information involved; and

(B) the involvement of the entity in any
activity that is contrary to the best interests of
a patient.

(8) Prevention of the use of revenue sources
that are contrary to a patient’s interests.
(9) Public disclosure of audits in a manner similar to financial audits required for publicly traded stock companies.

(10) Requiring notification to a participating entity that the information contained in such record may not be representative of the complete or accurate electronic health record of such account holder.

(f) COMPLIANCE REPORT.—Not later than 1 year after the date of the enactment of this Act, and annually thereafter, the Commission shall submit to the Committee on Health, Education, Labor, and Pensions and the Committee on Finance of the Senate and the Committee on Energy and Commerce and the Committee on Ways and Means of the House of Representatives, a report on compliance by and progress of independent health record trusts with this part. Such report shall describe the following:

(1) The number of complaints submitted about independent health record trusts, which shall be divided by complaints related to security breaches, and complaints not related to security breaches, and may include other categories as the Interagency Steering Committee established under subsection (b) determines appropriate.
(2) The number of enforcement actions undertaken by the Commission against independent health record trusts in response to complaints under paragraph (1), which shall be divided by enforcement actions related to security breaches and enforcement actions not related to security breaches and may include other categories as the Interagency Steering Committee established under subsection (b) determines appropriate.

(3) The economic progress of the individual owner or institution operator as achieved through independent health record trust usage and existing barriers to such usage.

(4) The progress in security auditing as provided for by the Interagency Steering Committee council under subsection (b).

(5) The other core responsibilities of the Commission as described in subsection (a).

(g) INTERAGENCY MEMORANDUM OF UNDERSTANDING.—The Interagency Steering Committee shall ensure, through the execution of an interagency memorandum of understanding, that—

(1) regulations, rulings, and interpretations issued by Federal officials relating to the same matter over which 2 or more such officials have respon-
sibility under this part are administered so as to
have the same effect at all times; and

(2) the memorandum provides for the coordina-
tion of policies related to enforcing the same require-
ments through such officials in order to have coordi-
nated enforcement strategy that avoids duplication
of enforcement efforts and assigns priorities in en-
forcement.

TITLE II—FAIRNESS FOR EVERY
AMERICAN PATIENT
Subtitle A—Medicaid
Modernization

SEC. 201. MEDICAID MODERNIZATION.

(a) In General.—Effective January 1, 2011, title
XIX of the Social Security Act (42 U.S.C. 1396 et seq.)
is amended to read as follows:

“TITLE XIX—GRANTS TO STATES
FOR MEDICAL ASSISTANCE
PROGRAMS

“TABLE OF CONTENTS OF TITLE

“Sec. 1900. References to pre-modernized Medicaid provisions; continuity for
commonwealths and territories.

“PART A—Grants to States for Acute Care for Individuals With
Disabilities and Certain Low-Income Individuals

“Sec. 1901. Purpose; appropriation.
“Sec. 1902. Payments to States for acute care medical assistance.
“Sec. 1903. Definitions of eligible individuals and acute care medical assist-
ance.
“Sec. 1904. State plan requirements for acute care medical assistance.
“Sec. 1905. Definitions.
"Sec. 1906. Enrollment of individuals under group health plans and other arrangements.
"Sec. 1907. Drug rebates.
"Sec. 1908. Managed care.
"Sec. 1909. Annual reports.

"PART B—GRANTS TO STATES FOR LONG-TERM CARE SERVICES AND SUPPORTS

"Sec. 1911. Purpose.
"Sec. 1912. State plan.
"Sec. 1913. State allotments.
"Sec. 1914. Use of grants.
"Sec. 1915. Administrative provisions.
"Sec. 1916. Definition of long-term care services and supports.
"Sec. 1917. Provision requirements for long-term care services and supports, including option for self-directed services and supports.
"Sec. 1918. Treatment of income and resources for certain institutionalized spouses.
"Sec. 1919. Annual reports.

"PART C—GRANTS TO STATES FOR SURVEY AND CERTIFICATION OF MEDICAL FACILITIES AND OTHER REQUIREMENTS

"Sec. 1931. Authorization of appropriations.
"Sec. 1932. Application of certain requirements under pre-modernized Medicaid.

"PART D—GRANTS TO STATES FOR PROGRAM INTEGRITY

"Sec. 1941. Authorization of appropriations.
"Sec. 1942. Application of certain requirements under pre-modernized Medicaid.

"PART E—GRANTS TO STATES FOR ADMINISTRATION

"Sec. 1951. Authorization of appropriations; payments to states.
"Sec. 1952. Cost-sharing protections.
"Sec. 1953. Application of certain requirements under pre-modernized Medicaid.

"PART F—OTHER PROVISIONS

"Sec. 1961. Application of certain requirements under pre-modernized Medicaid.

1 "SEC. 1900. REFERENCES TO PRE-MODERNIZED MEDICAID PROVISIONS; CONTINUITY FOR COMMONWEALTHS AND TERRITORIES.

2 "(a) IN GENERAL.—In this title, if a reference to this title or to a provision of this title is prefaced by the term"
‘old’, such reference is to this title or a provision of this title as in effect on December 31, 2010.

“(b) Regulations.—The Secretary shall promulgate regulations to bring requirements imposed under an old provision of this title that applies under this title after December 31, 2010, into conformity with the policies embodied in this title as in effect on and after January 1, 2011.

“(c) Continuity for Commonwealths and Territories.—In the case of Puerto Rico, the United States Virgin Islands, Guam, the Northern Mariana Islands, and American Samoa, this title as in effect on and after January 1, 2011, shall not apply to such commonwealths and territories, and old title XIX shall apply to a Medicaid program operated by such commonwealths or territories on and after that date.

“PART A—GRANTS TO STATES FOR ACUTE CARE FOR INDIVIDUALS WITH DISABILITIES AND CERTAIN LOW-INCOME INDIVIDUALS

“SEC. 1901. PURPOSE; APPROPRIATION.

“(a) Purpose.—It is the purpose of this part to enable each State, as far as practicable under the conditions in the State, to provide acute care medical assistance to eligible individuals described in section 1903 whose income and resources are insufficient to meet the costs of nec-
necessary medical services, and (2) rehabilitation and other 
services to help such individuals attain or retain capability 
for independence or self-care.

“(b) Appropriation.—For the purpose of making 
payments to States under this part, there is appropriated 
out of any money in the Treasury not otherwise appro-
 priated, such sums as are necessary for fiscal year 2011 
and each fiscal year thereafter.

“SEC. 1902. Payments to states for acute care medical 
assistance.

“(a) In general.—From the amounts appropriated 
under section 1901 for a fiscal year, the Secretary shall 
pay to each State which has a plan approved under this 
part, for each quarter, beginning with the quarter com-
mencing January 1, 2011, an amount equal to the Federal 
medical assistance percentage (as defined in section 
1905(b)) of the total amount expended during such quar-
ter as acute care medical assistance under the State plan 
under this part.

“(b) Administrative expenses.—Each State with 
a plan approved under this part shall receive a payment 
determined in accordance with part E for administrative 
expenses incurred in carrying out the plan under this part 
and part B (if the State has a plan approved under that 
part).
1 "SEC. 1903. DEFINITIONS OF ELIGIBLE INDIVIDUALS AND
2 ACUTE CARE MEDICAL ASSISTANCE.
3 "(a) ELIGIBLE INDIVIDUALS.—
4 "(1) IN GENERAL.—In this part, the term ‘eligible
5 individual’ means an individual—
6 "(A) who is—
7 "(i) a blind or disabled individual; or
8 "(ii) an individual described in para-
9 graph (2); and
10 "(B) who the State determines satisfies—
11 "(i) the income and resources eligi-
12 bility requirements established by the State
13 under the State plan under this part; and
14 "(ii) such other requirements for as-
15 assistance as are imposed under this title, in-
16 cluding documentation of citizenship or
17 status as a qualified alien under title IV of
18 the Personal Responsibility and Work Op-
19 portunity Reconciliation Act of 1996.
20 "(2) INDIVIDUALS DESCRIBED.—For purposes
21 of paragraph (1)(A)(ii), the following individuals are
22 described in this paragraph:
23 "(A) A child in foster care under the re-
24 sponsibility of the State.
“(B) A low-income woman with breast or cervical cancer described in old section 1902(aa).

“(C) Certain TB-infected individuals described in old section 1902(z)(1).

“(3) GRANDFATHERED INDIVIDUALS.—An individual shall be an eligible individual under the State plan under this part if—

“(A) the individual is described in paragraph (1)(A);

“(B) the individual satisfies the documentation requirements referred to in paragraph (1)(B)(ii); and

“(C) the State would have provided medical assistance under the State plan under old title XIX to the individual, but only so long as the individual continues to satisfy such old eligibility requirements.

“(4) CONCURRENT ELIGIBILITY FOR PART B.—An eligible individual under this part may be eligible under part B, but only if the individual satisfies the eligibility requirements of part B in addition to satisfying the requirements for eligibility under this part.
“(5) Presumptive eligibility for certain breast or cervical cancer patients.—Old section 1920B (relating to presumptive eligibility for certain breast or cervical cancer patients) shall apply under this part.

“(b) Benefits.—Subject to paragraph (3), in this part, the term ‘acute care medical assistance’ means the following:

“(1) Mandatory benefits.—The care and services listed in paragraphs (1) through (5), (17), and (21) of old section 1905(a) (but, in the case of paragraph (4)(A) of such section, without regard to any limitation based on age or services in an institution for mental diseases).

“(2) Optional benefits.—Any care or services listed in a paragraph of old section 1905(a) (other than paragraph (16)).

“(3) Exceptions.—

“(A) Certain services limited to part B.—Services described in paragraphs (15), (22), (23), (24), and (26) of old section 1905(a) shall only be provided under the State plan under part B.

“(B) Limit on provision of long-term care services and supports.—A care or
service that the Secretary determines is a long-
term care service and support (including nurs-
ing facility services described in old section
1905(a)(4)(A)) shall not be provided to an indi-
vidual under the State plan under this part for
more than 30 days within any 12-month period.

“(C) Exclusions.—Such term shall not
include any payments with respect to care or
services for any individual who is an inmate of
a public institution or a patient in an institu-
tion for mental diseases (regardless of age).

“Sec. 1904. State Plan Requirements for Acute Care
Medical Assistance.

“(a) In General.—In order to receive payments
under this part, a State shall have an approved State plan
for acute care medical assistance. For purposes of this
part, such assistance includes payments for preventive
care, primary care, diagnosis and treatment of acute and
chronic health conditions, emergency care, diagnosis and
treatment of mental illnesses and related conditions, and
rehabilitation and other services to help eligible individuals
attain or retain capability for independence or self-care.
A State medical assistance plan shall include a descrip-
tion, consistent with the requirements of this part of—
“(1) eligibility standards, including income and asset standards;

“(2) benefits, including the amount, duration, and scope of covered items and services;

“(3) strategies for improving access and quality of care; and

“(4) methods of service delivery.

“(b) Public Availability of State Plan.—The State shall make available to the public the State plan under this part and any amendments submitted by the State to the plan.

“(c) Amount, Duration, and Scope.—The State plan shall provide that the acute care medical assistance made available to any eligible individual shall not be less in amount, duration, or scope than the acute care medical assistance made available to any other eligible individual.

“(d) Application of Certain Pre-Modernized Medicaid Requirements.—

“(1) Old State Plan Requirements.—The following provisions of old section 1902 shall apply to the State plans under this part:

“(A) Old section 1902(a)(10)(C) (relating to certain eligibility and other requirements).

“(B) Old section 1902(a)(10)(D) (relating to home health services).
“(C) Old section 1902(a)(10)(G) (relating to nonapplication of certain supplemental security income eligibility criteria).

“(D) The subclauses in the flush matter following old section 1902(a)(10)(G) (relating to the provision of certain services) other than subclauses (V), (VII), (VIII), and (IX).

“(E) Old section 1902(a)(17) (relating to reasonable standards for determining eligibility).

“(F) Old section 1902(a)(19) (relating to eligibility safeguards).

“(G) Old section 1902(a)(34) (relating to eligibility beginning with the third month prior to the month of application).

“(H) Subparagraphs (A), (B), and (C) of old section 1902(a)(43) (relating to early and periodic screening, diagnostic, and treatment services).

“(I) Old section 1902(a)(46)(A) (relating to compliance with section 1137 requirements).

“(J) The fourth and sixth sentences of old section 1902(a) (relating to eligibility for certain individuals).

“(2) OTHER OLD TITLE XIX REQUIREMENTS.—
“(A) Old section 1902(e)(3) (relating to optional eligibility for certain disabled individuals).

“(B) Old section 1902(e)(9) (relating to optional respiratory care services).

“(C) Old section 1902(f) (relating to eligibility of certain aged, blind, or disabled individuals).

“(D) Old section 1902(m) (relating to eligibility of certain aged or disabled individuals), other than paragraph (4).

“(E) Old section 1902(o) (relating to disregard of certain supplemental security income benefits).

“(F) Old section 1902(v) (relating to eligibility determinations of blind or disabled individuals).

“(e) OTHER REQUIREMENTS.—The State plan under this part shall—

“(1) comply with the requirements of the other parts of this title; and

“(2) provide that the State will make the contributions specified under section 340A–1(e) of the Public Health Service Act.
“SEC. 1905. DEFINITIONS.

“(a) In General.—The definitions specified in this section shall apply for purposes of this part and, to the extent applicable and consistent with the policy embodied in such part, parts B, C, D, E, and F.

“(b) Federal Medical Assistance Percentage.—The term ‘Federal medical assistance percentage’ for any State shall be 100 percent less the State percentage; and the State percentage shall be that percentage which bears the same ratio to 45 percent as the square of the per capita income of such State bears to the square of the per capita income of the continental United States (including Alaska) and Hawaii, except that the Federal medical assistance percentage shall in no case be less than 50 percent or more than 83 percent. The Federal medical assistance percentage for any State shall be determined and promulgated in accordance with the provisions of section 1101(a)(8)(B).

“(c) Application of Certain Pre-Modernized Medicaid Provisions.—The following old provisions shall apply under this part:

“(1) Old Section 1905 Provisions.—The following provisions of old section 1905:

“(A) Old section 1905(d) (relating to the definition of an intermediate care facility for the mentally retarded).
“(B) Old section 1905(e) (relating to the definition of physicians services).

“(C) Old section 1905(f) (relating to the definition of nursing facility services).

“(D) Old section 1905(g) (relating to the provision of chiropractors’ services).

“(E) Old section 1905(j) (relating to State supplementary payments).

“(F) Old section 1905(k) (relating to supplemental security income benefits payable pursuant to section 211 of Public Law 93–66).

“(G) Old section 1905(l)(1) (relating to rural health clinic services).

“(H) Old section 1905(o) (relating to hospice care).

“(I) Old section 1905(q) (relating to the definition of a qualified severely impaired individual).

“(J) Old section 1905(r) (relating to the definition of early and periodic screening, diagnostic, and treatment services).

“(K) Old section 1905(s) (relating to the definition of a qualified disabled and working individual).
“(L) Old section 1905(t) (relating to the
definition of primary care case management
services).

“(M) Old section 1905(v) (relating to the
definition of an employed individual with a
medically improved disability).

“(N) Paragraphs (1) and (3) of old section
1905(w) (relating to the definition of an inde-
dependent foster care adolescent).

“(O) Old section 1905(x) (relating to
strategies, treatment, and services for individ-
uals with Sickle Cell Disease).

“(2) OTHER OLD PROVISIONS.—

“(A) Old section 1903(m) (relating to the
definition of a medicaid managed care organiza-
tion).

“SEC. 1906. ENROLLMENT OF INDIVIDUALS UNDER GROUP
HEALTH PLANS AND OTHER ARRANGEMENTS.

“The following old provisions shall apply under this
part:

“(1) Old section 1906 (relating to enrollment of
individuals under group health plans).

“(2) Old section 1902(a)(70) (relating to State
option to establish a non-emergency medical trans-
portation brokerage program).
“(3) Paragraphs (2) and (11) of old section 1902(e) (relating to eligibility for individuals enrolled with a group health plan or under a managed care arrangement during a minimum enrollment period).

“SEC. 1907. DRUG REBATES.

“Old sections 1902(a)(54) and 1927 (relating to payment for covered outpatient drugs and rebates) shall apply under this part.

“SEC. 1908. MANAGED CARE.

“The following old provisions shall apply under this part:

“(1) Old section 1932 (relating to managed care), other than subsection (a)(2) of such section.

“(2) Old section 1903(k) (relating to technical and actuarial assistance for States).

“SEC. 1909. ANNUAL REPORTS.

“(a) In General.—Each State that receives payments under this part shall submit an annual report to the Secretary, in such form and manner as the Secretary shall specify.

“(b) Application of Old EPSDT Reporting Requirements.—Each annual report shall include the information required to be reported under old section 1902(a)(43)(D)(iv).
“PART B—GRANTS TO STATES FOR LONG-TERM CARE SERVICES AND SUPPORTS

“SEC. 1911. PURPOSE.

“(a) IN GENERAL.—The purpose of this part is to increase the flexibility of States in operating a system of long-term care services and supports designed to—

“(1) provide assistance to needy families so that individuals with disabilities and low-income senior citizens may be served and supported in their own homes and communities;

“(2) emphasize the independence and dignity of the person served by public programs;

“(3) end the institutional bias that existed under the Medicaid program prior to January 1, 2011;

“(4) provide stable and predictable funding for States as they rebalance their long-term care systems from institutions to communities;

“(5) provide flexibility to States to adopt new and innovative service delivery methods; and

“(6) promote independence and support activities that will enable individuals to return or maintain ties to the community, including through employment.

“(b) NO INDIVIDUAL ENTITLEMENT.—No individual determined eligible for long-term care services and sup-
ports under this part shall be entitled to a specific service
or type of delivery of service.

“SEC. 1912. STATE PLAN.

“(a) IN GENERAL.—In order to receive payments
under this part, a State must have an approved State plan
for long-term care services and supports. A State long-
term care services and supports plan shall include a de-
scription, consistent with the requirements of this part,
of—

“(1) income and assets eligibility standards and
spousal impoverishment protections consistent with
subsection (b);

“(2) the standardized assessments tools used to
determine eligibility for specific long-term care serv-
ices and supports;

“(3) the person-centered plans used to provide
such services and supports;

“(4) the proposed uses of funding, if applicable,
to provide targeted methods to meet individual level
of support needs including tiering (preventive, emer-
gency, low, medium, high); and

“(5) the long-term care services and supports to
be available under the plan based on individual as-
ssessment of need in accordance with sections 1916
and 1917.
“(b) Minimum Eligibility Standards.—

“(1) Populations Covered.—The State plan shall specify the disabled and elderly populations who are eligible for long-term care services and supports.

“(2) Needs-Based Criteria.—The plan shall include a description of the needs-based criteria the State will use to assess an individual’s need for specific services and supports available under the State plan.

“(3) Other Eligibility Requirements.—

“(A) Income and Assets.—A State may use different income and asset standards and methodologies for determining eligibility than those used for determining eligibility for acute care medical assistance under part A. A State may not make eligibility standards related to income, asset, and spousal impoverishment protection more restrictive than the Federal minimum requirements of December 31, 2008.

“(B) Application of Spousal Impoverishment Protections.—The State plan shall provide that the State shall comply with the requirements of section 1918 (relating to spousal impoverishment protections).
“(C) STATEWIDENESS.—The State plan shall provide that, except with respect to methods used for determining homestead exemptions, the income and asset standards and methodologies shall be in effect in all political subdivisions of the State.

“(4) TRANSITION ASSISTANCE.—The State plan shall specify how the State will provide transition assistance for individuals who, on December 31, 2010, are enrolled under the State plan under old title XIX (or under a waiver of that plan) and receiving long-term care services or supports on that date. The State shall provide such assistance to individuals who are and are not likely to be determined eligible for long-term care services and supports under the State plan under this part, as in effect on January 1, 2011 (or the first day on which the State plan is in effect under this part).

“(c) PAYMENT METHODOLOGIES TO PROVIDERS.—

“(1) IN GENERAL.—The State plan shall describe the methodologies used to determine payments to providers. Such methodologies—

“(A) may be varied to assist in transitioning from facilities-based to community-based care; and
“(B) shall not be subject to Secretarial approval.

“(2) Transparency.—The State plan shall provide that the State shall make publicly available—

“(A) the payment methodologies applicable under the plan; and

“(B) the name of any provider that receives $1,000,000 or more in any 12-month period and the actual amount paid to the provider during that period.

“(d) Coordination of Effort With Other Related Public and Private Programs.—The plan shall include a description of the State’s efforts to coordinate the delivery of services and supports under the plan with other related public and private programs that serve individuals with disabilities or aged populations that need or may be at risk of needing long term care.

“(e) Public Availability of State Plan.—The State shall make available to the public the State plan under this part and any amendments submitted by the State to the plan.

“(f) Application of Old Title XIX Requirements.—The following old title XIX provisions shall apply to a State plan under this part:
“(1) Subsections (a)(50) and (q) of old section
1902 (relating to a monthly personal needs allow-
ance for certain institutionalized individuals and
couples).

“(2) Old section 1902(a)(67) (relating to pay-
ment for certain services furnished to a PACE pro-
gram eligible individual).

“(3) Paragraph (1) of old section 1902(r) (re-
ating to the post-eligibility treatment of income for
certain individuals) and paragraph (2) of such sec-
tion (relating to methodologies for determining in-
come and resource eligibility for individuals, but only
with respect to individuals who are eligible under
this part on or after January 1, 2011).

“(4) Old section 1905(i) (relating to the defini-
tion of an institution for mental diseases).

“(g) Other Requirements of Other Parts.—
The State plan under this part shall—

“(1) comply with the requirements of the other
parts of this title; and

“(2) provide that the State will make the con-
tributions specified under section 340A–1(e) of the
Public Health Service Act.
“SEC. 1913. STATE ALLOTMENTS.

“(a) APPROPRIATION.—For the purpose of providing allotments to States under this section, there is appropriated out of any money in the Treasury not otherwise appropriated—

“(1) for fiscal year 2011, $65,274,560,000;
“(2) for fiscal year 2012, $67,885,540,000;
“(3) for fiscal year 2013, $70,600,964,100;
“(4) for fiscal year 2014, $73,425,000,000;
“(5) for fiscal year 2015, $76,362,000,000;
“(6) for fiscal year 2016, $79,416,480,000;
“(7) for fiscal year 2017, $82,593,140,000;
“(8) for fiscal year 2018, $85,896,870,000; and
“(9) for fiscal year 2019, $89,332,743,000.

“(b) ALLOTMENTS TO 50 STATES AND THE DISTRICT OF COLUMBIA.—

“(1) FISCAL YEAR 2011 ALLOTMENTS.—Subject to subsection (e), the Secretary shall allot to each State with a long term care plan approved under this title an amount in fiscal year 2011 equal to the Federal expenditures made by the State for long-term care as defined in section 1916 in fiscal year 2008, increased by 8 percent.

“(2) SUBSEQUENT FISCAL YEAR ALLOTMENTS.—For fiscal year 2012 and each subsequent fiscal year through fiscal year 2019, the allotment
for a State under this section is equal to the allot-
ment for the State determined for the preceding fis-
cal year, increased by 4 percent.

“(c) LIMITATION.—

“(1) IN GENERAL.—Except as provided in para-
graph (2), no other Federal funds are available
under this title for expenditures incurred for long-
term care services and supports after December 31,
2010, except as provided under a State plan ap-
proved under this part.

“(2) EXCEPTION.—

“(A) IN GENERAL.—If a State does not
have an approved State plan by October 1,
2010, the Secretary may make payments equal
to 85 percent of the State’s estimated quarterly
allotment until June 30, 2011.

“(B) FULL FUNDING.—A State shall re-
ceive 100 percent of its allotment for fiscal year
2011 if the State has a plan approved under
this part by June 30, 2011.

“(d) MAINTENANCE OF EFFORT.—In order to qualify
for the grant payable under this section, the State must
demonstrate in each fiscal year that it made long-term
care service and supports expenditures (including funding
from local government sources) equal to the amount of
not less than 95 percent of the nonfederal share amount spent in fiscal year 2009 under the State plan under old title XIX on long term care services and supports (as defined in section 1916). Expenditures not made under this part shall not be recognized by the Secretary for purposes of this requirement.

“(e) Grants Reduced if Insufficient Appropriations.—

“(1) In general.—If the amount appropriated for fiscal year 2011 under subsection (a)(1) is less than the amount necessary to fund each State’s allotment for that fiscal year, the Secretary shall reduce the allotment for each State for that fiscal year based on the applicable percentage determined for the State under paragraph (2) provide a reduced percentage basis as follows: Each state shall receive a percentage of its allotment based on the ratio of non-institutional spending to total long term care spending in FY 2009.

“(2) Applicable Percentage.—For purposes of paragraph (1), the applicable percentage determined with respect to a State is as follows:

<table>
<thead>
<tr>
<th>If the ratio of the State's non-institutional spending for fiscal year 2009 is:</th>
<th>The applicable percentage is:</th>
</tr>
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<tbody>
<tr>
<td>50 percent or greater</td>
<td>100</td>
</tr>
<tr>
<td>at least 46, but less than 50 percent</td>
<td>99</td>
</tr>
<tr>
<td>at least 40, but less than 46 percent</td>
<td>98</td>
</tr>
<tr>
<td>at least 36, but less than 40</td>
<td>97</td>
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</tbody>
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“(f) Administrative Expenses.—

“(1) In general.—Each State with a plan approved under this part shall receive a payment determined in accordance with amounts appropriated for part E for administrative expenses incurred in carrying out the plan under this part and part A.

“(2) Assessment-related costs.—Costs attributable to providing an individualized needs-based assessment for purposes of identifying the long-term care services and supports to be provided under the State plan to an individual shall be considered a long-term care service and support and shall not be treated as an administrative expense.

“SEC. 1914. USE OF GRANTS.

“(a) In general.—A State shall use funds for long-term care services and supports as defined in section 1916.

“(b) Self-direction.—A State shall offer individuals the opportunity to self-direct their long-term care services and supports.

“SEC. 1915. ADMINISTRATIVE PROVISIONS.

“(a) Funding on a quarterly basis.—The Secretary shall make payments to States in equal amounts of a State’s annual allotment on a quarterly basis. Each
quarterly payment shall remain available for use by the State for twelve succeeding fiscal year quarters.

“(b) PUBLICATION.—The Secretary shall public each State’s applicable allotment.

“SEC. 1916. DEFINITION OF LONG-TERM CARE SERVICES AND SUPPORTS.

“(a) DEFINITION.—

“(1) IN GENERAL.—Subject to subsection (e), in this part, the term ‘long-term care services and supports’ means any of the services or supports specified in paragraphs (2) or (3) that may be provided in a nursing facility, an institution, a home, or other setting.

“(2) SERVICES AND SUPPORTS DESCRIBED.—For purposes of paragraph (1), the services and supports described in this paragraph include assistive technology, adaptive equipment, remote monitoring equipment, case management for the aged, case management for individuals with disabilities, nursing home services, long-term rehabilitative services necessary to restore functional abilities, services provided in intermediate care facilities for people with disabilities, habilitation services (including adult day care programs), community treatment teams for individuals with mental illness, home health services,
services provided in an institution for mental dis-

eease, a Program of All-Inclusive Care for the Elderly

(PACE), personal care (including personal assist-

ance services), recovery support including peer coun-

seling, supportive employment, training skills nec-

essary to assist the individual in achieving or main-

taining independence, training of family members in-

cluding foster parents in supportive and behavioral

modification skills, ongoing and periodic training to

maintain life skills, transitional care including room

and board not to exceed 60 days within a 12-month

period.

“(3) Inclusion of Certain Benefits Under

Old Title XIX.—Such services and supports may

include any of the following services:

“(A) Old section 1905(a)(15) (relating to

services in an intermediate care facility for the

mentally retarded).

“(B) Services described in subsections

(a)(16) and (h) of old section 1905, but without

regard to any restriction on such services on

the basis of age (relating to inpatient psy-

chiatric hospital services).

“(C) Old section 1905(a)(22) (relating to

home and community care (to the extent al-
allowed and as defined in old section 1929) for functionally disabled elderly individuals).

“(D) Old section 1905(a)(23) (relating to community supported living arrangements services (to the extent allowed and as defined in old section 1930)).

“(E) Subject to subsection (e), old section 1905(a)(24) but without regard to any restriction on furnishing services to patients or residents of facilities or institutions (relating to personal care services).

“(F) Old sections 1905(a)(26) and 1934 (relating to services furnished under a PACE program under old section 1934 to PACE program eligible individuals enrolled under the program under such old section).

“(G) Old section 1915(c)(5) (relating to the definition of habilitation services).

“(4) LIMITATION.—Long-term care services and supports cannot be used for services and administrative costs provided through the foster care (with the exception of training of foster care parents), child welfare, adult protective services, juvenile justice, public guardianship, or correctional systems.
“(b) Rehabilitative Care.—For purposes of rehabilitation due to acute care medical needs, a State may claim rehabilitative services provided in an institutional setting, nursing home, or as part of home health expenditures as acute care benefits under the State plan under part A rather than under the State plan under this part for a cumulative period of 30 days within a 12-month period if such care is directly related to the onset of an acute care need. A State shall demonstrate the services were provided as a direct result of an acute care need.

“(c) Managed Care.—If a State provides long-term care services and supports through managed care, the State shall submit a methodology for determining the level of expenditures attributed to long term care for approval by the Secretary.

“(d) Application of Part A Definitions.—A definition specified in section 1905 shall apply to the same term used in this part, unless the Secretary determines that the application of such definition would be inconsistent with the purpose of this part.

“(e) Exclusion.—No payments shall be made under the State plan under this part with respect to long-term care supports and services provided for any individual who is an inmate of a public institution. Nothing in the preceding sentence shall be construed as precluding the provi-
sion of long-term care services and supports under the
State plan under this part to an individual who is a pa-
tient in an institution for mental diseases.

“SEC. 1917. PROVISION REQUIREMENTS FOR LONG-TERM
CARE SERVICES AND SUPPORT, INCLUDING
OPTION FOR SELF-DIRECTED SERVICES AND
SUPPORTS.

“(a) REQUIREMENTS FOR THE PROVISION OF LONG-
TERM CARE SERVICES AND SUPPORTS.—

“(1) IN GENERAL.—Subject to the succeeding
provisions of this subsection, a State may provide
through a State plan amendment for the provision
of long-term care services and supports for individ-
uals eligible under the State plan under this part,
subject to the following requirements:

“(A) NEEDS-BASED CRITERIA FOR ELIGI-
BILITY FOR, AND RECEIPT OF, LONG-TERM
CARE SERVICES AND SUPPORTS.—The State es-
establishes needs-based criteria for determining
an individual’s eligibility under the State plan
for medical assistance for such long-term care
services and supports, and if the individual is
eligible for such services and supports, the spe-
cific services and supports that will be available
under the State plan to the individual.
“(B) Criteria for institutionalized versus non-institutionalized services.—

In establishing needs-based criteria, the State may establish criteria for determining eligibility for, and receipt of, services and supports provided in a facility or institution that are more stringent that the criteria established for eligibility and receipt of services and supports in a non-facility or non-institutionalized setting.

“(C) Authority to limit number of eligible individuals.—A State may limit the number of individuals who are eligible for such services and supports and may establish waiting lists for the receipt of such services and supports.

“(D) Criteria based on individual assessment.—

“(i) In general.—The criteria established by the State shall require an assessment of an individual’s support needs and capabilities, and may take into account the inability of the individual to perform 2 or more activities of daily living (as defined in section 7702B(c)(2)(B) of the Internal Revenue Code of 1986) or the need for sig-
significant assistance to perform such activities, and such other risk factors as the State determines to be appropriate.

“(ii) ADJUSTMENT AUTHORITY.—The State plan amendment provides the State with the option to modify the criteria established under subparagraph (A) (without having to obtain prior approval from the Secretary) in the event that the enrollment of individuals eligible for services exceeds the projected enrollment, but only if—

“(I) the State provides at least 60 days notice to the Secretary and the public of the proposed modification;

“(II) the State deems an individual receiving long-term care services and supports on the basis of the most recent version of the criteria in effect prior to the effective date of the modification to be eligible for such services and supports for a period of at least 12 months beginning on the date the individual first received med-
ical assistance for such services and supports; and

“(III) after the effective date of such modification, the State, at a minimum, applies the criteria for determining whether an individual requires the level of care provided in a facility or institutionalized setting which applied under the State plan immediately prior to the application of the modified criteria.

“(E) INDEPENDENT EVALUATION AND ASSESSMENT.—

“(i) ELIGIBILITY DETERMINATION.—

The State uses an independent evaluation for making the determinations described in subparagraph (A).

“(ii) ASSESSMENT.—In the case of an individual who is determined to be eligible for long-term care services and supports, the State uses an independent assessment, based on the needs of the individual to—

“(I) determine a necessary level of services and supports to be pro-
vided, consistent with an individual’s physical and mental capacity;

“(II) prevent the provision of unnecessary or inappropriate care; and

“(III) establish an individualized care plan for the individual in accordance with subparagraph (G).

“(F) ASSESSMENT.—The independent assessment required under subparagraph (E)(ii) shall include the following:

“(i) An objective evaluation of an individual’s inability to perform 2 or more activities of daily living (as defined in section 7702B(c)(2)(B) of the Internal Revenue Code of 1986) or the need for significant assistance to perform such activities.

“(ii) A face-to-face evaluation of the individual by an individual trained in the assessment and evaluation of individuals whose physical or mental conditions trigger a potential need for long-term care services and supports.

“(iii) Where appropriate, consultation with the individual’s family, spouse, guardian, or other responsible individual.
“(iv) Consultation with appropriate treating and consulting health and support professionals caring for the individual.

“(v) An examination of the individual’s relevant history, medical records, and care and support needs, guided by best practices and research on effective strategies that result in improved health and quality of life outcomes.

“(vi) An evaluation of the ability of the individual or the individual’s representative to self-direct the purchase of, or control the receipt of, such services and supports if the individual so elects.

“(G) INDIVIDUALIZED CARE PLAN.—

“(i) In general.—In the case of an individual who is determined to be eligible for long-term care services and supports, the State uses the independent assessment required under subparagraph (E)(ii) to establish a written individualized care plan for the individual.

“(ii) Plan requirements.—The State ensures that the individualized care plan for an individual—
“(I) is developed—

“(aa) in consultation with the individual, the individual’s treating physician, health care or support professional, or other appropriate individuals, as defined by the State, and, where appropriate the individual’s family, caregiver, or representative; and

“(bb) taking into account the extent of, and need for, any family or other supports for the individual;

“(II) identifies the long-term care services and supports to be furnished to the individual (or, if the individual elects to self-direct the purchase of, or control the receipt of, such services and supports, funded for the individual); and

“(III) is reviewed at least annually and as needed when there is a significant change in the individual’s circumstances.
“(iii) **STATE REQUIREMENT TO OFFER ELECTION FOR SELF-DIRECTED SERVICES AND SUPPORTS.**—

“(I) **INDIVIDUAL CHOICE.**—The State shall allow an individual or the individual’s representative the opportunity to elect to receive self-directed long-term care services and supports in a manner which gives them the most control over such services and supports consistent with the individual’s abilities and the requirements of subclauses (II) and (III).

“(II) **SELF-DIRECTED.**—The term ‘self-directed’ means, with respect to the long-term care services and supports offered under the State plan amendment, such services and supports for the individual which are planned and purchased under the direction and control of such individual or the individual’s authorized representative, including the amount, duration, scope, provider, and location of such services and supports, under the
State plan consistent with the following requirements:

“(aa) **Assessment.**—There is an assessment of the needs, capabilities, and preferences of the individual with respect to such services and supports.

“(bb) **Service Plan.**—Based on such assessment, there is developed jointly with such individual or the individual’s authorized representative a plan for such services and supports for such individual that is approved by the State and that satisfies the requirements of subclause (III).

“(III) **Plan Requirements.**—For purposes of subclause (II)(bb), the requirements of this subclause are that the plan—

“(aa) specifies those services and supports which the individual or the individual’s authorized
representative would be responsible for directing;

“(bb) identifies the methods by which the individual or the individual’s authorized representative will select, manage, and dismiss providers of such services and supports;

“(cc) specifies the role of family members and others whose participation is sought by the individual or the individual’s authorized representative with respect to such services and supports;

“(dd) is developed through a person-centered process that is directed by the individual or the individual’s authorized representative, builds upon the individual’s capacity to engage in activities that promote community life and that respects the individual’s preferences, choices, and abilities, and involves families, friends,
and professionals as desired or
required by the individual or the
individual’s authorized representa-
tive;

“(ee) includes appropriate
risk management techniques that
recognize the roles and sharing of
responsibilities in obtaining serv-
ices and supports in a self-di-
rected manner and assure the ap-
propriateness of such plan based
upon the resources and capabili-
ties of the individual or the indi-
vidual’s authorized representa-
tive; and

“(ff) may include an individ-
ualized budget which identifies
the dollar value of the services
and supports under the control
and direction of the individual or
the individual’s authorized repre-
sentative.

“(IV) Budget process.—With
respect to individualized budgets de-
scribed in subclause (III)(ff), the State plan amendment—

“(aa) describes the method for calculating the dollar values in such budgets based on reliable costs and service utilization;

“(bb) defines a process for making adjustments in such dollar values to reflect changes in individual assessments and service plans; and

“(cc) provides a procedure to evaluate expenditures under such budgets.

“(H) QUALITY ASSURANCE; CONFLICT OF INTEREST STANDARDS.—

“(i) QUALITY ASSURANCE.—The State ensures that the provision of long-term care services and supports meets Federal and State guidelines for quality assurance.

“(ii) CONFLICT OF INTEREST STANDARDS.—The State establishes standards for the conduct of the independent evalua-
tion and the independent assessment to safeguard against conflicts of interest.

“(I) Redeterminations and Appeals.—The State allows for at least annual redeterminations of eligibility, and appeals in accordance with the frequency of, and manner in which, redeterminations and appeals of eligibility are made under the State plan.

“(J) Presumptive Eligibility for Assessment.—The State, at its option, elects to provide for a period of presumptive eligibility (not to exceed a period of 60 days) only for those individuals that the State has reason to believe may be eligible for long-term care services and supports. Such presumptive eligibility shall be limited to medical assistance for carrying out the independent evaluation and assessment under subparagraph (E) to determine an individual’s eligibility for such services and if the individual is so eligible, the specific long-term care services and supports that the individual will receive.

“(2) Definition of Individual’s Representative.—In this section, the term ‘individual’s representative’ means, with respect to an indi-
individual, a parent, a family member, or a guardian of the individual, an advocate for the individual, or any other individual who is authorized to represent the individual.

“(b) Self-Directed Personal Assistance Services.—If a State includes personal care or personal assistance services in the long-term care services and supports available under the State plan, the State shall comply with the requirements of old section 1915(j) in the case of an individual who elects to self-direct the receipt of such care or services.

“SEC. 1918. TREATMENT OF INCOME AND RESOURCES FOR CERTAIN INSTITUTIONALIZED SPOUSES.

“Old section 1924 (relating to treatment of income and resources for certain institutionalized spouses), other than paragraphs (2) and (4)(A) of subsection (a) of such section, shall apply under this part.

“SEC. 1919. ANNUAL REPORTS.

“(a) In General.—Each State that receives payments under this part shall submit an annual report to the Secretary, in such form and manner as the Secretary shall specify.

“(b) Requirements.—The report shall include the following with respect to the most recent fiscal year ended:
“(1) The number of individuals served under the plan.

“(2) The number of individuals served by tier (preventive, emergency, low, medium, and high needs).

“(3) The number of individuals known to the State on waiting list for services (if any) and type of disability (physical, developmental, mental health) or aged.

“(4) Expenditures by service category.

“PART C—GRANTS TO STATES FOR SURVEY AND CERTIFICATION OF MEDICAL FACILITIES AND OTHER REQUIREMENTS

“SEC. 1931. AUTHORIZATION OF APPROPRIATIONS.

“For the purpose of carrying out our Federal activities and providing grants to States for expenses necessary to carry out this part, there is authorized to be appro-

—

“(1) for fiscal year 2011, $300,000,000; and

“(2) for each succeeding fiscal year, the amount authorized under this section for the preceding fiscal year, increased by 5 percent.
“SEC. 1932. APPLICATION OF CERTAIN REQUIREMENTS UNDER PRE-MODERNIZED MEDICAID.

“The following old provisions shall apply under this part:

“(1) Old section 1902(a)(9) (relating to health standards and applicable requirements for laboratory services).

“(2) Old section 1902(a)(28) (relating to nursing facilities and nursing facility services).

“(3) Old sections 1902(a)(29) and 1908 (relating to a State program for the licensing of administrators of nursing homes).

“(4) Old section 1902(a)(33)(B) (relating to licensing health institutions).

“(5) Old section 1902(d) (relating to medical or utilization review functions).

“(6) Old section 1902(i) (relating to intermediate care facilities for the mentally retarded).

“(7) Old section 1902(y) (relating to psychiatric hospitals).

“(8) Paragraphs (2) and (6) of old section 1903(g) (relating to the Secretarial requirement to conduct sample onsite surveys of private and public institutions and recertifications for the need for certain services).
“(9) Old section 1903(q)(4)(B) (relating to the definition of a board and care facility).

“(10) Old section 1910 (relating to certification and approval of rural health clinics and intermediate care facilities for the mentally retarded).

“(11) Old section 1911 (relating to Indian Health Service facilities).

“(12) Old section 1913 (relating to hospital providers of nursing facility services).

“(13) Old section 1919 (relating to requirements for nursing facilities).

“PART D—GRANTS TO STATES FOR PROGRAM INTEGRITY

“SEC. 1941. AUTHORIZATION OF APPROPRIATIONS.

“(a) In General.—For the purpose of carrying out Federal activities under this part and providing grants to States for expenses necessary to carry out this part, there is authorized to be appropriated—

“(1) for fiscal year 2011, $100,000,000; and

“(2) for each succeeding fiscal year, the amount authorized under this section for the preceding fiscal year, increased by 5 percent.

“(b) Availability; Authority for Use of Funds.—
“(1) Availability.—Amounts appropriated pursuant to subsection (a) shall remain available until expended.

“(2) Authority for use of funds for transportation and travel expenses for attendees at education, training, or consultative activities.—

“(A) In general.—The Secretary may use amounts appropriated pursuant to subsection (a) to pay for transportation and the travel expenses, including per diem in lieu of subsistence, at rates authorized for employees of agencies under subchapter I of chapter 57 of title 5, United States Code, while away from their homes or regular places of business, of individuals described in subsection (b)(4) who attend education, training, or consultative activities conducted under the authority of that subsection.

“(B) Public disclosure.—The Secretary shall make available on a website of the Centers for Medicare & Medicaid Services that is accessible to the public—

“(i) the total amount of funds expended for each conference conducted
under the authority of subsection (b)(4); and

“(ii) the amount of funds expended for each such conference that were for transportation and for travel expenses.

“(c) Annual Report.—Not later than 180 days after the end of each fiscal year, the Secretary shall submit a report to Congress which identifies—

“(1) the use of funds appropriated pursuant to subsection (a); and

“(2) the effectiveness of the use of such funds.

“SEC. 1942. APPLICATION OF CERTAIN REQUIREMENTS UNDER PRE-MODERNIZED MEDICAID.

“The following old provisions shall apply under this part:

“(1) Old subsections (a)(25) (other than sub paragraph (E)) and (g) of section 1902 and section 1903(o) (relating to third party liability).

“(2) Old section 1902(a)(30)(B) (relating to hospital, intermediate care facility for the mentally retarded, or hospital for mental diseases admission screening and review requirements).

“(3) Old section 1902(a)(32) (relating to certain payment requirements).
“(4) Old section 1902(a)(35) (relating to disclosing entities under section 1124).

“(5) Old section 1902(a)(37) and the fifth sentence (relating to claims payment procedures).

“(6) Old section 1902(a)(44) (relating to payment for inpatient hospital services, services in an intermediate care facility for the mentally retarded, or inpatient mental hospital services).

“(7) Old sections 1902(a)(45) and 1912 (relating to assignment of rights of payment).

“(8) Old sections 1902(a)(49) and 1921 (relating to information and access to information concerning sanctions taken by State licensing authorities against health care practitioners and providers).

“(9) Old sections 1902(a)(61) and 1903(q) (relating to requirements for a medicaid fraud and abuse control unit).

“(10) Old section 1902(a)(64) (relating to reports from beneficiaries and others and data compilation requirements concerning alleged instances of waste, fraud, and abuse).

“(11) Old section 1902(a)(65) (relating to provider number and surety bond requirement for suppliers of durable medical equipment).
“(12) Old section 1902(a)(68) (relating to requirements for certain entities).

“(13) Old sections 1902(a)(69) and 1936 (relating to the Medicaid Integrity Program) other than paragraphs (1), (2)(A), and (3) of old section 1936(e).

“(14) Old section 1902(a)(70)(B)(iv) (relating to prohibitions on referrals and conflict of interest for certain brokers of non-emergency medical transportation).

“(15) Old sections 1902(a)(71) and 1940 (relating to a required asset verification program).

“(16) Old section 1902(p) (relating to exclusion of certain individuals or entities).

“(17) Old section 1902(x) (relating to unique identifiers for physicians).

“(18) Old section 1903(p) (relating to interstate collection of rights of support).

“(19) Old section 1903(r)(2) (relating to requirements for mechanized claims processing and information retrieval systems).

“(20) Old section 1903(u) (relating to erroneous excess payments), other than clause (v) of paragraph (1)(D).
“(21) Old section 1903(v) and the seventh sentence of old section 1902(a) (relating to limitations on payments for services furnished to aliens), other than subparagraphs (A) and (B) of paragraph (4).

“(22) Old section 1903(x) (relating to citizenship documentation).

“(23) Old section 1909 (relating to State false claims act requirements for increased State share of recoveries).

“(24) Old section 1914 (relating to withholding of Federal share of payments for certain Medicare providers).

“(25) Old section 1917 (relating to liens, adjustments and recoveries, and transfers of assets).

“(26) Old section 1922 (relating to correction and reduction plans for intermediate care facilities for the mentally retarded).

“PART E—GRANTS TO STATES FOR ADMINISTRATION

“SEC. 1951. AUTHORIZATION OF APPROPRIATIONS; PAYMENTS TO STATES.

“(a) In General.—For the purpose of providing grants to States for administrative expenses necessary to carry out parts A and B, there is authorized to be appropriated—
“(1) for fiscal year 2011, $7,000,000,000; and
“(2) for each succeeding fiscal year, the amount authorized under this subsection for the preceding fiscal year, increased by 3 percent.

“(b) PAYMENTS TO STATES.—
“(1) IN GENERAL.—From the amount appropriated pursuant to subsection (a) for a fiscal year, the Secretary shall pay each State with approved plans under parts A and B for the fiscal year an amount equal to the product of the amount appropriated for the fiscal year and the ratio of the total amount of payments made to the State under paragraphs (2) through (7) of section 1903(a) for fiscal year 2008 (as such section was in effect for that fiscal year) to the total amount of such payments made to all States for such fiscal year.

“(2) PRO RATA ADJUSTMENT.—The Secretary shall make pro rata adjustments to the amounts determined under paragraph (1) for a fiscal year as necessary so as to not exceed the amount appropriated pursuant to subsection (a) for the fiscal year.

“SEC. 1952. COST-SHARING PROTECTIONS.
“(a) IN GENERAL.—A State may impose cost-sharing for individuals provided acute care medical assistance
under a State plan under part A or long-term care services
and supports under a State plan under part B consistent
with the following:

“(1) The State may (in a uniform manner) re-
quire payment of monthly premiums or other cost-
sharing set on a sliding scale based on family in-
come.

“(2) A premium or other cost-sharing require-
ment imposed under paragraph (1) may only apply
to the extent that, in the case of an individual whose
family income—

“(A) exceeds 150 percent of the poverty
line, the aggregate annual amount of such pre-
mium and other cost-sharing charges imposed
under the plan does not exceed 5 percent of the
individual’s annual income; and

“(B) exceeds 250 percent of the poverty
line, the aggregate annual amount of such pre-
mium and other cost-sharing charges do not ex-
ceed 7.5 percent of the individual’s annual in-
come.

“(3) A State shall not require prepayment of
any premium or cost-sharing imposed pursuant to
paragraph (1) and shall not terminate eligibility of
an individual under the State plan on the basis of
failure to pay any such premium or cost-sharing until such failure continues for a period of at least 60 days from the date on which the premium or cost-sharing became past due. The State may waive payment of any such premium or cost-sharing in any case where the State determines that requiring such payment would create an undue hardship.

“(b) Application to Institutionalized Individuals.—A State may impose cost-sharing consistent with subsection (a) to individuals who are patients in, or residents of, a medical institution or nursing facility except that rules relating to the post-eligibility treatment of income (including a minimum monthly personal needs allowance) applicable to institutionalized individuals under old title XIX shall apply in the same manner to individuals eligible for long-term care services and supports under a State plan under part B.

“(c) Poverty Line Defined.—In this section, the term ‘poverty line’ has the meaning given such term in section 673(2) of the Community Services Block Grant Act (42 U.S.C. 9902(2)), including any revision required by such section.
SEC. 1953. APPLICATION OF CERTAIN REQUIREMENTS UNDER PRE-MODERNIZED MEDICAID.

“The following old provisions shall apply to the State plans under this title:

“(1) OLD STATE PLAN REQUIREMENTS.—

“(A) Old section 1902(a)(1) (relating to the requirement for plans to be in effect in all political subdivisions of the State).

“(B) Old section 1902(a)(2) (relating to State financial participation).

“(C) Old section 1902(a)(3) (relating to opportunity for a fair hearing).

“(D) Old section 1902(a)(4) (relating to administration).

“(E) Old section 1902(a)(5) (relating to designation of a single State agency).

“(F) Old section 1902(a)(6) (relating to reporting requirements).

“(G) Old section 1902(a)(7) (relating to restrictions on the use or disclosure of information).

“(H) Old section 1902(a)(8) (relating to applications for assistance).

“(I) Old section 1902(a)(11) (relating to cooperative agreements with other State agencies).
“(J) Old section 1902(a)(12) (relating to
determinations of blindness).

“(K) Old section 1902(a)(13) (relating to
determination of rates of payment for certain
services), other than clause (iv) of subpara-
graph (A).

“(L) Subsections (a)(15) and (bb) of old
section 1902(a) (relating to payment for serv-
ices provided by rural health clinics and feder-
ally qualified health centers).

“(M) Old section 1902(a)(16) (relating to
furnishing services to individuals when absent
from the State).

“(N) Old section 1902(a)(22) (relating to
certain administrative provisions).

“(O) Paragraphs (23) and (25)(D) of old
section 1902(a) (relating to any willing provider
requirements).

“(P) Old section 1902(a)(24) (relating to
consultative services by other agencies).

“(Q) Old section 1902(a)(26) (relating to
review of need for inpatient mental hospital
services and written plan of care requirements).

“(R) Old section 1902(a)(27) (relating to
provider record keeping requirements).
“(S) Old section 1902(a)(30)(A) (relating to utilization review).

“(T) Old section 1902(a)(31) (relating to written plan of care for services and review for intermediate care facility for the mentally retarded services).

“(U) Old section 1902(a)(33)(A) (relating to quality review requirements).

“(V) Old section 1902(a)(36) (relating to public availability of facility surveys).

“(W) Old section 1902(a)(38) (relating to the provision of information described in section 1128(b)(9) by certain entities).

“(X) Old section 1902(a)(39) (relating to the exclusion of certain entities).

“(Y) Old section 1902(a)(40) (relating to requirement for uniform reporting systems).

“(Z) Old section 1902(a)(41) (relating to notice to State medical licensing boards).

“(AA) Old section 1902(a)(42) (relating to certain audit requirements).

“(BB) Old section 1902(a)(48) (relating to eligibility cards).

“(CC) Old section 1902(a)(55) (relating to the receipt and initial processing of applica-
tions, but only to the extent such section is consistent with the policy embodied in the State plans under parts A and B).

“(DD) Subsections (a)(56) and (s) of old section 1902 (relating to adjusted payments for certain inpatient hospital services).

“(EE) Old section 1902(a)(59) (relating to maintenance of list of participating physicians).

“(FF) The second sentence of old section 1902 (relating to designation of certain State agencies).

“(GG) Old section 1902(b) (relating to limitations on approval of plans).

“(HH) Old section 1902(j) (relating to application of requirements to American Samoa and the Northern Mariana Islands).

“(2) OTHER OLD TITLE XIX REQUIREMENTS.—

“(A) Old section 1903(b)(4) (relating to limitations on payments to enrollment brokers).

“(B) Old section 1903(c) (relating to furnishing of services included in a program or plan under part B or C of the Individuals with Disabilities Education Act).

“(C) Old section 1903(d) (relating to payments).
“(D) Old section 1903(e) (relating to costs with respect to certain hospital services).

“(E) Old section 1903(i) (relating to limitations on payments).

“(F) Old section 1903(r) (relating to requirements for mechanized claims processing and information retrieval systems).

“(G) Subsections (b)(5) and (w) of old section 1903 (relating to limitations on payments related to provider taxes).

“(H) Old section 1904 (relating to operation of State plans).

“(I) Old sections 1902(a)(60) and 1908A (relating to medical child support).

“(J) Paragraphs (32)(D) and (62) of old section 1902(a) and section 1928 (relating to program for distribution of pediatric vaccines).

“PART F—OTHER PROVISIONS

“SEC. 1961. APPLICATION OF CERTAIN REQUIREMENTS UNDER PRE-MODERNIZED MEDICAID.

“The following old provisions shall apply under this part:

“(1) The third sentence of old section 1902 (relating to nonapplication of certain old provisions to a religious nonmedical health care institution).
“(2) Old section 1918 (relating to application of provisions of title II relating to subpoenas).

“(3) Old section 1939 (relating to references to laws directly affecting the Medicaid program.”.

(b) REPEAL OF TITLE XXI.—Effective January 1, 2011, title XXI of the Social Security Act (42 U.S.C. 1397aa et seq.) is repealed.

SEC. 202. OUTREACH.

(a) AUTHORIZATION OF APPROPRIATIONS.—The following amounts are authorized to be appropriated to the Secretary of Health and Human Services:

(1) For fiscal year 2010, $100,000,000 for the design and implementation of a public outreach campaign to inform the public about the changes to the programs under such titles that take effect on January 1, 2011, as a result of the amendment made by section 201.

(2) For each of fiscal years 2011 and 2012, $200,000,000 to carry out such public outreach campaign.

(3) For fiscal year 2013, $50,000,000 to carry out such public outreach campaign.

(b) AVAILABILITY.—Funds appropriated under subsection (a) shall remain available for expenditure through September 30, 2012.
(c) Authority for Use of Funds.—The Secretary may use funds made available under paragraphs (2) and (3) of subsection (a) to award grants to, or enter into contracts with, public or private entities, including States, local governments, schools, churches, and community groups.

SEC. 203. TRANSITION RULES; MISCELLANEOUS PROVISIONS.

(a) In General.—

(1) Not later than June 30, 2011, a State that is one of the 50 States or the District of Columbia shall inform all individuals enrolled in a State plan under title XIX or XXI of the Social Security Act on such date (and any new enrollees after such date) of the changes to the programs under such titles that take effect on January 1, 2012, as a result of the amendment made by section 201.

(2) No State that is one of the 50 States or the District of Columbia shall approve any applications for medical assistance or child health assistance under a State plan under title XIX or XXI (as in effect for fiscal year 2011) after December 31, 2011.

(b) Submission of Legislative Proposal for Technical and Conforming Amendments.—Not later
than 6 months after the date of enactment of this Act, the Secretary of Health and Human Services shall submit to Congress a legislative proposal for such technical and conforming amendments as are necessary to carry out the amendments made by this Act.

Subtitle B—Supplemental Health Care Assistance for Low-Income Families

SEC. 211. SUPPLEMENTAL HEALTH CARE ASSISTANCE FOR LOW-INCOME FAMILIES.

Part D of title III of the Public Health Service Act (42 U.S.C. 254b et seq.) is amended by adding at the end the following:

“Subpart XI—Health Care Assistance to Low-income Families

“SEC. 340A–1. FINANCIAL ASSISTANCE TO LOW-INCOME FAMILIES.

“(a) In General.—The Secretary shall supplement the costs of private health insurance for eligible low-income families through the distribution of supplemental debit cards to eligible families, which may be used to pay for costs associated with health care for the members of such eligible families and provide direct support to such families in accessing health care.

“(b) Eligibility.—
‘‘(1) ELIGIBLE FAMILIES.—To be eligible for financial assistance under this section—

‘‘(A) a family shall—

‘‘(i) consist of 2 or more individuals living together who are related by marriage, birth, adoption, or guardianship;

‘‘(ii) have a gross income that does not exceed 200 percent of the poverty line, as applicable to a family of the size involved; and

‘‘(iii) include at least 1 individual who is a dependent under the age of 19; and

‘‘(B) no member of the family shall be covered by private health insurance.

‘‘(2) DETERMINATION OF GROSS INCOME.—The gross income of a family shall be determined by taking the sum of the income of each family member who is at least age 21 but not older than age 65, except that the income of any member of the family who qualifies for coverage under Medicaid Part A or B shall not be counted.

‘‘(3) LIMITATION ON INDIVIDUAL ELIGIBILITY; ASSISTANCE.—

‘‘(A) IN GENERAL.—No individual who is a member of an eligible family under paragraph
(1) is eligible to qualify separately for financial assistance under this section.

“(B) Aliens.—The Secretary shall ensure that financial assistance under this section is not provided for costs associated with health care for any member of an eligible family who is an alien individual who is not a lawful permanent resident of the United States.

“(c) Supplemental Debit Card for Health Care Expenditures.—

“(1) In general.—The Secretary shall issue to each eligible family that enrolls in the program in accordance with subsection (f) a supplemental debit card with a dollar-amount value, in accordance with subsection (d), that may be used to pay for qualifying health care expenses.

“(2) Use of the Debit Card.—

“(A) Qualifying health care expenses.—A supplemental debit card issued under this section may be used by members of the eligible family to pay for—

“(i) the purchase of health care insurance for any member of the family;

“(ii) cost sharing expenses related to health care, including deductibles, copay—
ments, and coinsurance, for any member of
the family; and

“(iii) the direct purchase of health
care services and supplies for any member
of the family.

“(B) GEOGRAPHIC RANGE.—Each supple-
mental debit card may be used to pay for quali-
fying health care expenses incurred anywhere in
the 50 States or the District of Columbia.

“(C) LIMITATIONS.—No supplemental
debit card shall be used to make a payment for
any cost—

“(i) incurred prior to the determina-
tion of the family’s eligibility for assistance
under this section; or

“(ii) that is not a health-related ex-
 pense.

“(3) ROLLOVER OF UNUSED AMOUNTS.—Not
more than one-quarter of the annual dollar amount
of a supplemental debit card that is unexpended at
the end of each 12-month period may rollover—

“(A) to the family’s supplemental debit
card for expenditure during the subsequent 12-
month period, provided that the family to which
the supplemental debit card was issued in the
previous 12-month period is eligible to receive a supplemental debit card in the subsequent 12-month period; or

“(B) to the family’s health savings account (as defined in section 223(g)(2) of the Internal Revenue Code of 1986).

“(4) MONTHLY STATEMENTS.—The Secretary shall issue a monthly statement to each family to which a supplemental debit card has been issued under this section, which shall state each payment made with the family’s supplemental debit card during the month covered by the statement, the dollar amount of each such payment, and the provider to which each such payment was made.

“(d) AMOUNT OF FINANCIAL ASSISTANCE.—

“(1) AMOUNTS FOR CALENDAR YEAR 2011.—Subject to paragraph (5), the amount of financial assistance available to each eligible family during the calendar year 2011 shall be determined as follows:

“(A) Each family whose annual income does not exceed 100 percent of the poverty level, as applicable to a family of the size involved, shall receive $5,000.

“(B) Each family whose annual income exceeds 100 percent, but does not exceed 200 per-
cent, of the poverty level, as applicable to a family of the size involved, shall receive an amount as follows:

“(i) For families whose annual income exceeds 100 percent but does not exceed 120 percent, of the poverty level, $4,000.

“(ii) For families whose annual income exceeds 120 percent but does not exceed 140 percent, of the poverty level, $3,500.

“(iii) For families whose annual income exceeds 140 percent but does not exceed 160 percent, of the poverty level, $3,000.

“(iv) For families whose annual income exceeds 160 percent but does not exceed 180 percent, of the poverty level, $2,500.

“(v) For families whose annual income exceeds 180 percent but does not exceed 200 percent, of the poverty level, $2,000.

“(2) ADDITIONAL AMOUNTS.—In addition to the amounts under paragraph (1), subject to para-
graph (5), the following amounts shall be added to the supplemental debit cards of qualifying families:

“(A) For each pregnancy during which a pregnant woman’s family is eligible for assistance under this section, an additional amount of $1,000 shall be added to the family’s supplemental debit card, except that no family shall receive such additional $1,000 for any pregnancy for which the family received such amount in the previous 12-month period.

“(B) For each member of an eligible family who is less than 1 year old on any day within the calendar year in which the family is eligible for assistance, an additional amount of $500 shall be added to the family’s supplemental debit card.

“(3) COST OF LIVING ADJUSTMENTS.—In the case of any taxable year beginning in a calendar year after 2011, each dollar amount contained in paragraphs (1) and (2) shall be increased in the same manner as the dollar amounts specified in section 25E(b)(3) of the Internal Revenue Code of 1986 are increased by the blended cost-of-living adjustment determined under subsection (k)(2) of sec-
tion 25E of the Internal Revenue Code for the taxable year involved.

“(4) State option to increase amounts.—

At the option of each State, amounts in excess of the annual dollar amounts under paragraphs (1) and (2) may be provided through the supplemental debit card to eligible families in that State, but no Federal funds shall be paid to any State for any amount provided in excess of such annual dollar amount.

“(5) Risk adjustment.—The Secretary may adjust the amount of financial assistance available to an eligible family for a calendar year under this section based on age, health indicators, and other factors that represent distinct patterns of health care services utilization and costs.

“(e) Contributions of States.—

“(1) In general.—As a condition for receiving Federal funds under Part A or Part B of Medicaid, each State shall contribute 50 percent of the total amount expended under the supplemental debit card program by the participating families that reside within the State during the time that the family resides in that State. For purposes of this section, the residency of a family is determined by the residency the legally responsible head of the household.
“(2) Payments from states.—

“(A) Billing notification.—

“(i) Timing.—On June 30th and December 31st of each year, the Secretary shall send written notification to each State of that State’s 50 percent share of expenses, as described in paragraph (1), for the 6-month period ending on the last day of the month previous to such notification.

“(ii) Contents.—Each such notification to a State shall clearly state—

“(I) the payment amount due from the State;

“(II) the name of each individual for whom payment was made through the supplemental debit card program;

“(III) the health care provider to whom each payment was made;

“(IV) the amount of each payment; and

“(V) any other information, as the Secretary requires.

“(B) Payments.—Each State shall make a payment to the Secretary, in the amount
billed, not later than 30 days after the billing notification date, in accordance with subpara-
graph (A)(i).

“(C) Penalties.—If a State fails to pay to the Secretary an amount required under sub-
paragraph (B), interest shall accrue on such amount at the rate provided under old section 1903(d)(5) of the Social Security Act. The amount so owed and applicable interest shall be immediately offset against amounts otherwise payable to the State under this section, in ac-
cordance with the Federal Claims Collection Act of 1996 and applicable regulations.

“(f) Enrollment.—

“(1) In general.—The Secretary shall estab-
lish procedures and times for enrollment in the sup-
plemental debit card program. Open enrollment shall be available not less than 4 times per calendar year.

“(2) Transition of individuals enrolled in Medicaid or the State Children’s Health Insurance Program.—

“(A) Information from the States.—

Each State shall—

“(i) not later than June 30, 2011, in-
form all individuals then enrolled in Med-
Medicaid or the State Children’s Health Insurance Program (SCHIP), of the changes in effect beginning on January 1, 2012; and

“(ii) not later than October 31, 2011, redetermine the eligibility of each individual enrolled in Medicaid or SCHIP, other than those individuals who qualify for Medicaid or SCHIP as disabled, elderly, or a special population, for the supplemental debit card program, according to the eligibility criteria under subsection (b).

“(B) AUTOMATIC ENROLLMENT.—The Secretary shall provide for the automatic enrollment in the supplemental debit card program of all individuals who are enrolled in Medicaid or SCHIP and who have been redetermined by a State under subparagraph (A) to be eligible for Medicaid or SCHIP. Any individual who is determined by a State not to qualify for the supplemental debit card program may retain coverage under Medicaid or SCHIP until June 30, 2012.

“(3) ASSISTANCE WITH QUALIFIED HEALTH INSURANCE CREDIT.—Each State shall, to the extent practicable, provide individuals residing within the
State with information regarding the qualified health
insurance credit described in section 25E of the In-
ternal Revenue Code of 1986, including information
regarding eligibility for, and how to claim, such
credit.

“(g) ADMINISTRATION.—

“(1) NATIONAL SYSTEM.—The Secretary may
enter into contracts or agreements with a State, a
consortium of States, or a private entity, including
a bank, enrollment broker, or similar entity, to es-
tablish and maintain a unified national system to
support the processes and transactions necessary to
administer this section.

“(2) AUTOMATED SYSTEM.—The Secretary
shall establish an automated means, such as an elec-
tronic benefit transfer system, by which the benefits
under this section shall be transferred to eligible
families.

“(3) VERIFICATION OF APPLICANT INFORM-
ATION.—The Secretary may verify information pro-
vided by applicants with the appropriate Federal,
State, and local agencies, including the Internal Rev-
ue Service, the Social Security Administration, the
Department of Labor, and child support enforce-
ment agencies.
“(4) **CHOICE COUNSELING.**—The Secretary may enter into contracts or agreements with a State, a consortium of a State, or a private entity, including an enrollment broker or community organization or other organization, to educate eligible families about their options and to assist in their enrollment in the supplemental debit card plan.

“(5) **APPEALS.**—The Secretary shall establish an independent appeals process, to be administered by an entity separate from the entity that makes initial eligibility determinations, which shall be available to individuals who are denied benefits under the supplemental debit card program.

“(6) **RESOLUTION OF ERRORS.**—The Secretary shall provide for a reconciliation process with the States to resolve any errors and adjudicate disputes due to incomplete or false information in a family’s application or in the billing process described in subsection (e).

“(7) **PENALTIES FOR FALSE INFORMATION.**—Any person who provides false information to qualify for the supplemental debit card program shall pay a penalty in the amount of 110 percent of the amount of assistance paid on behalf of such person and all members of such person’s family.
“(h) Implementation Plan.—Not later than 6 months after the date of enactment of this section, the Secretary shall submit to Congress a plan for implementing this program.

“(i) Authorization of Appropriations.—

“(1) Administration of the Supplemental Debit Card Program.—To administer the program under this section, there are authorized to be appropriated—

“(A) for fiscal year 2009, $300,000,000, for the design of a unified, national system of conducting the supplemental debit card program;

“(B) for fiscal year 2010, $1,000,000,000 for start-up costs, including, contracting, hiring and training employees, and testing the program; and

“(C) for fiscal year 2011 and each subsequent fiscal year, $3,000,000,000.

“(2) Authorization of Benefits Under the Supplemental Debit Card Program.—To provide the supplemental debit card benefits described in this section, there are authorized to be appropriated—
“(A) for fiscal year 2011, $24,020,000,000;  
“(B) for fiscal year 2012, $25,220,000,000;  
“(C) for fiscal year 2013, $26,480,000,000;  
“(D) for fiscal year 2014, $27,810,000,000; and  
“(E) for fiscal year 2015, $29,200,000,000.”

**TITLE III—MEDICARE REFORM**

**Subtitle A—New Medicare Program**

**SEC. 301. BENEFIT CHANGES.**

Title XVIII of the Social Security Act is amended by inserting after section 1808 the following new section:

“PROGRAM FOR NEW MEDICARE BENEFICIARIES

BEGINNING IN 2021

“Sec. 1810. (a) APPLICATION.—

“(1) IN GENERAL.—Notwithstanding any other provision of law (including sections 226 and 226A), the provisions of this section shall apply to individuals (other than individuals entitled to benefits only because of the application of section 1881(d)) who first become entitled to benefits under part A, or whose coverage period under part B begins, on or after January 1, 2021.
“(2) NO IMPACT ON FICA/SECA TAX REVENUES.—Nothing in this section shall be construed as affecting revenues through the payment of hospital insurance taxes under sections 1401(b), 3101(b), and 3111(b) of the Internal Revenue Code of 1986.

“(3) NO IMPACT ON OTHER BENEFICIARIES.—

“(A) IN GENERAL.—This section shall not apply to individuals not described in paragraph (1).

“(B) NO IMPACT ON COMPUTATION OF MEDICARE PREMIUMS FOR OLDER MEDICARE BENEFICIARIES.—Premiums under parts A, B, and D shall be computed for individuals not described in paragraph (1) based on the average costs that the Secretary estimates would have been applicable if this section did not apply.

“(b) ALTERNATIVE BENEFITS.—

“(1) IN GENERAL.—An individual described in subsection (a)(1) is only entitled to benefits under this title in accordance with this section. In the case of such an individual who has qualified health insurance coverage, the individual is entitled under this section—

“(A) to an income-related payment under subsection (c); and
“(B) in the case of a low-income individual (as defined in paragraph (3) of subsection (d)), to a contribution to a medical savings account of the individual in the amount specified in such subsection.

“(2) ALTERNATIVE PREMIUM OBLIGATIONS.—

An individual described in subsection (a)(1)—

“(A) is not responsible for payment of any premium otherwise applicable under part B or D; but

“(B) is responsible for payment of the premium for qualified health insurance coverage referred to in paragraph (1) and may apply the income-related payment under subsection (c) toward such premium.

“(3) QUALIFIED HEALTH INSURANCE COVERAGE.—

“(A) PUBLICATION OF LIST.—The Secretary of Health and Human Services shall publish an annual list of health insurance plans that meet the definition of qualified health insurance coverage, as described in subparagraph (B) below, at least one of such plans must address the special needs of Medicare’s highest-cost seniors, as determined by the Secretary.
“(B) Qualified health insurance coverage defined.—In this subsection, the term ‘qualified health insurance coverage’ means health benefits coverage, whether under a group health plan, health insurance coverage or otherwise, but does not include coverage under a health plan if substantially all of its coverage is coverage described in section 223(e)(1)(B) of the Internal Revenue Code of 1986.

“(c) Income-related payment.—

“(1) In general.—The amount of the income-related payment under this subsection for an individual for a year is equal to—

“(A) the annual amount specified for the year in paragraph (2);

“(B) subject to reduction under paragraph (3) (relating to higher income individuals);

“(C) further subject to adjustment under paragraph (4); and

“(D) subject to pro-ration under paragraph (5).

“(2) Annual amount.—

“(A) In general.—The annual amount specified in this paragraph—
“(i) for 2011 is the average nominal dollar value of the Medicare benefit; and

“(ii) for any subsequent year is the annual amount specified in this paragraph for the preceding year increased by the annual inflation adjustment described in subparagraph (B) for such subsequent year.

Any amount computed under clause (ii) that is not a multiple of $12 shall be rounded to the nearest multiple of $12.

“(B) Annual inflation adjustment.—

The annual inflation adjustment under this subparagraph for a year is equal to the average of—

“(i) the annual rate of increase in the consumer price index for urban consumers (all items; U.S. city average) for the year, as projected by the Secretary in consultation with the Bureau of Labor Statistics before the beginning of the year; and

“(ii) the annual rate of increase in the medical care component of the consumer price index for all urban consumers (U.S. city average) for the year, as projected by the Secretary in consultation with the Bu-
reates of Labor Statistics before the begin-
ning of the year.

“(3) REDUCTION FOR HIGHER-INCOME INDIVID-
UALS.—

“(A) IN GENERAL.—In the case of an indi-
vidual whose modified adjusted gross income
exceeds the threshold amount specified in para-
graph (2) of section 1839(i), as adjusted under
paragraph (5) of such section, the annual
amount under paragraph (2) shall be reduced
by the adjustment percentage specified in sub-
paragraph (B).

“(B) ADJUSTMENT PERCENTAGE.—In the
case of an individual for whom the applicable
percentage specified in section 1839(i)(3)(C)—

“(i) is less than 80 percent, the ad-
justment percentage under this subpara-
graph shall be 50 percent; or

“(ii) is equal to 80 percent, the ad-
justment percentage under this subpara-
graph shall be 70 percent.

“(C) APPLICATION OF CERTAIN PROVI-
SIONS.—The provisions of paragraphs (4)
through (6) of section 1839(i) shall apply under
this paragraph in the same manner as they apply for purposes of such section.

“(4) RISK, GEOGRAPHIC AREA, AND OTHER ADJUSTMENTS.—

“(A) RISK ADJUSTMENT.—The payment amount under this subsection for an individual shall be adjusted, using a methodology specified by the Secretary, in a manner that takes into account the relative risk factors (such as those described in section 1853(a)(1)(C)(i)) associated with such individual. Such adjustment shall be made in such a manner as not to change the total amount of payments made under this subsection as a result of such adjustment.

“(B) PARTIAL GEOGRAPHIC AREA ADJUSTMENT.—Such payment amount for an individual also shall be adjusted, using a methodology specified by the Secretary, in a manner that takes into account the relative differences in area health care costs for the area in which the individual resides compared to other areas. Such adjustment shall be made in such a manner as not to change the total amount of payments made under this subsection as a result of
such adjustment. The Secretary shall provide
for a decrease over time in the adjustment
made under this subparagraph.

“(C) Certain part A buy-in individuals.—Such payment amount for an individual
who is not eligible for benefits under part A
pursuant to section 226 or 226A shall be ad-
justed by such proportion or amount as the
Secretary determines appropriate to take into
account premiums that would otherwise be pay-
able under section 1818 or 1818A for benefits
under part A.

“(5) Pro-ratio for partial year of eligibility.—In the case of an individual whose entitle-
ment under this section is for less than an entire
year, the payment amount under this subsection
shall be pro-rated to reflect the portion of the year
included in such entitlement.

“(6) Payment on periodic basis.—The Sec-
retary shall provide for the payment under this sub-
section on an appropriate monthly or other periodic
basis.

“(d) Contribution to a Medical Savings Ac-
count (MSA) for Low-Income Individuals.—
“(1) IN GENERAL.—The amount of the contribution under subsection (b)(1)(B) to a medical savings account of a low-income individual is equal—

“(A) in the case of an individual described in clause (i) or (ii) of paragraph (4)(A), to the full MSA contribution amount (as defined in paragraph (2)); or

“(B) in the case of any other individual, to 75 percent of the full MSA contribution amount.

“(2) FULL MSA CONTRIBUTION AMOUNT.—For purposes of this subsection, the term ‘full MSA contribution amount’ means, for a year for an individual, an amount to be equivalent to the full amount of the average deductible of a high-deductible health plan (as defined in section 223(c)(2) of the Internal Revenue Code of 1986) as determined by the Secretary.

“(3) NO MEDICAID COVERAGE FOR MEDICARE-COVERED SERVICES.—

“(A) IN GENERAL.—In the case of an individual who is eligible to be provided a contribution to a medical savings account under this subsection, the individual is not entitled to any
payment under a State plan under title XIX with respect to any benefits relating to items and services for which coverage is provided under this title.

“(B) CONSTRUCTION.—Subparagraph (A) shall not affect the continued provision of medical assistance under title XIX for items and services, such as dental, vision, or long-term care facility services, for which benefits are not provided under this title regardless of medical necessity.

“(4) PERIODIC PAYMENT.—The Secretary shall provide for the contribution into medical savings accounts of amounts under this subsection on an appropriate monthly or other periodic basis.

“(5) LOW-INCOME INDIVIDUAL DEFINED.—

“(A) IN GENERAL.—For purposes of this section, the term ‘low-income individual’ means an individual described in subsection (a)(1)—

“(i) who meets the requirement of section 1936(c)(6)(A)(ii) (relating to a full-benefit dual eligible individual);

“(ii) whose income (as determined under section 1612 for purposes of the supplemental security income program, ex-
cept as provided in subparagraph (B))
does not exceed 100 percent of the official
income poverty line (referred to in section
1905(p)(1)) applicable to a family of the
size involved; or

“(iii) whose income (as so determined)
exceeds 100 percent, but does not exceed
150 percent, of such official income pov-
erty line applicable to a family of the size
involved.

“(B) APPLICATION OF SPECIAL RULE RE-
REGARDING APPLICATION OF SOCIAL SECURITY IN-
CREASES.—The provisions of subparagraph (D)
of section 1905(p)(2) shall apply to determina-
tions of income under subparagraph (A) in the
same manner they apply under such section.

“(C) DETERMINATION PROCESS.—The
Secretary shall specify a process for the deter-
mination of whether individuals are low-income
individuals.”.

SEC. 302. INCREASE IN MEDICARE ELIGIBILITY AGE.
Section 226 of the Social Security Act (42 U.S.C.
426) is amended by adding at the end the following new
subsection:

“(k) INCREASING MEDICARE QUALIFYING AGE.—
“(1) IN GENERAL.—Notwithstanding any other provision of law, any reference in this section or title XVIII (or title XIX insofar as it refers to title XVIII) to ‘age 65’ shall be deemed a reference to the medicare qualifying age specified in paragraph (2).

“(2) MEDICARE QUALIFYING AGE SPECIFIED.—
The medicare qualifying age specified in this paragraph is determined as follows:

“(A) In the case of an individual who attains 65 years of age before January 1, 2021, the medicare qualifying age is 65 years of age.

“(B) In the case of an individual who attains 65 years of age in a year after 2018 and before 2027, the medicare qualifying age is the medicare qualifying age specified in this paragraph for the previous year increased by 2 months.

“(C) In the case of an individual who attains 65 years of age—

“(i) in the 2-year period beginning on January 1, 2027, the medicare qualifying age is 67 years and 1 month; or

“(ii) in a subsequent 2-year period beginning before 2087, the medicare quali-
fying age is the medicare qualifying age
specified in this paragraph for the previous
2-year period (or, in the case of the first
2-year period, specified for 2026) increased
by 1 month.

“(D) In the case of an individual who at-
tains 65 years of age on or after January 1,
2086, the medicare qualifying age is the medi-
care qualifying age specified in this paragraph
is 69 years and 6 months.”.

**SEC. 303. UNIFIED MEDICARE TRUST FUND.**

(a) In General.—The Federal Hospital Insurance
Trust Fund (established under section 1817 of the Social
Security Act) and the Federal Supplementary Medical In-
surance Trust Fund (established under section 1841 of
such Act) are hereby consolidated into a unified Medicare
trust fund. Such trust fund shall have separate accounts
for parts A, B, and D of such title and shall be adminis-
tered by the same board of trustees that administers the
current Trust Funds.

(b) Construction.—Nothing in this section shall be
construed as affecting the actual transfer of funds or com-
putations of amounts of premiums under any part of the
Medicare program.
(c) Solvency.—The Medicare trustee shall establish
a measure of program solvency for the Medicare program
of total outlays as a measure of gross domestic product.

Subtitle B—Changes in Current
Medicare Program

SEC. 311. INCOME-RELATED REDUCTION IN PART D PRE-
MIUM SUBSIDY.

(a) Income-Related Reduction in Part D Pre-
mium Subsidy.—

(1) In general.—Section 1860D–13(a) of the
Social Security Act (42 U.S.C. 1395w–113(a)) is
amended by adding at the end the following new
paragraph:

“(7) Reduction in premium subsidy based
on income.—

“(A) In general.—In the case of an indi-
vidual whose modified adjusted gross income
exceeds the threshold amount applicable under
paragraph (2) of section 1839(i) (including ap-
plication of paragraph (5) of such section) for
the calendar year, the monthly amount of the
premium subsidy applicable to the premium
under this section for a month after December
2010 shall be reduced (and the monthly bene-
iciary premium shall be increased) by the
monthly adjustment amount specified in sub-
paragraph (B).

“(B) MONTHLY ADJUSTMENT AMOUNT.—
The monthly adjustment amount specified in
this subparagraph for an individual for a month
in a year is equal to the product of—

“(i) the quotient obtained by divid-
ing—

“(I) the applicable percentage de-
termined under paragraph (3)(C) of
section 1839(i) (including application
of paragraph (5) of such section) for
the individual for the calendar year
reduced by 25.5 percent; by

“(II) 25.5 percent; and

“(ii) the base beneficiary premium (as
computed under paragraph (2)).

“(C) MODIFIED ADJUSTED GROSS IN-
COME.—For purposes of this paragraph, the
term ‘modified adjusted gross income’ has the
meaning given such term in subparagraph (A)
of section 1839(i)(4), determined for the tax-
able year applicable under subparagraphs (B)
and (C) of such section.
“(D) Determination by Commissioner of Social Security.—The Commissioner of Social Security shall make any determination necessary to carry out the income-related reduction in premium subsidy under this paragraph.

“(E) Procedures to assure correct income-related reduction in premium subsidy.—

“(i) Disclosure of base beneficiary premium.—Not later than September 15 of each year beginning with 2011, the Secretary shall disclose to the Commissioner of Social Security the amount of the base beneficiary premium (as computed under paragraph (2)) for the purpose of carrying out the income-related reduction in premium subsidy under this paragraph with respect to the following year.

“(ii) Additional disclosure.—Not later than October 15 of each year beginning with 2010, the Secretary shall disclose to the Commissioner of Social Security the following information for the purpose of carrying out the income-related re-
duction in premium subsidy under this paragraph with respect to the following year:

“(I) The modified adjusted gross income threshold applicable under paragraph (2) of section 1839(i) (including application of paragraph (5) of such section).

“(II) The applicable percentage determined under paragraph (3)(C) of section 1839(i) (including application of paragraph (5) of such section).

“(III) The monthly adjustment amount specified in subparagraph (B).

“(IV) Any other information the Commissioner of Social Security determines necessary to carry out the income-related reduction in premium subsidy under this paragraph.

“(F) RULE OF CONSTRUCTION.—The formula used to determine the monthly adjustment amount specified under subparagraph (B) shall only be used for the purpose of determining
such monthly adjustment amount under such subparagraph.”.

(2) Collection of monthly adjustment amount.—Section 1860D–13(e) of the Social Security Act (42 U.S.C. 1395w–113(e)) is amended—

(A) in paragraph (1), by striking “(2) and (3)” and inserting “(2), (3), and (4)”; and

(B) by adding at the end the following new paragraph:

“(4) Collection of monthly adjustment amount.—

“(A) In general.—Notwithstanding any other provision of this subsection or section 1854(d)(2), subject to subparagraph (B), the amount of the income-related reduction in premium subsidy for an individual for a month (as determined under subsection (a)(7)) shall be paid through withholding from benefit payments in the manner provided under section 1840.

“(B) Agreements.—In the case where the monthly benefit payments of an individual that are withheld under subparagraph (A) are insufficient to pay the amount described in such subparagraph, the Commissioner of Social Se-
security shall enter into agreements with the Secretary, the Director of the Office of Personnel Management, and the Railroad Retirement Board as necessary in order to allow other agencies to collect the amount described in subparagraph (A) that was not withheld under such subparagraph.”.

(b) CONFORMING AMENDMENTS.—

(1) MEDICARE.—Part D of title XVIII of the Social Security Act (42 U.S.C. 1395w–101 et seq.) is amended—

(A) in section 1860D–13(a)(1)—

(i) by redesignating subparagraph (F) as subparagraph (G);

(ii) in subparagraph (G), as redesignated by clause (i), by striking “(D) and (E)” and inserting “(D), (E), and (F)”;

and

(iii) by inserting after subparagraph (E) the following new subparagraph:

“(F) INCREASE BASED ON INCOME.—The monthly beneficiary premium shall be increased pursuant to paragraph (7).”; and
(B) in section 1860D–15(a)(1)(B), by striking “paragraph (1)(B)” and inserting “paragraphs (1)(B) and (1)(F)”.

(2) INTERNAL REVENUE CODE.—Section 6103(l)(20) of the Internal Revenue Code of 1986 (relating to disclosure of return information to carry out Medicare part B premium subsidy adjustment) is amended—

(A) in the heading, by striking “PART B PREMIUM SUBSIDY ADJUSTMENT” and inserting “PARTS B AND D PREMIUM SUBSIDY ADJUSTMENTS”;

(B) in subparagraph (A)—

(i) in the matter preceding clause (i), by inserting “or 1860D–13(a)(7)” after “1839(i)”; and

(ii) in clause (vii), by inserting after “subsection (i) of such section” the following: “or under section 1860D–13(a)(7) of such Act”; and

(C) in subparagraph (B)—

(i) by inserting “or such section 1860D–13(a)(7)” before the period at the end;
(ii) as amended by clause (i), by inserting “or for the purpose of resolving taxpayer appeals with respect to any such premium adjustment” before the period at the end; and

(iii) by adding at the end the following new sentence: “Officers, employees, and contractors of the Social Security Administration may disclose such return information to officers, employees, and contractors of the Department of Health and Human Services, the Office of Personnel Management, the Railroad Retirement Board, the Department of Justice, and the courts of the United States to the extent necessary to carry out the purposes described in the preceding sentence.”; and

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

“(C) TIMING OF DISCLOSURE.—Return information shall be disclosed to officers, employees, and contractors of the Social Security Administration under subparagraph (A) not later than the date that is 90 days prior to the date on which the taxpayer first becomes entitled to
benefits under part A of title XVIII of the Social Security Act or eligible to enroll for benefits under part B of such title.”.

SEC. 312. REDUCTION IN HOSPITAL MARKETBASKET INCREASES.

Notwithstanding any other provision of law:

(1) OUTPATIENT HOSPITAL SERVICES.—For 2010 and each succeeding year, the OPD fee schedule increase factor otherwise computed under section 1833(t)(3)(C)(iv) of the Social Security Act (42 U.S.C. 1395l(t)(3)(C)(iv)) shall be reduced by .4 percentage points.

(2) INPATIENT HOSPITAL SERVICES.—For fiscal year 2010 and each succeeding fiscal year, the applicable percentage increase otherwise computed under clauses (i) and (ii) of section 1886(b)(3)(B) of such Act (42 U.S.C. 1395ww(b)(3)(B)) shall be reduced by .4 percentage points.

SEC. 313. ELIMINATION OF INDEXING OF INCOME THRESHOLDS FOR PART B INCOME-RELATED PREMIUMS.

(a) IN GENERAL.—Section 1839(i) of the Social Security Act (42 U.S.C. 1395r(i)) is amended by striking paragraph (5).
(b) **Effective Date.**—The amendment made by subsection (a) shall apply to premiums for years beginning with 2010.

**SEC. 314. REINSTATEMENT OF THE MEDICARE TRIGGER.**

(a) **Reinstatement of the Medicare Trigger.**—

(1) **Determinations of Excess General Revenue Medicare Funding.**—

(A) **In General.**—The Board of Trustees of each medicare trust fund shall include in the annual reports submitted under subsection (b)(2) of sections 1817 and 1841 of the Social Security Act (42 U.S.C. 1395i and 1395t)—

(i) the information described in paragraph (2); and

(ii) a determination as to whether there is projected to be excess general revenue medicare funding (as defined in paragraph (3)) for the fiscal year in which the report is submitted or for the previous fiscal year.

(B) **Medicare Funding Warning.**—For purposes of section 1105(h) of title 31, United States Code, and this subsection, an affirmative determination under subparagraph (A)(i) in 2 consecutive annual reports shall be treated as a
medicare funding warning in the year in which
the second such report is made.

(2) INFORMATION.—The information described
in this subsection for an annual report in a year is
as follows:

(A) PROJECTIONS OF GROWTH OF gen-
eral revenue spending.—A statement of the
general revenue medicare funding as a percent-
age of the total medicare outlays for each of the
following:

(i) The previous fiscal year.

(ii) Previous fiscal years and as of 10,
50, and 75 years after such year.

(B) COMPARISON WITH OTHER GROWTH
trends.—A comparison of the trend of such
percentages with the annual growth rate in the
following:

(i) The gross domestic product.

(ii) Private health costs.

(iii) National health expenditures.

(iv) Other appropriate measures.

(C) PART D SPENDING.—Expenditures, in-
cluding trends in expenditures, under part D of
title XVIII of the Social Security Act, as added
by section 101 of the Medicare Prescription

(D) Combined Medicare Trust Fund Analysis.—A financial analysis of the combined medicare trust funds if general revenue medicare funding were limited to the percentage specified in paragraph (3)(A)(ii) of total medicare outlays.

(3) Definitions.—For purposes of this section:

(A) Excess General Revenue Medicare Funding.—The term “excess general revenue medicare funding” means, with respect to a fiscal year, that—

(i) general revenue medicare funding (as defined in subparagraph (B)), expressed as a percentage of total medicare outlays (as defined in subparagraph (D)) for the fiscal year; exceeds

(ii) 45 percent.

(B) General Revenue Medicare Funding.—The term “general revenue medicare funding” means for a year—
(i) the total medicare outlays (as defined in subparagraph (D)) for the year; minus
(ii) the dedicated medicare financing sources (as defined in subparagraph (C)) for the year.

(C) DEDICATED MEDICARE FINANCING SOURCES.—The term “dedicated medicare financing sources” means the following:

(i) HOSPITAL INSURANCE TAX.—Amounts appropriated to the Hospital Insurance Trust Fund under the third sentence of section 1817(a) of the Social Security Act (42 U.S.C. 1395i(a)) and amounts transferred to such Trust Fund under section 7(c)(2) of the Railroad Retirement Act of 1974 (45 U.S.C. 231f(e)(2)).

(ii) TAXATION OF CERTAIN OASDI BENEFITS.—Amounts appropriated to the Hospital Insurance Trust Fund under section 121(e)(1)(B) of the Social Security Amendments of 1983 (Public Law 98–21), as inserted by section 13215(c) of the Om-

(iii) State Transfers.—The State share of amounts paid to the Federal Government by a State under section 1843 of the Social Security Act (42 U.S.C. 1395v) or pursuant to section 1935(e) of such Act.

(iv) Premiums.—The following premiums:

(I) Part A.—Premiums paid by non-Federal sources under sections 1818 and section 1818A (42 U.S.C. 1395i–2 and 1395i–2a) of such Act.

(II) Part B.—Premiums paid by non-Federal sources under section 1839 of such Act (42 U.S.C. 1395r), including any adjustments in premiums under such section.

(III) Part D.—Monthly beneficiary premiums paid under part D of title XVIII of such Act, as added by section 101 of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (Public Law 108–173), and MA monthly prescrip-
ation drug beneficiary premiums paid
under part C of such title insofar as
they are attributable to basic prescrip-
tion drug coverage.

(IV) DESCRIPTION.—Premiums
under subclauses (II) and (III) shall
be determined without regard to any
reduction in such premiums attrib-
utable to a beneficiary rebate under
section 1854(b)(1)(C) of such title, as
amended by section 222(b)(1) of the
Medicare Prescription Drug, Improve-
ment, and Modernization Act of 2003
(Public Law 108–173), and premiums
under clause (iii) are deemed to in-
clude any amounts paid under section
1860D–13(b) of such title, as added
by section 101 of the Medicare Pre-
scription Drug, Improvement, and
Modernization Act of 2003 (Public

(v) GIFTS.—Amounts received by the
medicare trust funds under section 201(i)
of the Social Security Act (42 U.S.C.
401(i)).
(D) **Total Medicare Outlays.** — The term “total medicare outlays” means total outlays from the medicare trust funds and shall—

(i) include payments made to plans under part C of title XVIII of the Social Security Act that are attributable to any rebates under section 1854(b)(1)(C) of such Act (42 U.S.C. 1395w–24(b)(1)(C)), as amended by section 222(b)(1) of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (Public Law 108–173);

(ii) include administrative expenditures made in carrying out title XVIII of the Social Security Act and Federal outlays under section 1935(b) of such Act, as added by section 103(a)(2) of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (Public Law 108–173); and

(iii) offset outlays by the amount of fraud and abuse collections insofar as they are applied or deposited into a medicare trust fund.
(E) Medicare Trust Fund.—The term “medicare trust fund” means—

(i) the Federal Hospital Insurance Trust Fund established under section 1817 of the Social Security Act (42 U.S.C. 1395i); and

(ii) the Federal Supplementary Medical Insurance Trust Fund established under section 1841 of such Act (42 U.S.C. 1395t), including the Medicare Prescription Drug Account under such Trust Fund.

(4) Conforming Amendments.—

(A) Federal Hospital Insurance Trust Fund.—The last sentence of section 1817(b)(2) (42 U.S.C. 1395i(b)(2)) is amended to read as follows: “Each report provided under paragraph (2) beginning with the report in 2010 shall include the information specified in section 314 of the Roadmap for America’s Future Act of 2010.”.

(B) Federal Supplementary Medical Insurance Trust Fund.—The last sentence of section 1841(b)(2) (42 U.S.C. 1395t(b)(2)) is amended to read as follows: “Each report pro-
vided under paragraph (2) beginning with the report in 2010 shall include the information specified in section 314 of the Roadmap for America’s Future Act of 2010.”.

(5) NOTICE OF MEDICARE FUNDING WARNING.—Whenever any report described in subsection (a) contains a determination that for the previous fiscal year reporting period there will be excess general revenue medicare funding, Congress and the President should address the matter under existing rules and procedures.

(b) PRESIDENTIAL SUBMISSION OF LEGISLATION.—

(1) IN GENERAL.—Section 1105(h) of title 31, United States Code, is amended to read as follows:

“(h)(1) If there is a medicare funding warning under section 314 of the Roadmap for America’s Future Act of 2010 made in a year, the President shall submit to Congress, within the 15-day period beginning on the date of the budget submission to Congress under subsection (a) for the succeeding year, proposed legislation to respond to such warning.

“(2) Paragraph (1) does not apply if, during the year in which the warning is made, legislation is enacted which eliminates excess general revenue medicare funding (as defined in section 314 of the Roadmap for America’s Future
Act of 2010) for the previous fiscal year, as certified by
the Board of Trustees of each medicare trust fund (as de-
ified in section 314 of such Act) not later than 30 days
after the date of the enactment of such legislation.”.

(2) SENSE OF CONGRESS.—It is the sense of
Congress that legislation submitted pursuant to sec-
tion 1105(h) of title 31, United States Code, in a
year should be designed to reduce payments by 1
percent for services furnished in Medicare’s fee-for-
service sector for the fiscal year that begins in such
year.

(c) PROCEDURES IN THE HOUSE OF REPRESENTA-
tives.—

(1) INTRODUCTION AND REFERRAL OF PRESI-
DENT’S LEGISLATIVE PROPOSAL.—

(A) INTRODUCTION.—In the case of a leg-
islative proposal submitted by the President
pursuant to section 1105(h) of title 31, United
States Code, within the 15-day period specified
in paragraph (1) of such section, the majority
leader of the House of Representatives (or his
designee) and the minority leader of the House
of Representatives (or his designee) shall intro-
duce such proposal (by request), the title of
which is as follows: “A bill to respond to a
such bill shall be introduced within 3 legislative days after Congress receives such proposal.

(B) Referral.—Any legislation introduced pursuant to paragraph (1) shall be referred to the appropriate committees of the House of Representatives.

(2) Direction to the Appropriate House Committees.—

(A) In General.—In the House, in any year during which the President is required to submit proposed legislation to Congress under section 1105(h) of title 31, United States Code, the appropriate committees shall report medicare funding legislation by not later than June 30 of such year.

(B) Medicare Funding Legislation.—For purposes of this section, the term "medicare funding legislation" means—

(i) legislation introduced pursuant to subsection (c)(1), but only if the legislative proposal upon which the legislation is based was submitted within the 15-day period referred to in such subsection; or
(ii) any bill the title of which is as fol-

lows: “A bill to respond to a medicare
funding warning.”.

(C) CERTIFICATION.—With respect to any
medicare funding legislation or any amendment
to such legislation to respond to a medicare
funding warning, the chairman of the Com-
mittee on the Budget of the House shall cer-
tify—

(i) whether or not such legislation
eliminates excess general revenue medicare
funding (as defined in subsection (a)(3))
for the previous fiscal year; and

(ii) with respect to such an amend-
ment, whether the legislation, as amended,
would reduce payments by 1 percent for
services furnished in Medicare’s fee-for-
service sector for the fiscal year that be-
gins in such year.

(3) FALLBACK PROCEDURE FOR FLOOR CON-
SIDERATION IF THE HOUSE FAILS TO VOTE ON
FINAL PASSAGE BY JULY 30.—

(A) After July 30 of any year during
which the President is required to submit pro-
posed legislation to Congress under section
1105(h) of title 31, United States Code, unless the House of Representatives has voted on final passage of any medicare funding legislation for which there is an affirmative certification under paragraph (2)(C)(i), then, after the expiration of not less than 30 calendar days (and concurrently 5 legislative days), it is in order to move to discharge any committee to which medicare funding legislation which has such a certification and which has been referred to such committee for 30 calendar days from further consideration of the legislation.

(B) A motion to discharge may be made only by an individual favoring the legislation, may be made only if supported by one-fifth of the total membership of the House (a quorum being present), and is highly privileged in the House. Debate thereon shall be limited to not more than one hour, the time to be divided in the House equally between those favoring and those opposing the motion. An amendment to the motion is not in order, and it is not in order to move to reconsider the vote by which the motion is agreed to or disagreed to.
(C) Only one motion to discharge a particular committee may be adopted under this subsection in any session of a Congress.

(D) Notwithstanding subparagraph (A), it shall not be in order to move to discharge a committee from further consideration of medicare funding legislation pursuant to this subsection during a session of a Congress if, during the previous session of the Congress, the House passed medicare funding legislation for which there is an affirmative certification under paragraph (2)(C)(i).

(4) Floor Consideration in the House of Discharged Legislation.—

(A) In the House, not later than 3 legislative days after any committee has been discharged from further consideration of legislation under paragraph (3), the Speaker shall resolve the House into the Committee of the Whole for consideration of the legislation.

(B) The first reading of the legislation shall be dispensed with. All points of order against consideration of the legislation are waived. General debate shall be confined to the legislation and shall not exceed five hours,
which shall be divided equally between those fa-
voring and those opposing the legislation. After
general debate the legislation shall be consid-
ered for amendment under the five-minute rule.
During consideration of the legislation, no
amendments shall be in order in the House or
in the Committee of the Whole except those for
which there has been an affirmative certifi-
cation under paragraph (2)(C)(ii). All points of
order against consideration of any such amend-
ment in the Committee of the Whole are
waived. The legislation, together with any
amendments which shall be in order, shall be
considered as read. During the consideration of
the bill for amendment, the Chairman of the
Committee of the Whole may accord priority in
recognition on the basis of whether the Member
offering an amendment has caused it to be
printed in the portion of the Congressional
Record designated for that purpose in clause 8
of Rule XVIII of the Rules of the House of
Representatives. Debate on any amendment
shall not exceed one hour, which shall be di-
vided equally between those favoring and those
opposing the amendment, and no pro forma
amendments shall be offered during the debate. The total time for debate on all amendments shall not exceed 10 hours. At the conclusion of consideration of the legislation for amendment, the Committee shall rise and report the legislation to the House with such amendments as may have been adopted. The previous question shall be considered as ordered on the legislation and amendments thereto to final passage without intervening motion except one motion to recommit with or without instructions. If the Committee of the Whole rises and reports that it has come to no resolution on the bill, then on the next legislative day the House shall, immediately after the third daily order of business under clause 1 of Rule XIV of the Rules of the House of Representatives, resolve into the Committee of the Whole for further consideration of the bill.

(C) All appeals from the decisions of the Chair relating to the application of the Rules of the House of Representatives to the procedure relating to any such legislation shall be decided without debate.
(D) Except to the extent specifically provided in the preceding provisions of this subsection, consideration of any such legislation and amendments thereto (or any conference report thereon) shall be governed by the Rules of the House of Representatives applicable to other bills and resolutions, amendments, and conference reports in similar circumstances.

(5) LEGISLATIVE DAY DEFINED.—As used in this section, the term “legislative day” means a day on which the House of Representatives is in session.

(6) RESTRICTION ON WAIVER.—In the House, the provisions of this section may be waived only by a rule or order proposing only to waive such provisions.

(7) RULEMAKING POWER.—The provisions of this section are enacted by the Congress—

(A) as an exercise of the rulemaking power of the House of Representatives and, as such, shall be considered as part of the rules of that House and shall supersede other rules only to the extent that they are inconsistent therewith; and

(B) with full recognition of the constitutional right of that House to change the rules
(so far as they relate to the procedures of that House) at any time, in the same manner, and to the same extent as in the case of any other rule of that House.

(d) **Procedures in the Senate.—**

(1) **Introduction and referral of President's Legislative Proposal.—**

(A) **Introduction.—** In the case of a legislative proposal submitted by the President pursuant to section 1105(h) of title 31, United States Code, within the 15-day period specified in paragraph (1) of such section, the majority leader and minority leader of the Senate (or their designees) shall introduce such proposal (by request), the title of which is as follows: “A bill to respond to a medicare funding warning.”. Such bill shall be introduced within 3 days of session after Congress receives such proposal.

(B) **Referral.—** Any legislation introduced pursuant to paragraph (1) shall be referred to the Committee on Finance.

(2) **Medicare Funding Legislation.—** For purposes of this section, the term “medicare funding legislation” means—
(A) legislation introduced pursuant to sub-
section (d)(1), but only if the legislative pro-
posal upon which the legislation is based was
submitted within the 15-day period referred to
in such subsection; or

(B) any bill the title of which is as follows:
“A bill to respond to a medicare funding warn-
ing.”.

(3) QUALIFICATION FOR SPECIAL PROCE-
DURES.—

(A) IN GENERAL.—The special procedures
set forth in paragraphs (4) and (5) shall apply
to medicare funding legislation, as described in
paragraph (2), only if the legislation—

(i) is medicare funding legislation that
is passed by the House of Representatives;
or

(ii) contains matter within the juris-
diction of the Committee on Finance in the
Senate.

(B) FAILURE TO QUALIFY FOR SPECIAL
PROCEDURES.—If the medicare funding legisla-
tion does not satisfy subparagraph (A), then
the legislation shall be considered under the or-
ordinary procedures of the Standing Rules of the
Senate.

(4) Discharge.—

(A) In general.—If the Committee on
Finance has not reported medicare funding leg-
islation described in subparagraph (3)(A) by
June 30 of a year in which the President is re-
quired to submit medicare funding legislation to
Congress under section 1105(h) of title 31,
United States Code, then any Senator may
move to discharge the Committee of any single
medicare funding legislation measure. Only one
such motion shall be in order in any session of
Congress.

(B) Debate limits.—Debate in the Sen-
ate on any such motion to discharge, and all
appeals in connection therewith, shall be limited
to not more than 2 hours. The time shall be
equally divided between, and controlled by, the
maker of the motion and the majority leader, or
their designees, except that in the event the ma-
ajority leader is in favor of such motion, the time
in opposition thereto shall be controlled by the
minority leader or the minority leader’s des-
ignee. A point of order under this subsection
may be made at any time. It is not in order to move to proceed to another measure or matter while such motion (or the motion to reconsider such motion) is pending.

(C) Amendments.—No amendment to the motion to discharge shall be in order.

(D) Exception if certified legislation enacted.—Notwithstanding subparagraph (A), it shall not be in order to discharge the Committee from further consideration of medicare funding legislation pursuant to this subsection during a session of a Congress if the chairman of the Committee on the Budget of the Senate certifies that medicare funding legislation has been enacted that reduce payments by 1 percent for services furnished in Medicare’s fee-for-service sector for the next fiscal year.

(5) Consideration.—After the date on which the Committee on Finance has reported medicare funding legislation described in paragraph (3)(A), or has been discharged (under paragraph (4)) from further consideration of, such legislation, it is in order (even though a previous motion to the same effect has been disagreed to) for any Member of the Sen-
to move to proceed to the consideration of such legislation.

(6) Rules of the Senate.—This section is enacted by the Senate—

(A) as an exercise of the rulemaking power of the Senate and as such it is deemed a part of the rules of the Senate, but applicable only with respect to the procedure to be followed in the Senate in the case of a bill described in this paragraph, and it supersedes other rules only to the extent that it is inconsistent with such rules; and

(B) with full recognition of the constitutional right of the Senate to change the rules (so far as relating to the procedure of the Senate) at any time, in the same manner, and to the same extent as in the case of any other rule of the Senate.

SEC. 315. ELIMINATING INEFFICIENCIES AND INCREASING CHOICE IN MEDICARE ADVANTAGE.

(a) Reimbursement Benchmarks.—In implementing section 1853 of the Social Security Act (42 U.S.C. 1395w–23)—
(1) in calculating the benchmark amounts 
under subsection (k), the Secretary shall use the av-
erage amount of local plan bids; and 

(2) in addition to the amounts under subsection 
(k), the Secretary may provide bonus payments to 
local plans that implement care coordination pro-
grams, as defined by the Secretary.

Subtitle C—Medical Liability 
Reform

PART 1—ENACTING REAL MEDICAL LIABILITY 
REFORM

SEC. 321. ENCOURAGING SPEEDY RESOLUTION OF CLAIMS.

(a) TIMING OF LAWSUIT.—The time for the com-
mencement of a health care lawsuit shall be 3 years after 
the date of manifestation of injury or 1 year after the 
claimant discovers, or through the use of reasonable dili-
gence should have discovered, the injury, whichever occurs 
first. In no event shall the time for commencement of a 
health care lawsuit exceed 3 years after the date of mani-
festation of injury unless tolled for any of the following:

(1) Upon proof of fraud.

(2) Intentional concealment.

(3) The presence of a foreign body, which has 
no therapeutic or diagnostic purpose or effect, in the 
person of the injured person.
(b) ACTIONS BY MINORS.—Actions by a minor shall be commenced within 3 years from the date of the alleged manifestation of injury except that actions by a minor under the full age of 6 years shall be commenced within 3 years of manifestation of injury or prior to the minor’s 8th birthday, whichever provides a longer period. Such time limitation shall be tolled for minors for any period during which a parent or guardian and a health care provider or health care organization have committed fraud or collusion in the failure to bring an action on behalf of the injured minor.

SEC. 322. COMPENSATING PATIENT INJURY.

(a) UNLIMITED AMOUNT OF DAMAGES FOR ACTUAL ECONOMIC LOSSES IN HEALTH CARE LAWSUITS.—In any health care lawsuit, nothing in this part shall limit a claimant’s recovery of the full amount of the available economic damages, notwithstanding the limitation in subsection (b).

(b) ADDITIONAL NONECONOMIC DAMAGES.—In any health care lawsuit, the amount of noneconomic damages, if available, may be as much as $250,000, regardless of the number of parties against whom the action is brought or the number of separate claims or actions brought with respect to the same injury.
(c) No Discount of Award for Noneconomic Damages.—For purposes of applying the limitation in subsection (b), future noneconomic damages shall not be discounted to present value. The jury shall not be informed about the maximum award for noneconomic damages. An award for noneconomic damages in excess of $250,000 shall be reduced either before the entry of judgment, or by amendment of the judgment after entry of judgment, and such reduction shall be made before accounting for any other reduction in damages required by law. If separate awards are rendered for past and future noneconomic damages and the combined awards exceed $250,000, the future noneconomic damages shall be reduced first.

(d) Fair Share Rule.—In any health care lawsuit, each party shall be liable for that party’s several share of any damages only and not for the share of any other person. Each party shall be liable only for the amount of damages allocated to such party in direct proportion to such party’s percentage of responsibility. Whenever a judgment of liability is rendered as to any party, a separate judgment shall be rendered against each such party for the amount allocated to such party. For purposes of this section, the trier of fact shall determine the propor-
tion of responsibility of each party for the claimant’s harm.

SEC. 323. MAXIMIZING PATIENT RECOVERY.

(a) Court Supervision of Share of Damages Actually Paid to Claimants.—In any health care lawsuit, the court shall supervise the arrangements for payment of damages to protect against conflicts of interest that may have the effect of reducing the amount of damages awarded that are actually paid to claimants. In particular, in any health care lawsuit in which the attorney for a party claims a financial stake in the outcome by virtue of a contingent fee, the court shall have the power to restrict the payment of a claimant’s damage recovery to such attorney, and to redirect such damages to the claimant based upon the interests of justice and principles of equity. In no event shall the total of all contingent fees for representing all claimants in a health care lawsuit exceed the following limits:

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

(2) 33 1/3 percent of the next $50,000 recovered by the claimant(s).

(3) 25 percent of the next $500,000 recovered by the claimant(s).
(4) 15 percent of any amount by which the recovery by the claimant(s) is in excess of $600,000.

(b) APPLICABILITY.—The limitations in this section shall apply whether the recovery is by judgment, settlement, mediation, arbitration, or any other form of alternative dispute resolution. In a health care lawsuit involving a minor or incompetent person, a court retains the authority to authorize or approve a fee that is less than the maximum permitted under this section. The requirement for court supervision in the first two sentences of subsection (a) applies only in civil actions.

SEC. 324. ADDITIONAL HEALTH BENEFITS.

In any health care lawsuit involving injury or wrongful death, any party may introduce evidence of collateral source benefits. If a party elects to introduce such evidence, any opposing party may introduce evidence of any amount paid or contributed or reasonably likely to be paid or contributed in the future by or on behalf of the opposing party to secure the right to such collateral source benefits. No provider of collateral source benefits shall recover any amount against the claimant or receive any lien or credit against the claimant’s recovery or be equitably or legally subrogated to the right of the claimant in a health care lawsuit involving injury or wrongful death. This section shall apply to any health care lawsuit that is settled
as well as a health care lawsuit that is resolved by a fact
finder. This section shall not apply to section 1862(b) (42
1396a(a)(25)) of the Social Security Act.

SEC. 325. PUNITIVE DAMAGES.

(a) In General.—Punitive damages may, if other-
wise permitted by applicable State or Federal law, be
awarded against any person in a health care lawsuit only
if it is proven by clear and convincing evidence that such
person acted with malicious intent to injure the claimant,
or that such person deliberately failed to avoid unneces-
sary injury that such person knew the claimant was sub-
stantially certain to suffer. In any health care lawsuit
where no judgment for compensatory damages is rendered
against such person, no punitive damages may be awarded
with respect to the claim in such lawsuit. No demand for
punitive damages shall be included in a health care lawsuit
as initially filed. A court may allow a claimant to file an
amended pleading for punitive damages only upon a mo-
tion by the claimant and after a finding by the court, upon
review of supporting and opposing affidavits or after a
hearing, after weighing the evidence, that the claimant has
established by a substantial probability that the claimant
will prevail on the claim for punitive damages. At the re-
quest of any party in a health care lawsuit, the trier of fact shall consider in a separate proceeding—

(1) whether punitive damages are to be awarded and the amount of such award; and

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

(b) **SEPARATE PROCEEDING.**—If a separate proceeding is requested, evidence relevant only to the claim for punitive damages, as determined by applicable State law, shall be inadmissible in any proceeding to determine whether compensatory damages are to be awarded.

(c) **DETERMINING AMOUNT OF PUNITIVE DAMAGES.**—

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

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

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

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

(D) the number of products sold or medical procedures rendered for compensation, as
the case may be, by such party, of the kind
causing the harm complained of by the claim-
ant;

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

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

(2) MAXIMUM AWARD.—The amount of punitive
damages, if awarded, in a health care lawsuit may
be as much as $250,000 or as much as two times
the amount of economic damages awarded, which-
ever is greater. The jury shall not be informed of
this limitation.

SEC. 326. AUTHORIZATION OF PAYMENT OF FUTURE DAM-
AGES TO CLAIMANTS IN HEALTH CARE LAW-
SUITS.

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

(b) APPLICABILITY.—This section applies to all actions which have not been first set for trial or retrial before the effective date of this part.

SEC. 327. DEFINITIONS.

In this part:

(1) ALTERNATIVE DISPUTE RESOLUTION; ADR.—The term “alternative dispute resolution system” or “ADR” means a system that provides for the resolution of health care lawsuits in a manner other than through a civil action brought in a State or Federal court.

(2) CLAIMANT.—The term “claimant” means any person who brings a health care lawsuit, including a person who asserts or claims a right to legal or equitable contribution, indemnity, or subrogation, arising out of a health care liability claim or action, and any person on whose behalf such a claim is asserted or such an action is brought, whether deceased, incompetent, or a minor.

(3) COLLATERAL SOURCE BENEFITS.—The term “collateral source benefits” means any amount
paid or reasonably likely to be paid in the future to
or on behalf of the claimant, or any service, product,
or other benefit provided or reasonably likely to be
provided in the future to or on behalf of the claim-
ant, as a result of the injury or wrongful death, pur-
suant to—

(A) any State or Federal health, sickness,
income-disability, accident, or workers’ com-
pensation law;

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

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

(D) any other publicly or privately funded
program.

(4) COMPENSATORY DAMAGES.—The term
“compensatory damages” means objectively
verifiable monetary losses incurred as a result of the
 provision of, use of, or payment for (or failure to
provide, use, or pay for) health care services or med-
ical products, such as past and future medical ex-
penses, loss of past and future earnings, cost of ob-
taining domestic services, loss of employment, and
loss of business or employment opportunities, dam-
ages for physical and emotional pain, suffering, in-
convenience, physical impairment, mental anguish,
disfigurement, loss of enjoyment of life, loss of soci-
ety and companionship, loss of consortium (other
than loss of domestic service), hedonic damages, in-
jury to reputation, and all other nonpecuniary losses
of any kind or nature. The term “compensatory
damages” includes economic damages and non-
economic damages, as such terms are defined in this
section.

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

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

(7) Health care lawsuit.—The term “health care lawsuit” means any health care liability claim concerning the provision of health care goods or services or any medical product affecting inter-
state commerce, or any health care liability action concerning the provision of health care goods or services or any medical product affecting interstate commerce, brought in a State or Federal court or pursuant to an alternative dispute resolution system, against a health care provider, a health care organ-
ization, or the manufacturer, distributor, supplier, marketer, promoter, or seller of a medical product, regardless of the theory of liability on which the claim is based, or the number of claimants, plain-
tiffs, defendants, or other parties, or the number of claims or causes of action, in which the claimant al-
leges a health care liability claim. Such term does not include a claim or action which is based on criminal liability; which seeks civil fines or penalties paid to Federal, State, or local government; or which is grounded in antitrust.

(8) Health care liability action.—The term “health care liability action” means a civil ac-
tion brought in a State or Federal court or pursuant to an alternative dispute resolution system, against a health care provider, a health care organization, or the manufacturer, distributor, supplier, marketer, promoter, or seller of a medical product, regardless of the theory of liability on which the claim is based, or the number of plaintiffs, defendants, or other parties, or the number of causes of action, in which the claimant alleges a health care liability claim.

(9) **HEALTH CARE LIABILITY CLAIM.**—The term “health care liability claim” means a demand by any person, whether or not pursuant to ADR, against a health care provider, health care organization, or the manufacturer, distributor, supplier, marketer, promoter, or seller of a medical product, including, but not limited to, third-party claims, cross-claims, counter-claims, or contribution claims, which are based upon the provision of, use of, or payment for (or the failure to provide, use, or pay for) health care services or medical products, regardless of the theory of liability on which the claim is based, or the number of plaintiffs, defendants, or other parties, or the number of causes of action.

(10) **HEALTH CARE ORGANIZATION.**—The term “health care organization” means any person or en-
tity which is obligated to provide or pay for health
benefits under any health plan, including any person
or entity acting under a contract or arrangement
with a health care organization to provide or admin-
ister any health benefit.

(11) HEALTH CARE PROVIDER.—The term
“health care provider” means any person or entity
required by State or Federal laws or regulations to
be licensed, registered, or certified to provide health
care services, and being either so licensed, reg-
istered, or certified, or exempted from such require-
ment by other statute or regulation.

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

(13) MALICIOUS INTENT TO INJURE.—The
term “malicious intent to injure” means inten-
tionally causing or attempting to cause physical in-
jury other than providing health care goods or serv-
ices.
(14) MEDICAL PRODUCT.—The term “medical
product” means a drug, device, or biological product
intended for humans, and the terms “drug”, “de-
vice”, and “biological product” have the meanings
given such terms in sections 201(g)(1) and 201(h)
of the Federal Food, Drug and Cosmetic Act (21
U.S.C. 321(g)(1) and (h)) and section 351(a) of the
Public Health Service Act (42 U.S.C. 262(a)), re-
spectively, including any component or raw material
used therein, but excluding health care services.

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

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

(17) **RECOVERY.**—The term “recovery” means the net sum recovered after deducting any disbursements or costs incurred in connection with prosecution or settlement of the claim, including all costs paid or advanced by any person. Costs of health care incurred by the plaintiff and the attorneys’ office overhead costs or charges for legal services are not deductible disbursements or costs for such purpose.

(18) **STATE.**—The term “State” means each of the several States, the District of Columbia, the Commonwealth of Puerto Rico, the Virgin Islands, Guam, American Samoa, the Northern Mariana Islands, the Trust Territory of the Pacific Islands, and any other territory or possession of the United States, or any political subdivision thereof.

**SEC. 328. EFFECT ON OTHER LAWS.**

(a) **VACCINE INJURY.**—

(1) **IN GENERAL.**—To the extent that title XXI of the Public Health Service Act establishes a Federal rule of law applicable to a civil action brought for a vaccine-related injury or death—

(A) this part does not affect the application of the rule of law to such an action; and
(B) any rule of law prescribed by this part
in conflict with a rule of law of such title XXI
shall not apply to such action.

(2) APPLICATION.—If there is an aspect of a
civil action brought for a vaccine-related injury or
death to which a Federal rule of law under title XXI
of the Public Health Service Act does not apply,
then this part or otherwise applicable law (as deter-
mined under this part) will apply to such aspect of
such action.

(b) Other Federal Law.—Except as provided in
this section, nothing in this part shall be deemed to affect
any defense available to a defendant in a health care law-
suit or action under any other provision of Federal law.

SEC. 329. STATE FLEXIBILITY AND PROTECTION OF
STATES’ RIGHTS.

(a) Health Care Lawsuits.—The provisions gov-
erning health care lawsuits set forth in this part preempt,
subject to subsections (b) and (c), State law to the extent
that State law prevents the application of any provisions
of law established by or under this part. The provisions
governing health care lawsuits set forth in this part super-
cede chapter 171 of title 28, United States Code, to the
extent that such chapter—
(1) provides for a greater amount of damages or contingent fees, a longer period in which a health care lawsuit may be commenced, or a reduced applicability or scope of periodic payment of future damages, than provided in this part; or

(2) prohibits the introduction of evidence regarding collateral source benefits, or mandates or permits subrogation or a lien on collateral source benefits.

(b) Protection of States’ Rights and Other Laws.—

(1) In General.—Any issue that is not governed by any provision of law established by or under this part (including State standards of negligence) shall be governed by otherwise applicable State or Federal law.

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

(e) State Flexibility.—No provision of this part shall be construed to preempt—
(1) any State law (whether effective before, on, or after the date of the enactment of this Act) that specifies a particular monetary amount of compensatory or punitive damages (or the total amount of damages) that may be awarded in a health care lawsuit, regardless of whether such monetary amount is greater or lesser than is provided for under this part, notwithstanding section 323(a); or

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

SEC. 330. APPLICABILITY; EFFECTIVE DATE.

This part shall apply to any health care lawsuit brought in a Federal or State court, or subject to an alternative dispute resolution system, that is initiated on or after the date of the enactment of this Act, except that any health care lawsuit arising from an injury occurring prior to the date of the enactment of this Act shall be governed by the applicable statute of limitations provisions in effect at the time the injury occurred.
PART 2—ENDING LAWSUIT ABUSE

SEC. 331. STATE GRANTS TO CREATE HEALTH COURT SOLUTIONS.

Part P of title III of the Public Health Service Act (42 U.S.C. 280g et seq.) is amended by adding at the end the following:

“SEC. 399R. STATE GRANTS TO CREATE HEALTH COURT SOLUTIONS.

“(a) IN GENERAL.—The Secretary may award grants to States for the development, implementation, and evaluation of alternatives to current tort litigation that comply with this section, for the resolution of disputes concerning injuries allegedly caused by health care providers or health care organizations.

“(b) CONDITIONS FOR DEMONSTRATION GRANTS.—

“(1) APPLICATION.—To be eligible to receive a grant under this section, a State shall submit to the Secretary an application at such time, in such manner, and containing such information as may be required by the Secretary. A grant shall be awarded under this section on such terms and conditions as the Secretary determines appropriate.

“(2) STATE REQUIREMENTS.—To be eligible to receive a grant under this section, a State shall—

“(A) develop and implement an alternative to current tort litigation for resolving disputes
over injuries allegedly caused by health care providers or health care organizations based on one or more of the models described in subsection (d); and

“(B) implement policies that provide for a reduction in health care errors through the collection and analysis by organizations that engage in voluntary efforts to improve patient safety and the quality of health care delivery, of patient safety data related to disputes resolved under the alternatives under subparagraph (A).

“(3) DEMONSTRATION OF EFFECTIVENESS.—To be eligible to receive a grant under subsection (a), a State shall demonstrate how the proposed alternative to be implemented under paragraph (2)(A) will—

“(A) make the medical liability system of the State more reliable through the prompt and fair resolution of disputes;

“(B) encourage the early disclosure of health care errors;

“(C) enhance patient safety; and

“(D) maintain access to medical liability insurance.
“(4) SOURCES OF COMPENSATION.—To be eligible to receive a grant under subsection (a), a State shall identify the sources from, and methods by which, compensation would be paid for medical liability claims resolved under the proposed alternative to current tort litigation implemented under paragraph (2)(A). Funding methods shall, to the extent practicable, provide financial incentives for activities that improve patient safety.

“(5) SCOPE.—

“(A) IN GENERAL.—To be eligible to receive a grant under subsection (a), a State shall utilize the proposed alternative identified under paragraph (2)(A) for the resolution of all types of disputes concerning injuries allegedly caused by health care providers or health care organizations.

“(B) CURRENT STATE EFFORTS TO ESTABLISH ALTERNATIVE TO TORT LITIGATION.—

“(i) IN GENERAL.—Nothing in this section shall be construed to limit the efforts that any State has made prior to the date of enactment of this section to establish any alternative to tort litigation.
“(ii) Alternative for Practice Areas or Injuries.—In the case of a State that has established an alternative to tort litigation for a certain area of health care practice or a category of injuries, the alternative selected as provided for in this section shall supplement not replace or invalidate such established alternative unless the State intends otherwise.

“(6) Notification of Patients.—To be eligible to receive a grant under subsection (a), the State shall demonstrate how patients will be notified when they are receiving health care services that fall within the scope of the alternative selected under this section by the State to current tort litigation.

“(c) Representation by Counsel.—A State that receives a grant under this section may not preclude any party to a dispute that falls within the jurisdiction of the alternative to current tort litigation that is implemented under the grant from obtaining legal representation at any point during the consideration of the claim under such alternative.

“(d) Models.—

“(1) In General.—The models in this section are the following:
“(2) EXPERT PANEL REVIEW AND EARLY OFFER GUIDELINES.—

“(A) IN GENERAL.—A State may use amounts received under a grant under this section to develop and implement an expert panel and early offer review system that meets the requirements of this paragraph.

“(B) ESTABLISHMENT OF PANEL.—Under the system under this paragraph, the State shall establish an expert panel to review any disputes concerning injuries allegedly caused by health care providers or health care organizations according to the guidelines described in this paragraph.

“(C) COMPOSITION.—

“(i) IN GENERAL.—An expert panel under this paragraph shall be composed of 3 medical experts (either physicians or health care professionals) and 3 attorneys to be appointed by the head of the State agency responsible for health.

“(ii) LICENSURE AND EXPERTISE.—Each physician or health care professional appointed to an expert panel under clause (i) shall—
“(I) be appropriately credentialed or licensed in the State in which the dispute takes place to deliver health care services; and

“(II) typically treat the condition, make the diagnosis, or provide the type of treatment that is under review.

“(iii) INDEPENDENCE.—

“(I) IN GENERAL.—Subject to subclause (II), each individual appointed to an expert panel under this paragraph shall—

“(aa) not have a material familial, financial, or professional relationship with a party involved in the dispute reviewed by the panel; and

“(bb) not otherwise have a conflict of interest with such a party.

“(II) EXCEPTION.—Nothing in subclause (I) shall be construed to prohibit an individual who has staff privileges at an institution where the
treatment involved in the dispute was provided from serving as a member of an expert panel merely on the basis of such affiliation, if the affiliation is disclosed to the parties and neither party objects.

“(iv) PRACTICING HEALTH CARE PROFESSIONAL IN SAME FIELD.—

“(I) IN GENERAL.—In a dispute before an expert panel that involves treatment, or the provision of items or services—

“(aa) by a physician, the medical experts on the expert panel shall be practicing physicians (allopathic or osteopathic) of the same or similar specialty as a physician who typically treats the condition, makes the diagnosis, or provides the type of treatment under review; or

“(bb) by a health care professional other than a physician, at least two medical experts on the expert panel shall be prac-
ticing physicians (allopathic or osteopathic) of the same or similar specialty as the health care professional who typically treats the condition, makes the diagnosis, or provides the type of treatment under review, and, if determined appropriate by the State agency, the third medical expert shall be a practicing health care professional (other than such a physician) of such a same or similar specialty.

“(II) Practicing defined.—In this paragraph, the term ‘practicing’ means, with respect to an individual who is a physician or other health care professional, that the individual provides health care services to individual patients on average at least 2 days a week.

“(v) Pediatric expertise.—In the case of dispute relating to a child, at least 1 medical expert on the expert panel shall
have expertise described in clause (iv)(I) in pediatrics.

“(D) DETERMINATION.—After a review, an expert panel shall make a determination as to the liability of the parties involved and compensation based on a schedule of compensation that is developed by the panel. Such a schedule shall at least include—

“(i) payment for the net economic loss incurred by the patient, on a periodic basis, reduced by any payments received by the patient under—

“(I) any health or accident insurance;

“(II) any wage or salary continuation plan; or

“(III) any disability income insurance;

“(ii) payment for the non-economic damages incurred by the patient, if appropriate for the injury, based on a defined payment schedule developed by the State, in consultation with relevant experts and with the Secretary;

“(iii) reasonable attorney’s fees; and
“(iv) regular updates of the schedule under clause (ii) as necessary.

“(E) Acceptance.—If the parties to a dispute who come before an expert panel under this paragraph accept the determination of the expert panel concerning liability and compensation, such compensation shall be paid to the claimant and the claimant shall agree to forgo any further action against the health care providers or health care organizations involved.

“(F) Failure to Accept.—If any party decides not to accept the expert panel’s determination under this paragraph, the State may choose whether to allow the panel to review the determination de novo, with deference, or to provide an opportunity for parties to reject the determination of the panel.

“(G) Review by State Court after Exhaustion of Administrative Remedies.—

“(i) Right to File.—If the State elects not to permit the expert panel under this paragraph to conduct its own reviews of determinations, or if the State elects to permit such reviews but a party is not satisfied with the final decision of the panel
after such a review, the party shall have
the right to file a claim relating to the in-
jury involved in a State court of competent
jurisdiction.

“(ii) FORFEIT OF AWARDS.—Any
party filing an action in a State court
under clause (i) shall forfeit any compensa-
tion award made under subparagraph (C).

“(iii) ADMISSIBILITY.—The deter-
minations of the expert panel pursuant to
a review under subparagraph (C) shall be
admissible into evidence in any State court
proceeding under this subparagraph.

“(3) ADMINISTRATIVE HEALTH CARE TRIBU-
NALS.—

“(A) IN GENERAL.—A State may use
amounts received under a grant under this sec-
tion to develop and implement an administra-
tive health care tribunal system under which
the parties involved shall have the right to re-
quest a hearing to review any dispute con-
cerning injuries allegedly caused by health care
providers or health care organizations before an
administrative health care tribunal established
by the State involved.
“(B) REQUIREMENTS.—In establishing an administrative health care tribunal under this paragraph, a State shall—

“(i) ensure that such tribunals are presided over by special judges with health care expertise who meet applicable State standards for judges and who agree to preside over such court voluntarily;

“(ii) provide authority to such judges to make binding rulings, rendered in written decisions, on standards of care, causation, compensation, and related issues with reliance on independent expert witnesses commissioned by the tribunal;

“(iii) establish a legal standard for the tribunal that shall be the same as the standard that would apply in the State court of competent jurisdiction which would otherwise handle the claim; and

“(iv) provide for an appeals process to allow for review of decisions by State courts.

“(C) DETERMINATION.—After a tribunal conducts a review under this paragraph, the tribunal shall make a determination as to the li-
ability of the parties involved and the amount
of compensation that should be paid based on
a schedule of compensation developed by the
tribunal. Such a schedule shall at a minimum
include—

“(i) payment for the net economic loss
incurred by the patient, on a periodic
basis, reduced by any payments received by
the patient under—

“(I) any health or accident insur-
ance;

“(II) any wage or salary continu-
ation plan; or

“(III) any disability income in-
surance;

“(ii) payment for the non-economic
damages incurred by the patient, if appro-
priate for the injury, based on a defined
payment schedule developed by the State
in consultation with relevant experts and
with the Secretary;

“(iii) reasonable attorney’s fees; and

“(iv) regular updates of the schedule
under clause (ii) as necessary.
“(D) Review by state court after exhaustion of administrative remedies.—

“(i) Right to file.—Nothing in this paragraph shall be construed to prohibit any individual who is not satisfied with the determinations of a tribunal under this paragraph, from filing a claim for the injury involved in a State court of competent jurisdiction.

“(ii) Forfeiture of award.—Any party filing an action in a State court under clause (i) shall forfeit any compensation award made under subparagraph (C).

“(iii) Admissibility.—The determinations of the tribunal under subparagraph (C) shall be admissible into evidence in any State court proceeding under this subparagraph.

“(4) Expert panel review and administrative health care tribunal combination model.—

“(A) In general.—A State may use amounts received under a grant under this section to develop and implement an expert panel review and administrative health care tribunal
combination system to review any dispute concerning injuries allegedly caused by health care providers or health care organizations. Under such system, a dispute concerning injuries allegedly caused by health care providers or health care organizations shall proceed through the procedures described in this subparagraph prior to the submission of such dispute to a State court.

“(B) General procedure.—

“(i) Establishment of expert panel.—Prior to submitting any dispute described in subparagraph (A) to an administrative health care tribunal under the system established under this paragraph, the State shall establish an expert panel (in accordance with subparagraph (C)) to review the allegations involved in such dispute.

“(ii) Referral to tribunal.—If either party to a dispute described in clause (i) fails to accept the determination of the expert panel, the dispute shall then be referred to an administrative health care tri-
bunal (in accordance with subparagraph (D).

“(C) EXPERT REVIEW PANEL.—

“(i) IN GENERAL.—The provisions of paragraph (2) shall apply with respect to the establishment and operation of an expert review panel under this subparagraph, except that the subparagraphs (F) and (G) of such paragraph shall not apply.

“(ii) FAILURE TO ACCEPT DETERMINATION OF PANEL.—If any party to a dispute before an expert panel under this subparagraph refuses to accept the panel’s determination, the dispute shall be referred to an administrative health care tribunal under subparagraph (D).

“(D) ADMINISTRATIVE HEALTH CARE TRIBUNALS.—

“(i) IN GENERAL.—Upon the failure of any party to accept the determination of an expert panel under subparagraph (C), the parties shall request a hearing concerning the liability or compensation involved by an administrative health care tri-
bunal established by the State involved under this subparagraph.

“(ii) REQUIREMENTS.—The provisions of paragraph (3) shall apply with respect to the establishment and operation of an administrative health care tribunal under this subparagraph.

“(iii) FORFEIT OF AWARDS.—Any party proceeding to the second step-administrative health care tribunal-under this model shall forfeit any compensation awarded by the expert panel.

“(iv) ADMISSIBILITY.—The determinations of the expert panel under subparagraph (C) shall be admissible into evidence in any administrative health care tribunal proceeding under this subparagraph.

“(E) RIGHT TO FILE.—Nothing in this paragraph shall be construed to prohibit any individual who is not satisfied with the determination of the tribunal (after having proceeded through both the expert panel under subparagraph (C) and the tribunal under subparagraph (D)) from filing a claim for the injury involved in a State court of competent jurisdiction.
“(F) Admissibility.—The determinations of both the expert panel and the tribunal under this paragraph shall be admissible into evidence in any State court proceeding under this paragraph.

“(G) Forfeiture of Awards.—Any party filing an action in State court under subparagraph (E) shall forfeit any compensation award made by both the expert panel and the administrative health care tribunal under this paragraph.

“(e) Definitions.—In this section:

“(1) Current Tort Litigation.—The term ‘current tort litigation’ means the tort litigation system existing in the State on the date on which the State submits an application under subsection (b)(1), for the resolution of disputes concerning injuries allegedly caused by health care providers or health care organizations.

“(2) Health Care Organization.—The term ‘health care organization’ means any individual or entity that is obligated to provide, pay for, or administer health benefits under any health plan.

“(3) Net Economic Loss.—The term ‘net economic loss’ means—
“(A) reasonable expenses incurred for products, services and accommodations needed for health care, training and other remedial treatment and care of an injured individual;

“(B) reasonable and appropriate expenses for rehabilitation treatment and occupational training;

“(C) 100 percent of the loss of income from work that an injured individual would have performed if not injured, reduced by any income from substitute work actually performed; and

“(D) reasonable expenses incurred in obtaining ordinary and necessary services to replace services an injured individual would have performed for the benefit of the individual or the family of such individual if the individual had not been injured.

“(4) NON-ECONOMIC DAMAGES.—The term ‘non-economic damages’ means losses for physical and emotional pain, suffering, inconvenience, physical impairment, mental anguish, disfigurement, loss of enjoyment of life, loss of society and companionship, loss of consortium (other than loss of domestic service), injury to reputation, and all other non-pe-
cuniary losses of any kind or nature, to the extent permitted under State law.

“(f) FUNDING.—

“(1) ONE-TIME INCREASE IN MEDICAID PAYMENT.—In the case of a State awarded a grant to carry out this section, the total amount of the Federal payment determined for the State under section 1913 of the Social Security Act (as amended by section 401) for fiscal year 2011 (in addition to the any increase applicable for that fiscal year under section 203(b) but determined without regard to any such increase) shall be increased by an amount equal to 1 percent of the total amount of payments made to the State for fiscal year 2010 under section 1903(a) of the Social Security Act (42 U.S.C. 1396b(a)) for purposes of carrying out a grant awarded under this section. Amounts paid to a State pursuant to this subsection shall remain available until expended.

“(2) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated for any fiscal year such sums as may be necessary for purposes of making payments to States pursuant to paragraph (1).”.
TITLE IV—SOCIAL SECURITY REFORM

SEC. 401. SHORT TITLE.
This title may be cited as the “Social Security Personal Savings Guarantee and Prosperity Act of 2010”.

SEC. 402. ESTABLISHMENT OF PERSONAL SOCIAL SECURITY SAVINGS PROGRAM.
(a) In General.—Title II of the Social Security Act is amended—
(1) by inserting before section 201 the following:

“PART A—INSURANCE BENEFITS”;

and

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

“PART B—PERSONAL SOCIAL SECURITY SAVINGS PROGRAM

“SEC. 251. DEFINITIONS.
“For purposes of this part—
“(1) PARTICIPATING INDIVIDUAL.—The term ‘participating individual’ has the meaning provided in section 253(a).
“(2) BOARD.—The term ‘Board’ means the Personal Social Security Savings Board established under section 260.
“(3) Executive director.—The term ‘Executive Director’ means the Executive Director appointed under section 261.

“(4) Personal social security savings account.—The term ‘personal social security savings account’ means an account established under section 254(a).

“(5) Personal social security savings annuity.—The term ‘personal social security savings annuity’ means an annuity approved by the Board under section 258(b)(3).

“(6) Savings fund.—The term ‘Savings Fund’ means the Social Security Personal Savings Fund established under section 252.

“(7) Tier I investment fund.—The term ‘Tier I Investment Fund’ means the trust fund created under section 255.

“(8) Tier II investment fund.—The term ‘Tier II Investment Fund’ means the trust fund created under section 256.

“(9) Tier III investment option.—The term ‘Tier III Investment Option’ means an investment option which is—

“(A) offered by an eligible entity certified by the Board under section 257(b); and
“(B) approved by the Board under section 257(c).

“SEC. 252. SOCIAL SECURITY PERSONAL SAVINGS FUND.

“(a) ESTABLISHMENT OF SAVINGS FUND.—

“(1) ESTABLISHMENT.—There is established in the Treasury of the United States a trust fund to be known as the ‘Social Security Personal Savings Fund’.

“(2) AMOUNTS IN FUND.—The Savings Fund shall consist of—

“(A) all amounts transferred to or deposited into the Savings Fund under subsection (b), increased by the total net earnings from investments of sums in the Savings Fund attributable to such transferred or deposited amounts, and reduced by the total net losses from investments of such sums, and

“(B) the reserves held in the Annuity Reserves Account established under section 258(b)(3), increased by the total net earnings from investments of such reserves, and reduced by the total net losses from investments of such reserves.

“(3) TRUSTEES.—The Board shall serve as trustees of the Savings Fund.
“(4) Budget authority; appropriation.—
This part constitutes budget authority in advance of appropriations Acts and represents the obligation of the Board to provide for the payment of amounts provided under this part. The amounts held in the Savings Fund are appropriated and shall remain available without fiscal year limitation.

“(b) Deposits into Fund.—

“(1) In general.—During each calendar year, the Secretary of the Treasury shall deposit into the Savings Fund, from amounts held in the Federal Old-Age and Survivors Insurance Trust Fund, a total amount equal, in the aggregate, to 100 percent of the redirected Social Security contribution for such calendar year of each individual who is a participating individual for such calendar year.

“(2) Transfers based on estimates.—

“(A) In general.—The amounts deposited pursuant to paragraph (1) shall be transferred in at least weekly payments from the Federal Old-Age and Survivors Insurance Trust Fund to the Savings Fund.

“(B) Determination of amounts.—The amounts transferred under subparagraph (A) shall be determined on the basis of estimates,
made by the Commissioner of Social Security and certified to the Secretary of the Treasury, of the wages paid to, and self-employment income derived by, participating individuals. Proper adjustments shall be made in amounts subsequently transferred to the extent prior estimates were in excess of or were less than actual amounts transferred.

“(3) Redirected social security contributions.—For purposes of paragraph (1)—

“(A) In general.—The term ‘redirected social security contributions’ means, with respect to an individual for a calendar year, the sum of—

“(i) the product derived by multiplying—

“(I) the sum of the total wages paid to, and self-employment income derived by, such individual during such calendar year, to the extent such total wages and self-employment income do not exceed the base amount for such calendar year; by

“(II) the applicable base percentage for the calendar year; and
“(ii) the product derived by multiplying—

“(I) the sum of the total wages paid to, and self-employment income derived by, such individual during such calendar year, to the extent such total wages and self-employment income exceed the base amount (taking into account the limits imposed by the contribution and benefit base under section 230); by

“(II) the applicable supplemental percentage for the calendar year.

“(B) BASE AMOUNT.—For purposes of subparagraph (A)—

“(i) INITIAL BASE AMOUNT.—The base amount for calendar year 2012 is $10,000.

“(ii) ADJUSTMENTS TO BASE AMOUNT.—The base amount for any calendar year after 2011 is the product derived by multiplying $10,000 by a fraction—

“(I) the numerator of which is the national average wage index (as
defined in section 209(k)) for the first
of the 2 preceding calendar years; and
“(II) the denominator of which is
the national average wage index (as so
defined) for 2010.
“(C) APPLICABLE BASE PERCENTAGE.—
For purposes of subparagraph (A), the applicable base percentage for a calendar year is—
“(i) for calendar years after 2011 and
before 2022, 2 percent;
“(ii) for calendar years after 2021 and
before 2032, 4 percent;
“(iii) for calendar years after 2031 and
before 2042, 6 percent; and
“(iv) for calendar years after 2041, 8
percent.
“(D) APPLICABLE SUPPLEMENTAL PER-
centage.—For purposes of subparagraph (A),
the applicable supplemental percentage for a calendar year is—
“(i) for calendar years after 2011 and
before 2022, 1 percent;
“(ii) for calendar years after 2021 and
before 2032, 2 percent;
“(iii) for calendar years after 2031 and before 2042, 3 percent; and

“(iv) for calendar years after 2041, 4 percent.

“(c) AVAILABILITY.—The sums in the Savings Fund are appropriated and shall remain available without fiscal year limitation—

“(1) to invest funds in the Tier I Investment Fund of the Savings Fund and the Tier II Investment Fund of the Savings Fund under sections 255 and 256, respectively;

“(2) to transfer into Tier III Investment Options under section 257;

“(3) to make distributions in accordance with section 258; and

“(4) to pay the administrative expenses of the Board in accordance with subsection (e).

“(d) LIMITATIONS ON USE OF FUNDS.—

“(1) IN GENERAL.—Sums in the Savings Fund credited to a participating individual’s personal social security savings account may not be used for, or diverted to, purposes other than for the exclusive benefit of the participating individual or the participating individual’s beneficiaries under this part.
“(2) ASSIGNMENTS.—Sums in the Savings Fund may not be assigned or alienated and are not subject to execution, levy, attachment, garnishment, or other legal process.

“(e) PAYMENT OF ADMINISTRATIVE EXPENSES.—Administrative expenses incurred to carry out this part shall be paid out of net earnings in the Savings Fund in conjunction with the allocation of investment earnings and losses under section 254(e).

“(f) LIMITATION.—The sums in the Savings Fund shall not be appropriated for any purpose other than the purposes specified in this part and may not be used for any other purpose.

“SEC. 253. PARTICIPATION IN PROGRAM.

“(a) PARTICIPATING INDIVIDUAL.—For purposes of this part, the term ‘participating individual’ means any individual—

“(1)(A) who receives wages in any calendar year after December 31, 2011, on which there is imposed a tax under section 3101(a) of the Internal Revenue Code of 1986, or

“(B) who derives self-employment income for a taxable year beginning after December 31, 2011, on which there is imposed a tax under section 1401(a) of the Internal Revenue Code of 1986,
“(2) who is born on or after January 1, 1956,
and
“(3) who has filed an election to be treated as
a participating individual under subsection (b) and
has not subsequently filed an election to renounce
such individual’s status as a participating individual
under subsection (c).
“(b) Election of Participation.—
“(1) In general.—An individual who has not
become entitled to old-age insurance benefits under
section 202(a) may elect, subject to paragraph (2)
and in such form and manner as shall be prescribed
in regulations of the Board, to be treated as a ‘par-
ticipating individual’ for purposes of this part. Such
regulations shall provide for regular, periodic oppor-
tunities for the filing of such an election. The Board
shall provide for immediate notification to the Com-
missioner of Social Security, the Secretary of the
Treasury, and the Executive Director of such elec-
tion.
“(2) Deadline for election.—An election
under paragraph (1) may be made by an individual
not later than the later of—
“(A) the date on which such individual at-
tains age 25, or

“(3) Effectiveness of Election.—An election under this subsection shall be effective with respect to wages earned, and self-employment income derived, on the earliest date on which the Board determines is practicable to make such election effective following the date of the filing of the election.

“(e) Revocation of Election.—

“(1) In General.—An individual may, in such form and manner as shall be prescribed in regulations of the Board, revoke an election made by such individual under subsection (b) within 1 year after the date of a qualifying event described in paragraph (2). Upon completion of the procedures provided for under paragraph (3), any such individual who has made such an election shall not be treated as a participating individual under this part, effective as if such individual had never been a participating individual. The Board shall provide for immediate notification of such election to the Commissioner of Social Security, the Secretary of the Treasury, and the Executive Director.

“(2) Qualifying Events.—For purposes of paragraph (1), the term ‘qualifying event’ means, in
connection with an individual, any of the following events:

“(A) The death of the individual’s spouse.

“(B) The entry into marriage by the individual.

“(C) The divorce or legal separation of the individual from the individual’s spouse.

“(D) A dependent child of the individual ceasing to be a dependent child of the individual under section 202(d)(3).

“(3) PROCEDURE.—The Board shall prescribe by regulation procedures governing the termination of an individual’s status as ‘participating individual’ pursuant to a revocation under this subsection. Such procedures shall include—

“(A) prompt closing of the individual’s personal social security savings account established under section 254, and

“(B) prompt transfer to the Federal Old-Age and Survivors Insurance Trust Fund as general receipts of any amount held in the Tier II Investment Fund of the Savings Fund or under a Tier III Investment Option pursuant to section 256 or 257 and credited to such individual’s personal social security savings account.
“SEC. 254. PERSONAL SOCIAL SECURITY SAVINGS ACCOUNTS.

“(a) Establishment of Publicly Administered System of Personal Security Savings Accounts.—
As soon as practicable after the later of January 1, 2011, or the date on which an individual becomes a participating individual under this part, the Executive Director shall establish a personal social security savings account for such individual. Such account shall be the means by which amounts held in the Tier I Investment Fund and the Tier II Investment Fund of the Savings Fund under sections 255 and 256 and amounts held under Tier III Investment Options under section 257 are credited to such individual, under procedures which shall be established by the Board by regulation. Each account of a participating individual shall be identified to such participating individual by means of the participating individual’s Social Security account number.

“(b) Account Balance.—The balance in a participating individual’s account at any time is the sum of—

“(1) the balance in the Tier I Investment Fund of the Savings Fund credited to such participating individual prior to transfer of the credited amount to the Tier II Investment Fund of the Savings Fund;

plus

“(2) the excess of—
“(A) all deposits in the Tier II Investment Fund of the Savings Fund credited to such participating individual’s personal social security savings account, subject to such increases and reductions as may result from allocations made to and reductions made in the account pursuant to subsection (e)(1); over

“(B) amounts paid out of the Tier II Investment Fund in connection with amounts credited to such participating individual’s personal social security savings account; plus

“(3) the excess of—

“(A) the deposits in the Tier III Investment Options credited to such participating individual’s personal social security savings account, subject to such increases and reductions as may result from amounts credited to, and reductions made in, the account pursuant to subsection (e)(2); over

“(B) amounts paid out of the Tier III Investment Options of such participating individual.

The calculation made under paragraph (3) shall be made separately for each Tier III Investment Option of the participating individual. The Board shall also hold for the
participating individual any benefit credit certificate as-
signed to the participating individual’s personal social se-
curity savings account under section 255.

“(c) ALLOCATION OF EARNINGS AND LOSSES.—Pur-
suant to regulations which shall be prescribed by the
Board, the Executive Director shall allocate to each per-
sonal social security savings account an amount equal to
the net earnings and net losses from each investment of
sums—

“(1) in the Tier I Investment Fund and the
Tier II Investment Fund which are attributable to
sums credited to such account reduced by an appro-
priate share of the administrative expenses paid out
of the net earnings, as determined by the Executive
Director; and

“(2) in the Tier III Investment Options which
are attributable to sums credited to such account re-
duced by the administrative expenses paid out of the
net earnings.

“SEC. 255. TIER I INVESTMENT FUND.

“(a) ESTABLISHMENT OF TIER I INVESTMENT
FUND.—

“(1) IN GENERAL.—The Savings Fund shall in-
clude a separate fund to be known as the ‘Tier I In-
vestment Fund’.
'(2) AMOUNTS IN FUND.—The Tier I Investment Fund consists of all amounts derived from payments into the Fund under section 252(b) and remaining after investment of such amounts under subsection (b), including additional amounts derived as income from such investments.

'(3) USE OF FUNDS.—The amounts held in the Fund are appropriated and shall remain available without fiscal year limitation—

'(A) to be held for investment on behalf of participating individuals under subsection (b),

'(B) to pay the administrative expenses related to the Fund, and

'(C) to make transfers from the Fund under subsection (c)(2).

'(b) INVESTMENT OF FUND BALANCE.—For purposes of investment of the Tier I Investment Fund, the Board shall contract with appropriate professional asset managers, recordkeepers, and custodians selected for investment of amounts held in the Fund, so as to provide for investment of the balance of the Fund, in a manner providing broad diversification in accordance with regulations of the Board, in—

'(1) insurance contracts,

'(2) certificates of deposit, or
“(3) other instruments or obligations selected by such asset managers, which return the amount invested and pay interest, at a specified rate or rates, on that amount during a specified period of time.

“(c) Separate Crediting to Personal Social Security Savings Accounts and Transfers to the Tier II Investment Fund or to Tier III Investment Options.—

“(1) Crediting to Accounts.—

“(A) In general.—Subject to this paragraph, the Board shall provide for prompt, separate crediting, as soon as practicable, of the amounts deposited in the Tier I Investment Fund to the personal social security savings account of each participating individual with respect to the redirected social security contributions (as defined in section 252(b)(3)) of such participating individual. The Board shall include in such crediting, with respect to each such individual, any increases or decreases in such amounts so as to reflect the net returns and losses from investment of the balance of the Fund prior to such crediting. For purposes of determining such increases and decreases for
each calendar year, the amounts deposited into
the Fund in connection with such individual
during such calendar year shall be deemed to
have been deposited on June 30 of such year.

“(B) TREATMENT OF MARRIED PARTICI-
PATING INDIVIDUALS.—If the participating in-
dividual is married as of the end of the calendar
year in which the amounts to be credited were
deposited in the Tier I Investment Fund and
the spouse is also a participating individual, the
personal social security savings account of the
participating individual and the personal social
security savings account of his or her spouse
shall each be credited with 50 percent of such
amounts.

“(2) TRANSFERS FROM THE TIER I INVEST-
MENT FUND.—In accordance with elections filed
with the Board by a participating individual, any
amount credited to the personal social security sav-
ings account of such participating individual under
paragraph (1) shall be promptly transferred to the
Tier II Investment Fund of the Savings Fund for
investment in accordance with section 256 and, to
the extent available under section 257, to Tier III
Investment Options in accordance with section 257.
“(d) Treatment of Amounts Held in Tier I Investment Fund.—Subject to this part—

“(1) until amounts deposited into the Tier I Investment Fund during any calendar year are credited to personal social security savings accounts, such amounts shall be treated as the unallocated property of all participating individuals with respect to whom amounts were deposited in the Fund during such year, jointly held in trust for such participating individuals in the Savings Fund, and

“(2) amounts deposited into the Fund which are credited to the personal social security savings account of a participating individual shall be treated as property of the participating individual, held in trust for such participating individual in the Savings Fund.

“Sec. 256. Tier II Investment Fund.

“(a) Establishment of Tier II Investment Fund.—

“(1) In General.—The Savings Fund shall include a separate fund to be known as the ‘Tier II Investment Fund’.

“(2) Amounts in Fund.—The Tier II Investment Fund consists of all amounts derived from payments into the Fund under section 255(c)(2) and
remaining after investment of such amounts under
subsection (b), including additional amounts derived
as income from such investments.

“(3) USE OF FUNDS.—The amounts held in the
Fund are appropriated and shall remain available
without fiscal year limitation—

“(A) to be held for investment under sub-
section (b),

“(B) to pay the administrative expenses re-
lated to the Fund, and

“(C) to make transfers to Tier III Invest-
ment Options under section 257 or to make
payments under section 258.

“(b) PAYMENTS INTO TIER II INVESTMENT FUND.—

“(1) IN GENERAL.—Upon the crediting under
section 252 to the personal social security savings
account of a participating individual of any amount
held in the Tier I Investment Fund for any calendar
year, the Board shall transfer from the Tier I In-
vestment Fund into the Tier II Investment Fund
any amount so credited to such participating individ-
ual's account which is not transferred to a Tier III
Investment Option pursuant to an election under
section 257(a).
“(2) ONGOING SEPARATE CREDITING.—Subject to this paragraph, the Board shall provide for ongo-
ing separate crediting to each participating individ-
ual’s personal social security savings account of the amounts deposited in the Tier II Investment Fund with respect to such participating individual, to-
gether with any increases or decreases therein so as to reflect the net returns and losses from investment thereof while held in the Fund.

“(c) INVESTMENT ACCOUNTS.—

“(1) IN GENERAL.—For purposes of investment of the Tier II Investment Fund, the Board shall di-
vide the Fund into 6 investment accounts. The Board shall contract with appropriate investment managers, recordkeepers, and custodians selected for investment of amounts held in each investment ac-
count. Such accounts shall consist of—

“(A) a Lifecycle Investment Account,

“(B) a Government Securities Investment Account,

“(C) a Fixed Income Investment Account,

“(D) a Common Stock Index Investment Account,

“(E) a Small Capitalization Stock Index Investment Account, and
“(F) an International Stock Index Investment Account.

“(2) Election of Investment Options.—

“(A) Default Investment Account.— Except as provided in an election in effect under subparagraph (B), amounts held in the Tier II Investment Fund shall be credited to the Lifecycle Investment Account.

“(B) Election of Transfers Between Investment Accounts.—In any case in which a participating individual who has an amount in such individual’s personal social security savings account credited to any of the investment accounts in the Tier II Investment Fund files with the Secretary of the Treasury a written election under this subparagraph, not more frequently than annually and in accordance with regulations of the Board, the Secretary of the Treasury shall transfer the full amount so credited in such investment account from such investment account to any one of the other investment accounts in the Tier II Investment Fund (whichever is designated in such election).

“(d) Lifecycle Investment Account.—
“(1) IN GENERAL.—The investment manager, recordkeeper, and custodian selected for investment of amounts held in the Lifecycle Investment Account shall invest such amounts under regulations which shall be prescribed by the Board in a mix of equities and fixed income instruments so as to ensure, to the maximum extent practicable, that, of the total balance in the Fund credited to such account and available for investment (after allowing for administrative expenses), the percentage invested in fixed income instruments by individuals in designated cohorts, ranging in age up to those of at least retirement age, will increase in a linear progression from 0 percent to 100 percent as the cohort approaches retirement age.

“(2) INVESTMENT IN EQUITIES.—In accordance with regulations which shall be prescribed by the Board, the Board shall establish standards which must be met by equities selected for investment in the Lifecycle Investment Account. In conformity with such standards, the Board shall select, for purposes of such investment, indices which are comprised of equities the aggregate market value of which is, in each case, a reasonably broad representation of companies whose shares are traded on the
equity markets. Amounts invested in equities under an investment option shall be held in a portfolio designed to replicate the performance of one or more of such indices.

“(3) INVESTMENT IN FIXED INCOME INSTRUMENTS.—In accordance with regulations which shall be prescribed by the Board, the Board shall establish standards which must be met by fixed income instruments selected for investment in the Lifecycle Investment Account. Such standards shall take into account the competing considerations of risk and return. Amounts invested in fixed income instruments in an investment option shall be held in a portfolio which shall consist of a diverse range of fixed income instruments, taking into full account the opposing considerations of risk and maximization of return.

“(e) GOVERNMENT SECURITIES INVESTMENT ACCOUNT.—

“(1) IN GENERAL.—Amounts in the Government Securities Investment Account shall be invested in securities of the United States Government as provided in this subsection

“(2) ISSUANCE OF SPECIAL OBLIGATIONS.—The Secretary of the Treasury is authorized to issue special interest-bearing obligations of the United
States for purchase by the Tier II Investment Fund for purposes of investment of amounts in the Government Securities Investment Account. Such obligations shall have maturities fixed with due regard to the needs of the Fund as determined by the Board, and shall bear interest at a rate equal to the average market yield (computed by the Secretary of the treasury on the basis of market quotations as of the end of the calendar month next preceding the date of issue of such obligations) on all marketable interest-bearing obligations of the United States then forming a part of the public debt which are not due or callable earlier than 4 years after the end of such calendar month. Any average market yield computed under this paragraph which is not a multiple of one-eighth of 1 percent shall be rounded to the nearest multiple of one-eighth of 1 percent.

“(f) FIXED INCOME INVESTMENT ACCOUNT.—Amounts in the Fixed Income Investment Account shall be invested in instruments or obligations which return the amount invested and pay interest, at a specified rate or rates, on that amount during a specified period of time, consisting of instruments or obligations in one or more of the following categories:

“(1) insurance contracts;
“(2) certificates of deposit; or
“(3) other instruments or obligations selected
by qualified professional asset managers.
“(g) COMMON STOCK INDEX INVESTMENT AC-
COUNT.—
“(1) PORTFOLIO DESIGN.—Amounts held in the
Common Stock Investment Account shall be invested
in a portfolio of common stock designed to replicate
the performance of the index selected under para-
graph (2). The portfolio shall be designed such that,
to the extent practicable, the percentage of the bal-
ance in the Common Stock Index Investment Ac-
count that is invested in each stock is the same as
the percentage determined by dividing the aggregate
market value of all shares of that stock by the ag-
gregate market value of all shares of all stocks in-
cluded in such index.
“(2) SELECTION OF INDEX.—The Board shall
select, for purposes of investment of amounts held in
the Common Stock Investment Account, an index
which is a commonly recognized index comprised of
common stock the aggregate market value of which
is a reasonably complete representation of the
United States equity markets.
“(h) Small Capitalization Stock Index Investment Account.—

“(1) Portfolio Design.—Amounts held in the Small Capitalization Stock Index Investment Account shall be invested in a portfolio of common stock designed to replicate the performance of the index selected under paragraph (2). The portfolio shall be designed such that, to the extent practicable, the percentage of the balance in the Small Capitalization Stock Index Investment Account that is invested in each stock is the same as the percentage determined by dividing the aggregate market value of all shares of that stock by the aggregate market value of all shares of all stocks included in such index.

“(2) Selection of Index.—The Board shall select, for purposes of investment of amounts held in the Small Capitalization Stock Index Investment Account, an index which is a commonly recognized index comprised of common stock the aggregate market value of which represents the United States equity markets excluding the common stocks included in the Common Stock Index Investment Account.
“(i) International Stock Index Investment Account.—

“(1) Portfolio Design.—Amounts held in the International Stock Index Investment Account shall be invested in a portfolio of stock designed to replicate the performance of the index selected under paragraph (2). The portfolio shall be designed such that, to the extent practicable, the percentage of the balance in the International Stock Index Investment Account that is invested in each stock is the same as the percentage determined by dividing the aggregate market value of all shares of that stock by the aggregate market value of all shares of all stocks included in such index.

“(2) Selection of Index.—The Board shall select, for purposes of investment of amounts held in the International Stock Index Investment Account, an index which is a commonly recognized index comprised of common stock the aggregate market value of which is a reasonably complete representation of the international equity markets excluding the United States equity markets.

“(j) Additional Investment Options.—The Board may from time to time, as determined by regulation
as appropriate to further the purposes of this section, shall—

“(1) establish investment accounts in the Tier II Investment Fund meeting the requirements of this section in addition to those established by this section, and

“(2) terminate investment accounts in the Tier II Investment Fund established pursuant to paragraph (1).

“(k) DISCLOSURE OF ADMINISTRATIVE COSTS.—The Board shall provide to each participating individual an annual disclosure of the rate of administrative costs chargeable with respect to investment in each investment account in the Tier II Investment Fund. Such disclosure shall be written in a manner calculated to be understood by the average participating individual.

“(l) TREATMENT OF AMOUNTS HELD IN TIER II INVESTMENT FUND.—Subject to this part, amounts deposited into, and held and accounted for in, the Tier II Investment Fund with respect to any participating individual shall continue to be treated as property of such participating individual, held in trust for such participating individual in the Fund.
“SEC. 257. TIER III INVESTMENT OPTIONS.

“(a) ELECTION OF TIER III INVESTMENT OPTIONS.—

“(1) IN GENERAL.—A participating individual may elect to direct transfers from amounts in the Savings Fund credited to the personal social security savings account of such individual into 1 or more Tier III Investment Options in accordance with paragraph (2).

“(2) COMMENCEMENT OF TIER III INVESTMENT OPTIONS UPON ATTAINMENT OF ELECTION THRESHOLD.—In any case in which, as of the end of any calendar year, the total balance in the Savings Fund credited to a participating individual’s personal social security savings account exceeds for the first time the election threshold, the Board shall, by regulation, provide for an opportunity for such participating individual to make, at any time thereafter, such individual’s first election of one or more of the Tier III Investment Options for investment of an amount in the Savings Fund credited to such account. Such election may be in lieu of or in addition to investment in the options available with respect to the Tier II Investment Fund of the Savings Fund.

“(3) ALLOCATION OF FUNDS.—In the case of an election under paragraph (1), funds credited to
the personal social security savings account of the participating individual and elected for transfer to one or more Tier III Investment Options shall be transferred to the Tier III Investment Options so elected for such calendar year, in percentages specified in the election by the participating individual for each applicable portfolio.

“(4) ELECTION THRESHOLD.—

“(A) IN GENERAL.—Subject to subparagraph (B), for purposes of this subsection the term ‘election threshold’ means an amount equal to $25,000.

“(B) ADJUSTMENTS.—The Board shall adjust annually (effective for annual reporting months occurring after December 2011) the dollar amount set forth in subparagraph (A) under procedures providing for adjustments in the same manner and to the same extent as adjustments are provided for under the procedures used to adjust benefit amounts under section 215(i)(2)(A), except that any amount so adjusted that is not a multiple of $1.00 shall be rounded to the nearest multiple of $1.00.

“(5) SUBSEQUENT INVESTMENT OF AMOUNTS HELD IN TIER III INVESTMENT OPTIONS.—Any
amounts held in one or more Tier III Investment Options may be—

“(A) transferred at any time to one or more other Tier III Investment Options, subject to applicable regulations of the Board and the terms governing the affected Tier III Investment Options, and

“(B) transferred, not more frequently than annually, to the Tier II Investment Fund, for deposit in the applicable investment account then selected by the participating individual under section 256.

“(b) Certification of Eligible Entities.—

“(1) In General.—The Board shall certify eligible entities to offer Tier III Investment Options under this part.

“(2) Application.—Any eligible entity that desires to be certified by the Board to offer a Tier III Investment Option shall submit an application to the Board at such time, in such manner, and containing such information as the Board may require.

“(3) Requirements for Approval.—The Board shall not certify an eligible entity unless such eligible entity agrees to the following requirements:
“(A) SEPARATE ACCOUNTING.—Each eligible entity shall, with respect to each Tier III Investment Option offered by such eligible entity to participating individuals—

“(i) establish separate accounts for the contributions of each participating individual, and any earnings properly allocable to the contributions, and

“(ii) maintain separate recordkeeping with respect to each account.

“(B) TREATMENT OF AMOUNTS HELD IN FUND.—Amounts deposited into, and held and accounted for in, a Tier III Investment Option with respect to any participating individual shall be treated as property of such participating individual, held in trust for such participating individual.

“(C) TRUST REQUIREMENTS.—Amounts held and accounted for with respect to a participating individual shall be held in a trust created or organized in the United States for the exclusive benefit of such individual or his beneficiaries.

“(D) EXEMPTION FROM THIRD PARTY CLAIMS.—Each Tier III Investment Option
shall be exempt from any and all third party claims against the eligible entity.

"(E) Disclosure of Administrative Costs.—Each eligible entity offering a Tier III Investment Option under this section shall provide to each participating individual an annual disclosure of the rate of administrative costs chargeable with respect to investment in such Option. Such disclosure shall be written in a manner calculated to be understood by the average participating individual. The Board shall provide for coordination of disclosures with respect to Tier III Investment Options under this subparagraph so as to assist participating individuals in comparing alternative Options based on administrative costs.

"(F) Reporting to the Executive Director and the Board.—Each eligible entity shall provide reports to the Executive Director and the Board at such time, in such manner, and containing such information as the Board may require.

"(4) Eligible Entity Defined.—For purposes of this section, the term ‘eligible entity’ means any investment company (as defined in section 3 of
the Investment Company Act of 1940) or other person that the Board determines appropriate to offer Tier III Investment Options under this part.

“(c) APPROVAL OF TIER III INVESTMENT OPTIONS.—

“(1) IN GENERAL.—No funds may be transferred into a Tier III Investment Option unless the Board has approved an application submitted under paragraph (2) with respect to the option.

“(2) APPLICATION.—With respect to each Tier III Investment Option that an eligible entity certified under subsection (b)(1) seeks to offer, such entity shall submit an application to the Board at such time, in such manner, and containing such information as the Board may require.

“(3) QUALIFICATIONS FOR APPROVAL.—The Board may not approve an application submitted under paragraph (2) in connection with a Tier III Investment Option unless the following requirements are met:

“(A) OPTION MUST BE OFFERED BY CERTIFIED ELIGIBLE ENTITY.—The Tier III Investment Option is offered by an eligible entity certified under subsection (b).
“(B) Option must meet quality factors.—

“(i) In general.—The Tier III Investment Option meets qualifications which shall be prescribed by the Board relating to the quality factors described in clause (ii).

“(ii) Quality factors.—The quality factors described in this clause are—

“(I) the safety and soundness of the Tier III Investment Option’s proposed investment policy;

“(II) the experience and record of performance of the proposed investment option, if any;

“(III) the experience and record of performance of the entity issuing or offering such option; and

“(IV) such other factors as the Board may determine appropriate.

“(d) Considerations for Certification and Approval.—In determining whether to certify an eligible entity under subsection (b) or to approve a Tier III Investment Option under subsection (c), the Board shall—
“(1) act in the best interests of the participating individuals;

“(2) base its determination solely on considerations of balancing safety and soundness of the Tier III Investment Option with the maximization of returns of such option; and

“(3) not base any determination related to the entity or option on political or other extraneous considerations.

“(e) Sponsorship of Tier III Investment Options by Membership and Labor Organizations.—

“(1) In general.—A membership or labor organization (as defined by the Board) may sponsor Tier III Investment Options under contracts with eligible entities certified under subsection (b) who shall administer the investment option if such investment option is approved by the Board under subsection (c).

“(2) Limitation to membership.—A membership or labor organization (as so defined) may limit to the members of such organization participation in a Tier III Investment Option sponsored by such organization.

“(f) Distributions in case of death.—Upon the death of a participating individual, the amount of any as-
sets held under a Tier III Investment Option credited to
the personal social security savings account of such indi-
vidual shall be distributed in accordance with section
258(e).

“SEC. 258. PERSONAL SOCIAL SECURITY SAVINGS ANNUITY
AND OTHER DISTRIBUTIONS.

“(a) DATE OF INITIAL DISTRIBUTION.—Except as
provided in subsection (c), distributions may be made to
a participating individual from amounts credited to the
personal social security savings account of such individual
only on or after the earliest of—

“(1) the date the participating individual at-
tains retirement age (as defined in section 216(l)(1))
or, if elected by the individual, early retirement age
(as defined in section 216(l)(2)); or

“(2) the date on which the amount credited to
the participating individual’s personal social security
savings account is sufficient to purchase a personal
social security savings annuity with a monthly ben-
efit that is at least equal to the minimum annuity
payment amount (as defined in subsection
(b)(4)(C)(iii)).

“(b) PERSONAL SOCIAL SECURITY SAVINGS ANNU-
ITIES.—
“(1) NOTICE OF AVAILABLE ANNUITIES.—Not later than the date determined under subsection (a), the Board shall notify each participating individual of—

“(A) the most recent listing of personal social security savings annuities offered by the Annuity Issuance Authority under paragraph (2); and

“(B) the entitlement of the participating individual to purchase such an annuity.

“(2) ANNUITY ISSUANCE AUTHORITY.—There is established in the office of the Board an agency which shall be known as the ‘Annuity Issuance Authority’. The Authority shall provide, in accordance with regulations of the Board, for the issuance of personal social security savings annuities for purchase from the Authority under this section and to otherwise administer the issuance of such annuities in accordance with such regulations.

“(3) ANNUITY RESERVES ACCOUNT.—There is established in the Savings Fund an Annuity Reserves Account. The Account shall consist of all amounts received by the Authority from the purchase of personal social security savings annuities under this section (plus such amounts as may be
transferred to the Account under paragraph (5)(B)),
increased by the total net earnings from investments
of such reserves under subparagraph (A) of para-
graph (5) and reduced by the total net losses from
investments of such reserves under such subpara-
graph.

“(4) PURCHASE OF ANNUITIES.—

“(A) SELECTION OF ANNUITY.—On a date
elected by the participating individual, but no
earlier than the date determined under sub-
section (a), a participating individual may pur-
chase a personal social security savings annuity
selected from among the annuities offered by
the Authority under paragraph (2).

“(B) TRANSFER OF ASSETS.—Upon the
selection of an annuity by a participating indi-
vidual under subparagraph (A), the Board shall
provide for the transfer of assets, credited to
the personal social security savings account of
the participating individual and held in the Tier
II Investment Fund or under 1 or more Tier
III Investment Options (or any combination
thereof), in a total amount sufficient to pur-
chase the annuity selected by the participating
individual from annuities offered by the Author-
ity.

“(C) MINIMUM ANNUITY PAYMENT AMOUNT.—

“(i) IN GENERAL.—Subject to sub-
paragraph (D), if, at the time a personal
social security savings annuity is pur-
chased under subparagraph (A), the assets
credited to the personal social security sav-
ings account of the participating individual
are sufficient to purchase a personal social
security savings annuity offered by the Au-
thority under paragraph (2) with a month-
ly annuity payment that is at least equal
to the minimum annuity payment amount,
the amount of the monthly annuity pay-
ment provided by such annuity may not be
less than the minimum annuity payment
amount.

“(ii) CONSTRUCTION.—Nothing in
this subparagraph shall be construed to
prohibit a participating individual from
using personal social security savings ac-
count assets to purchase a personal social
security savings annuity offered by the Au-
authority under paragraph (2) which provides
for a monthly payment in excess of the
minimum amount required under clause
(i).

“(iii) Minimum annuity payment
amount defined.—For purposes of this
part, the term ‘minimum annuity payment
amount’ means, as of any date, an amount
equal to the monthly equivalent of 150 per-
cent of the poverty line for an individual
(as in effect on such date), determined
under the poverty guidelines of the Depart-
ment of Health and Human Services
issued under sections 652 and 673(2) of
the Omnibus Budget Reconciliation Act of
1981.

“(D) Purchase of annuities in the
event of insufficient assets.—If a partici-
pating individual desires, or is required under
subsection (f), to purchase a personal social se-
curity savings annuity under subsection (b) on
or after the date determined under subsection
(a)(1) and the assets of the personal social se-
curity savings account of such individual are in-
sufficient to purchase a personal social security
savings annuity that provides for a monthly payment that is at least equal to the minimum annuity payment amount (as defined in paragraph (4)(C)(iii)), the participating individual shall purchase a personal social security savings annuity with a monthly payment equal to the maximum amount that the participating individual’s personal social security savings account can fund, as determined in accordance with regulations which shall be prescribed by the Authority, and that otherwise meets the requirements of this subsection (including the cost-of-living protection requirement of subsection (c)(1)(C)), and the Authority shall provide for appropriate certification to the Secretary of the Treasury with respect to the participating individual’s eligibility for guarantee payments under section 259.

“(5) MAINTENANCE OF RESERVES FOR PAYMENT OF ANNUITIES.—

“(A) INVESTMENT OF RESERVES.—For purposes of investment of reserves held in the Annuity Reserves Account, the Authority shall contract with appropriate investment managers, recordkeepers, and custodians selected by the
Authority for investment of such reserves. Such reserves shall be invested under regulations which shall be prescribed by the Authority so as to ensure, to the maximum extent practicable, that, of the total balance of the reserves (after payment of administrative expenses to such managers, recordkeepers, and custodians)—

“(i) 65 percent is invested in equities in the same manner and under the same standards as are provided in section 256(c)(4), and

“(ii) 35 percent is invested in fixed income instruments in the same manner and under the same standards as are provided in section 256(c)(5).

“(B) Provision for Full Payment of Annuities.—Payment of personal social security savings annuities in accordance with the terms of such annuities shall be made, irrespective of the sufficiency of reserves in the Annuity Reserves Fund attributable to funds obtained from the purchase of such annuities. In the event of any impending insufficiency in the Annuity Reserves Account for the next fiscal year, the Authority shall certify to the Secretary of
the Treasury the amount of such insufficiency, and the Secretary of the Treasury shall transfer from the Federal Old-Age and Survivors Insurance Trust Fund to the Annuity Reserves Account the amount of the insufficiency, as so certified, in such installments, made prior to or during such fiscal year, as are necessary to eliminate in advance such insufficiency.

“(c) Personal Social Security Savings Annuity.—

“(1) In general.—For purposes of this part, the term ‘personal social security savings annuity’ means an annuity that meets the following requirements:

“(A) The annuity starting date (as defined in section 72(c)(4) of the Internal Revenue Code of 1986) commences on the first day of the month beginning after the date of the purchase of the annuity.

“(B) The terms of the annuity provide—

“(i) for a monthly payment to the participating individual during the life of the participating individual equal to at least the minimum annuity payment
amount (as defined in subsection (b)(4)(C)(iii)), or

“(ii) in the case of an annuity purchased under subparagraph (D) of subsection (b)(4), the maximum monthly payment determined under regulations prescribed under such subparagraph.

“(C) The terms of the annuity include procedures providing for adjustments in the amount of the monthly payments in the same manner and to the same extent as adjustments are provided for under the procedures used to adjust benefit amounts under section 215(i)(2)(A). Nothing in this subparagraph shall be construed to preclude the terms governing such an annuity from providing for adjustments in the amount of monthly payments resulting in a payment for any month greater than the payment for that month that would result from adjustments required under the preceding sentence (b)(4)(D).

“(D) The terms of the annuity include such other terms and conditions as the Board requires for the protection of the annuitant.
“(2) Exemption from Third Party Claims.—Each personal social security savings annuity shall be exempt from any and all third party claims against the issuer.

“(d) Right to Use Excess Personal Social Security Savings Account Assets.—To the extent assets credited to a participating individual’s personal social security savings account remain after the purchase of an annuity under subsection (b), the remaining assets shall be payable to the participating individual at such time, in such manner, and in such amounts as the participating individual may specify, subject to subsection (f).

“(e) Distributions in Case of Death.—If the participating individual dies before all amounts which are held in the Tier I Investment Fund or the Tier II Investment Fund of the Savings Fund or held under a Tier III Investment Option and which are credited to the personal social security savings account of the individual are otherwise distributed in accordance with this section, such amounts shall be distributed, under regulations which shall be prescribed by the Board—

“(1) in any case in which one or more beneficiaries have been designated in advance, to such beneficiaries in accordance with such designation as provided in such regulations, and
“(2) in the case of any amount not distributed as described in paragraph (1), to such individual’s estate.

“(f) Date of Final Distribution.—All amounts credited to the personal social security savings account of an individual shall be distributed, by means of the purchase of annuities or otherwise in a manner consistent with the requirements of this section, not later than 5 years after the date the individual attains retirement age (as defined in section 216(l)). The Board shall provide by regulation for means of distribution necessary to ensure compliance with the requirements of this subsection.

“SEC. 259. GUARANTEE OF ACCOUNT SAVINGS.

“(a) In General.—If, as of immediately before the month for which the first monthly payment under a participating individual’s personal social security savings annuity is paid, the amount credited to such individual’s personal social security savings account is less that the sum of all deposits made to the account under section 252(b), adjusted as provided in subsection (b), the Annuity Issuance Authority shall so certify to the Secretary of the Treasury and, upon receipt of such certification, such Secretary shall transfer to such individual’s Tier I Investment Fund, from amounts in the Federal Old-Age and Survivors Insurance Trust Fund, an amount equal to the ex-
cess of such sum of such deposits, as so adjusted, over such amount credited to such account.

“(b) ADJUSTMENTS.—

“(1) IN GENERAL.—For purposes of subsection (a), deposits described in subsection (a) which are made in any calendar year shall be deemed to be equal to the product of—

“(A) the deposits made in such year (as determined without regard to this subsection); and

“(B) the quotient obtained by dividing—

“(i) the Consumer Price Index for the calendar quarter beginning on July 1 and ending on September 30 preceding the year in which the month referred to in subsection (a) occurs; by

“(ii) the Consumer Price Index for the calendar quarter beginning on July 1 and ending on September 30 preceding the calendar year in which such deposits were made.

“(2) CONSUMER PRICE INDEX.—For purposes of paragraph (1), the Consumer Price Index for a calendar quarter shall be the arithmetical mean of the Consumer Price Index for Urban Wage Earners...
and Clerical Workers (CPI–W) for the 3 months in such quarter.

“SEC. 260. PERSONAL SOCIAL SECURITY SAVINGS BOARD.

“(a) ESTABLISHMENT.—There is established in the executive branch of the Government a Personal Social Security Savings Board.

“(b) COMPOSITION.—The Board shall be composed of—

“(1) 3 members appointed by the President, of whom 1 shall be designated by the President as Chairman; and

“(2) 2 members appointed by the President, of whom—

“(A) 1 shall be appointed by the President after taking into consideration the recommendation made by the Speaker of the House of Representatives in consultation with the minority leader of the House of Representatives; and

“(B) 1 shall be appointed by the President after taking into consideration the recommendation made by the majority leader of the Senate in consultation with the minority leader of the Senate.
“(c) ADVICE AND CONSENT.—Appointments under subsection (b) shall be made by and with the advice and consent of the Senate.

“(d) MEMBERSHIP REQUIREMENTS.—Members of the Board shall have substantial experience, training, and expertise in the management of financial investments and pension benefit plans.

“(e) LENGTH OF APPOINTMENTS.—

“(1) TERMS.—A member of the Board shall be appointed for a term of 4 years, except that of the members first appointed under subsection (b)—

“(A) the Chairman shall be appointed for a term of 4 years;

“(B) the members appointed under subsection (b)(2) shall be appointed for terms of 3 years; and

“(C) the remaining members shall be appointed for terms of 2 years.

“(2) VACANCIES.—

“(A) IN GENERAL.—A vacancy on the Board shall be filled in the manner in which the original appointment was made and shall be subject to any conditions that applied with respect to the original appointment.
“(B) COMPLETION OF TERM.—An individual chosen to fill a vacancy shall be appointed for the unexpired term of the member replaced.

“(3) EXPIRATION.—The term of any member shall not expire before the date on which the member’s successor takes office.

“(f) DUTIES.—The Board shall—

“(1) administer the program established under this part;

“(2) establish policies for the investment and management of the Savings Fund, including the Tier I Investment Fund and the Tier II Investment Fund, and amounts held under Tier III Investment Options, including policies applicable to the asset managers, recordkeepers, and custodians with responsibility for managing the investment of amounts credited to personal social security investment accounts, and for the management and operation of personal social security savings annuities, which shall provide for—

“(A) prudent investments suitable for accumulating funds for payment of retirement income;

“(B) sound management practices; and
“(C) low administrative costs;

“(3) review the performance of investments made for the Tier I Investment Fund and the Tier II Investment Fund;

“(4) review the performance of investments made under Tier III Investment Options;

“(5) review the management and operation of personal social security savings annuities;

“(6) review and approve the budget of the Board; and

“(7) comply with the fiduciary requirements of part 4 of subtitle B of title I of the Employee Retirement Income Security Act of 1974 (relating to fiduciary responsibility) in connection with any exercise of discretion in connection with the assets of the Savings Fund.

“(g) ADMINISTRATIVE PROVISIONS.—

“(1) IN GENERAL.—The Board may—

“(A) adopt, alter, and use a seal;

“(B) except as provided in paragraph (4), direct the Executive Director to take such action as the Board considers appropriate to carry out the provisions of this part and the policies of the Board in accordance with delegations under this part;
“(C) upon the concurring votes of 4 members, remove the Executive Director from office for good cause shown;

“(D) provide to the Executive Director such resources as are necessary to carry out the duties of the Executive Director; and

“(E) take such other actions as may be necessary to carry out the functions of the Board.

“(2) MEETINGS.—The Board shall meet—

“(A) not less than once during each month; and

“(B) at additional times at the call of the Chairman.

“(3) EXERCISE OF POWERS.—

“(A) IN GENERAL.—Except as provided in paragraph (1)(C), the Board shall perform the functions and exercise the powers of the Board on a majority vote of a quorum of the Board. Three members of the Board shall constitute a quorum for the transaction of business.

“(B) VACANCIES.—A vacancy on the Board shall not impair the authority of a quorum of the Board to perform the functions and exercise the powers of the Board.
“(4) Limitations on Investments.—The Board may not direct any person to invest or to cause to be invested any sums in the Tier II Investment Fund or any personal social security investment account in a specific asset or to dispose of or cause to be disposed of any specific asset of such Fund or any such account.

“(h) Compensation.—

“(1) In general.—Each member of the Board who is not an officer or employee of the Federal Government shall be compensated at the daily rate of basic pay for level IV of the Executive Schedule for each day during which such member is engaged in performing a function of the Board.

“(2) Expenses.—A member of the Board shall be paid travel, per diem, and other necessary expenses under subchapter I of chapter 57 of title 5, United States Code, while traveling away from such member’s home or regular place of business in the performance of the duties of the Board.

“(3) Source of Funds.—Payments authorized under this subsection shall be paid from the Tier I Investment Fund or the Tier II Investment Fund, as determined appropriate by the Board.
“(i) Discharge of Responsibilities.—The members of the Board shall discharge their responsibilities solely in the interest of the participating individuals and their beneficiaries under this part.

“(j) Annual Independent Audit.—The Board shall annually engage an independent qualified public accountant to audit the activities of the Board.

“(k) Submission of Budget to Congress.—The Board shall prepare and submit to the President, and, at the same time, to the appropriate committees of Congress, an annual budget of the expenses and other items relating to the Board which shall be included as a separate item in the budget required to be transmitted to Congress under section 1105 of title 31, United States Code.

“(l) Submission of Legislative Recommendations.—The Board may submit to the President, and, at the same time, shall submit to each House of Congress, any legislative recommendations of the Board relating to any of its functions under this part or any other provision of law.

“SEC. 261. EXECUTIVE DIRECTOR.

“(a) Appointment of Executive Director.—The Board shall appoint, without regard to the provisions of law governing appointments in the competitive service, an
Executive Director by action agreed to by a majority of
the members of the Board.

“(b) DUTIES.—The Executive Director shall, as de-
termined appropriate by the Board—

“(1) carry out the policies established by the
Board;

“(2) invest and manage the Tier I Investment
Fund and the Tier II Investment Fund in accord-
ance with the investment policies and other policies
established by the Board;

“(3) administer the provisions of this part re-
lating to the Tier I Investment Fund and the Tier
II Investment Fund; and

“(4) prescribe such regulations (other than reg-
ulations relating to fiduciary responsibilities) as may
be necessary for the administration of this part re-
lating to the Tier I Investment Fund and the Tier
II Investment Fund.

“(c) ADMINISTRATIVE AUTHORITY.—The Executive
Director may, within the scope of the duties of the Execu-
tive Director as determined by the Board—

“(1) appoint such personnel as may be nec-
essary to carry out the provisions of this part relat-
ing to the Tier I Investment Fund and the Tier II
Investment Fund;

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“(2) subject to approval by the Board, procure the services of experts and consultants under section 3109 of title 5, United States Code;

“(3) secure directly from an Executive agency, the United States Postal Service, or the Postal Rate Commission any information necessary to carry out the provisions of this part and the policies of the Board relating to the Tier I Investment Fund and the Tier II Investment Fund;

“(4) make such payments out of sums in the Tier I Investment Fund and the Tier II Investment Fund as the Executive Director determines, in accordance with regulations of the Board, are necessary to carry out the provisions of this part and the policies of the Board;

“(5) pay the compensation, per diem, and travel expenses of individuals appointed under paragraphs (1), (2), and (6) from the Tier I Investment Fund or the Tier II Investment Fund, in accordance with regulations of the Board;

“(6) accept and use the services of individuals employed intermittently in the Government service and reimburse such individuals for travel expenses, authorized by section 5703 of title 5, United States
Code, including per diem as authorized by section 5702 of such title;

“(7) except as otherwise expressly prohibited by law or the policies of the Board, delegate any of the Executive Director’s functions to such employees under the Board as the Executive Director may designate and authorize such successive redelegations of such functions to such employees under the Board as the Executive Director may consider to be necessary or appropriate; and

“(8) take such other actions as are appropriate to carry out the functions of the Executive Director.”.

(b) EFFECTIVE DATE.—The amendments made by this section shall apply with respect to wages paid after December 31, 2011, for pay periods ending after such date and self-employment income for taxable years beginning after such date.

SEC. 403. MONTHLY INSURANCE BENEFITS FOR PARTICIPATING INDIVIDUALS.

Section 202 of the Social Security Act (42 U.S.C. 402) is amended by adding at the end the following new subsection:

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“Benefits for Participants Under Part B

“(z)(1) Notwithstanding the preceding provisions of this section—

“(A) a participating individual under the Personal Social Security Savings Program under part B shall not be entitled to old-age insurance benefits under subsection (a); and

“(B) except as provided in paragraph (2), no individual shall be entitled to benefits under this section on the basis of the wages and self-employment income of such a participating individual.

“(2) In the case of any such participating individual who dies before such individual purchases a personal social security savings annuity under section 258, paragraph (1)(B) shall not apply with respect to child’s insurance benefits under subsection (d), widow’s insurance benefits under subsection (e), widower’s insurance benefits under subsection (f), mother’s and father’s insurance benefits under subsection (g), and parent’s insurance benefits under subsection (h).”.

SEC. 404. TAX TREATMENT OF ACCOUNTS.

(a) IN GENERAL.—

(1) IN GENERAL.—Subchapter F of chapter 1 of the Internal Revenue Code of 1986 (relating to
exempt organizations) is amended by adding at the end the following new part:

“PART IX—PERSONAL SOCIAL SECURITY SAVINGS PROGRAM

“Sec. 530A. Personal social security savings program.

“SEC. 530A. PERSONAL SOCIAL SECURITY SAVINGS PROGRAM.

“(a) GENERAL RULE.—The Social Security Personal Savings Fund and each Tier III Investment Option are exempt from taxation under this subtitle. Notwithstanding the preceding sentence, sums in a personal social security savings account which are attributable to a Tier III Option shall be subject to the taxes imposed by section 511 (relating to imposition of tax on unrelated business income of charitable, etc. organizations).

“(b) DISTRIBUTIONS.—

“(1) IN GENERAL.—Any qualified distribution from—

“(A) amounts credited to a personal social security savings account from the Social Security Personal Savings Fund or attributable to a Tier III Investment Option, or

“(B) a personal social security savings annuity,
shall not be included in the gross income of the distributee.

“(2) Qualified Distribution.—For purposes of paragraph (1), the term ‘qualified distribution’ means a distribution which meets the requirements of section 258 of the Social Security Act and which is not a guaranty payment (as defined by section 259 of such Act).

“(e) Definitions.—For purposes of this section—

“(1) Personal Social Security Savings Account.—The term ‘personal social security savings account’ means an account established under section 254(a) of the Social Security Act.

“(2) Personal Social Security Savings Annuity.—The term ‘personal social security savings annuity’ means an annuity approved by the Personal Social Security Savings Board under section 258(b)(3) of the Social Security Act.


“(4) Tier III Investment Option.—The term ‘Tier III Investment Option’ has the meaning given
such term by section 251(9) of the Social Security Act.

“(d) ESTATE TAX TREATMENT.—No amount shall be includible in the gross estate of any individual for purposes of chapter 11 by reason of an interest in the Tier I Investment Fund or the Tier II Investment Fund of the Savings Fund or held under a Tier III Investment Option and which is credited to the personal social security savings account of the individual.”.

(2) CONFORMING AMENDMENT.—Section 86(d)(1)(A) of such Code is amended by inserting “part A of” after “under”.

(3) CLERICAL AMENDMENT.—The table of parts for subchapter F of chapter 1 of such Code is amended by adding after the item relating to part VIII the following new item:

“PART IX. PERSONAL SOCIAL SECURITY SAVINGS PROGRAM.”.

(b) GUARANTY PAYMENTS.—Paragraph (1) of section 86(d) of the Internal Revenue Act of 1986, as amended by subsection (a)(2), is amended by striking “or” at the end of subparagraph (A), by striking the period and inserting “, or” at the end of subparagraph (B), and by adding at the end the following new subparagraph:

“(C) a guaranty payment under section 259(a), and a payment of an additional amount
under section 259(c), of the Social Security Act.”.

(c) Effective Date.—The amendments made by this section shall apply to taxable years beginning after December 31, 2011.

SEC. 405. SELF-LIQUIDATING SOCIAL SECURITY TRANSITION FUND.

Part B of title II of the Social Security Act (as added by section 101 of this Act) is amended by adding at the end the following new section:

“SEC. 262. SELF-LIQUIDATING SOCIAL SECURITY TRANSITION FUND.

“(a) Establishment.—There is hereby created on the books of the Treasury of the United States a trust fund to be known as the Self-Liquidating Social Security Transition Fund (in this section referred to as the ‘Transition Fund’).

“(b) Board of Trustees.—

“(1) Establishment.—With respect to the Transition Fund, there is hereby created a body to be known as the Board of Trustees of the Transition Fund (in this section referred to as the ‘Board of Trustees’) composed of the Commissioner of Social Security, the Secretary of the Treasury, and the
members of the Personal Social Security Savings Board.

“(2) DUTIES.—The Board of Trustees shall—

“(A) provide for the issuance of obligations by the Transition Fund pursuant to subsection (c),

“(B) provide for the receipt and management of amounts paid into the Transition Fund pursuant to subsection (d),

“(C) use all funds paid into the Transition Fund to redeem obligations issued under subsection (c) as soon as practicable,

“(D) report to Congress not later than the first day of April of each year on the operation and status of the Transition Fund during the preceding fiscal year and on its expected operation and status during the current fiscal year and the next 2 fiscal years, and

“(E) review the general policies followed in managing the Transition Fund, and recommend changes in such policies, including necessary changes in the provisions of law which govern the way in which the Transition Fund is to be managed.
“(3) MEETINGS.—The Board of Trustees shall meet not less frequently than once each calendar year.

“(c) ISSUANCE OF TRANSITION FUND BONDS.—

“(1) ISSUANCE.—

“(A) IN GENERAL.—The purposes for which obligations of the United States may be issued under chapter 31 of title 31, United States Code, are hereby extended to authorize the issuance at par of public-debt obligations by the Transition Fund.

“(B) REQUIRED ISSUANCE.—Beginning on January 1, 2012, whenever any obligation held in the Federal Old-Age and Survivors Insurance Trust Fund or the Federal Disability Insurance Trust Fund is repaid from the general fund of the Treasury to either of such Trust Funds, the Transition Fund shall issue an obligation under this subsection in an amount equal to the amount of interest and principal so repaid.

“(C) TRANSFER OF PROCEEDS TO GENERAL FUND OF THE TREASURY.—Proceeds from the issuance of any obligation issued under this section shall be transferred to the general fund of the Treasury.
“(D) ACCOUNTING.—The debt owed on any obligation issued under this section shall be considered to be debt of the Transition Fund and shall be accounted for in such manner.

“(2) MATURITIES AND INTEREST RATE.—Such obligations issued by the Transition Fund for purchase by the public shall have maturities fixed with due regard for the needs of the Transition Fund and shall bear interest at a rate equal to the average market yield (computed by the Secretary of the Treasury on the basis of market quotations as of the end of the calendar month next preceding the date of such issue) on all marketable interest-bearing obligations of the United States then forming a part of the public debt which are not due or callable until after the expiration of 4 years from the end of such calendar month, except that where such average market yield is not a multiple of one-eighth of 1 per centum, the rate of interest on such obligations shall be the multiple of one-eighth of 1 per centum nearest such market yield.

“(3) REPAYMENT OF OBLIGATIONS.—Obligations issued under this subsection may be redeemed only by funds in the Transition Fund.

“(d) DEPOSIT OF OASDI TRUST FUND SURPLUS.—
“(1) IN GENERAL.—In advance of the initial repayment from the general fund of the Treasury described in subsection (c)(1)(B), the Chief Actuary of the Social Security Administration shall certify to the Secretary of the Treasury the date of such repayment. There are appropriated to the Transition Fund for the fiscal year during which such date occurs, and for each fiscal year thereafter, out of any moneys in the Federal Old-Age and Survivors Insurance Trust Fund, amounts equivalent to the OASDI trust fund surplus (as defined in paragraph (2)) for the preceding fiscal year.

“(2) TRANSFERS BASED ON ESTIMATES.—The amounts appropriated by paragraph (1) shall be transferred from time to time from the Federal Old-Age and Survivors Insurance Trust Fund to the Transition Fund, such amounts to be determined on the basis of estimates by the Commissioner of Social Security. Proper adjustments shall be made in amounts subsequently transferred to the extent prior estimates were in excess of or were less than such surplus.

“(3) OASDI TRUST FUND SURPLUS DEFINED.—In this section, the term ‘OASDI trust fund surplus’ for a fiscal year means the dollar
amount by which the Federal Old-Age and Survivors Insurance Trust Fund could be reduced as of the end of such fiscal year so as to result in an OASDI trust fund ratio (as defined in section 201(p)(4)) for such fiscal year equal to 125 percent.

“(4) Rule of Construction.—This section shall not be construed to require redemption of obligations of the Trust Fund for the purpose of making transfers to the Transition Fund under this section or for any other purpose other than to provide for payment of benefits under part A of title II of the Social Security Act.

“(e) Redemption of Obligations Upon Deposit of Funds.—Obligations issued under subsection (c) may be redeemed only by funds in the Transition Fund. The Board of Trustees shall provide for the redemption of such obligations as soon as possible with funds deposited into the Transition Fund pursuant to subsection (d).

“(f) Sunset.—On the first date as of which all of the obligations issued under subsection (c) have been redeemed, any balance remaining in the Transition Fund as of such date shall be deposited in the Federal Old-Age and Survivors Insurance Trust Fund, the terms of the Board of Trustees shall end, the Transition Fund shall cease to exist, and this section shall be repealed.”.
SEC. 406. BUDGETARY TREATMENT OF SOCIAL SECURITY.

(a) In General.—Section 710 of the Social Security Act (42 U.S.C. 911) is amended to read as follows:

“BUDGETARY TREATMENT OF SOCIAL SECURITY

“Sec. 710.

“Notwithstanding any other provision of law and except as provided in subsection (b), the receipts and disbursements shall be treated in the same manner as section 13301 of the Budget Enforcement Act of 1990.”.

(b) Effective Date.—The amendments made by this section shall apply with respect to fiscal years beginning on or after October 1, 2011.

SEC. 407. ACCOUNTING FOR THE OLD-AGE, SURVIVORS, AND DISABILITY INSURANCE PROGRAM AND THE PERSONAL SOCIAL SECURITY SAVINGS PROGRAM.

Title VII of the Social Security Act is amended by inserting after section 705 (42 U.S.C. 906) the following new section:

“ACCOUNTING FOR THE OLD-AGE, SURVIVORS, AND DISABILITY INSURANCE PROGRAM AND THE PERSONAL SOCIAL SECURITY SAVINGS PROGRAM

“Social Security Lockbox Budget

“Sec. 706. (a) At the time of the transmittal to the Congress by the President of the budget of the United States Government, the President shall transmit to each
House of the Congress a separate report (to be known as
the ‘Social Security Lockbox Budget’) detailing the per-
formance during the preceding fiscal year of each of the
accounts established under subsection (b). Such report
shall set forth, as determined as of the end of the year—
“(1) the amount of the balance of each account,
“(2) the amount of the total charges and the
amount of the total credits to each account for the
year, and
“(3) the amount of the total for the year of
each category of charges and credits itemized in sub-
section (b).
“Establishment of Accounts
“(b) For purposes of accounting for certain receipts
and disbursement of the Treasury of the United States
in connection with the Old-Age, Survivors, and Disability
Insurance Program under part A of title II of the Social
Security Act and the Personal Security Savings Program
under part B of such title, the Secretary of the Treasury
shall establish and maintain a Social Security Part A Ac-
count, a Social Security Part B Account, and a Self-Liqui-
dating Social Security Transition Fund Account.
“Credits and Charges to the Social Security Part A Account

“(c)(1) For each fiscal year, the Social Security Part A Account shall be credited with the sum of—

“(A) all receipts during the year by the Federal Old-Age and Survivors Insurance Trust Fund and the Federal Disability Insurance Trust Fund under section 201 (including amounts received as interest on notes and obligations purchased by the Trust Funds under section 201(d) of such Act, and excluding amounts received in redemption of such notes and obligations and amounts received by either such Trust Fund as transfers from the other such Trust Fund), and

“(B) all receipts during the year by the Federal Old-Age and Survivors Insurance Trust Fund and the Federal Disability Insurance Trust Fund under section 121(e) of the Social Security Amendments of 1983 (relating to appropriation of amounts equivalent to taxes on social security benefits) (42 U.S.C. 401 note).

“(2) For each fiscal year, the Social Security Part A Account shall be charged with the sum of—

“(A) all benefits paid during the year from the Federal Old-Age and Survivors Insurance Trust
Fund and the Federal Disability Insurance Trust Fund under part A of title II of the Social Security Act,

“(B) all redirected social security contributions transferred during the year to the Social Security Personal Savings Fund under section 252(b),

“(C) all other expenditures during the year from the Trust Funds under part A of title II (excluding amounts expended as transfers by either such Trust Fund to the other such Trust Fund and amounts paid for the purchase of notes and obligations under section 201(d)), and

“(D) all transfers from the Federal Old-Age and Survivors Insurance Trust Fund to the Self-Liqui-
idating Social Security Transition Fund under section 262(d).

Charges and Credits to the Social Security Part B Account

“(d)(1) For each fiscal year, the Social Security Part B Account shall be credited with—

“(A) all redirected social security contributions transferred during the year to the Personal Social Security Savings Fund under section 252(b) of the Social Security Act, and
“(B) any net increase in the Tier I Investment Fund attributable to investment for the fiscal year, any net increase in the Tier II Investment Fund attributable to investment for the fiscal year, and the total amount of any net increases in Tier III Investment Options attributable to investment for the fiscal year.

“(2) For each fiscal year, the Social Security Part B Account shall be charged with—

“(A) all administrative costs incurred for the fiscal year with respect to the Tier I Investment Fund, the Tier II Investment Fund, and the Tier III Investment Options,

“(B) any net decrease in the Tier I Investment Fund attributable to investment for the fiscal year, any net decrease in the Tier II Investment Fund attributable to investment for the fiscal year, and the total amount of any net decreases in Tier III Investment Options attributable to investment for the fiscal year, and

“(C) annuity payments made during the year under section 258 from the Annuity Reserve Account in the Savings Fund.
“Charges and Credits to the Self-Liquidating Social Security Transition Fund Account

“(e)(1) For each fiscal year, the Self-Liquidating Social Security Transition Account shall be credited with—

“(A) all transfers to the Transition Fund from the Federal Old-Age and Survivors Insurance Trust Fund under section 262(b), and

“(B) all amounts expended during the fiscal year from the Trust Funds in the redemption under section 262(e) of obligations issued by the Transition fund under section 262(e).

“(2) For each fiscal year, the Self-Liquidating Social Security Transition Fund Account shall be charged with the total amount of obligations issued during the fiscal year by the Transition Fund under section 262(e)”.

SEC. 408. PROGRESSIVE INDEXING OF BENEFITS FOR OLD-AGE, WIFE’S, AND HUSBAND’S INSURANCE BENEFITS.

(a) In General.—Section 215(a) of the Social Security Act (42 U.S.C. 415(a)) is amended—

(1) by striking “The” in paragraph (1)(A) and inserting “In the case of any benefit other than an applicable benefit to which paragraph (2) applies, the”, and
(2) by redesignating paragraphs (2) through (7) as paragraphs (3) through (8), respectively, and by inserting after paragraph (1) the following new paragraph:

“(2)(A) In the case of an applicable benefit with respect to any individual who initially becomes eligible for old-age insurance benefits or who dies (before becoming eligible for such benefits) in calendar year 2018 or later, the primary insurance amount of the individual shall be equal to the sum of—

“(i) 90 percent of the individual’s average indexed monthly earning (determined under subsection (b)) to the extent that such earnings do not exceed the amount established for purposes of paragraph (1)(A)(i) by paragraph (1)(B);

“(ii) 32 percent of the individual’s average indexed monthly earnings to the extent that such earnings exceed the amount established for purposes of paragraph (1)(A)(i) by paragraph (1)(B) but do not exceed the amount established for purposes of this clause by subparagraph (B);

“(iii) 32 percent (reduced as provided in subparagraph (C)) of the individual’s average indexed monthly earnings to the extent that such earnings exceed the amount established for purposes of clause...
(ii) but do not exceed the amount established for purposes of paragraph (1)(A)(ii) by paragraph (1)(B); and

“(iv) 15 percent (reduced as provided in subparagraph (C)) of the individual’s average indexed monthly earnings to the extent that such earnings exceed the amount established for purposes of paragraph (1)(A)(ii) by paragraph (1)(B).

“(B)(i) For purposes of subparagraph (A)(ii), the amount established under this subparagraph for calendar year 2016 shall be the level of average indexed monthly earnings determined by the Chief Actuary of the Social Security Administration under clause (ii) as being at the 30th percentile for the period of calendar years 2007 through 2009.

“(ii) For purposes of clause (i), the average indexed monthly earnings for the period of calendar years 2007 through 2009 shall be determined by—

“(I) determining the average indexed monthly earnings for each individual who initially became eligible for old-age insurance benefits or who died (before becoming eligible for such benefits) during such period, except that in determining such average indexed monthly earnings under subsection (b), subsection (b)(3)(A)(ii)(I) shall be applied by sub-
stituting calendar year 2004 for the second calendar
year described in such subsection; and

“(II) multiplying the amount determined for
each individual under subclause (I) by the quotient
obtained by dividing the national average wage index
(as defined in section 209(k)(1)) for the calendar
year 2016 by such index for the calendar year 2004.

“(iii) For purposes of subparagraph (A)(ii), the
amount established under this subparagraph for any cal-
endar year after 2018 shall be equal to the product of
the amount in effect under clause (i) with respect to cal-
endar year 2018 and the quotient obtained by dividing—

“(I) the national average wage index (as de-
defined in section 209(k)(1)) for the second calendar
year preceding the calendar year for which the de-
termination is being made, by

“(II) the national average wage index (as so de-
defined) for 2016.

“(iv) The amount established under this subpara-
graph for any calendar year shall be rounded to the near-
est $1, except that any amount so established which is
a multiple of $0.50 but not of $1 shall be rounded to the
next higher $1.

“(C)(i) Except as provided in clause (ii), in the case
of any calendar year after 2017, each of the percentages
to which this subparagraph applies by reason of clauses
(iii) or (iv) of subparagraph (A) shall be a percentage
equal to such percentage multiplied by the quotient ob-
tained by dividing—

“(I) the difference of the maximum CPI-in-
dexed benefit amount for such year over the amount
determined under this paragraph for an individual
whose average indexed monthly earnings are equal
to the amount established for purposes of subpara-
graph (A)(ii) for such year, by

“(II) the difference of the maximum wage-in-
dexed benefit amount for such year over the amount
determined under this paragraph for an individual
whose average indexed monthly earnings are equal
to the amount established for purposes of subpara-
graph (A)(ii) for such year.

“(ii)(I) In the case of any calendar year which is a
positive balance year, clause (i) shall not apply and each
of the percentages to which this subparagraph applies by
reason of clause (iii) or (iv) of subparagraph (B) shall be
a percentage equal to the percentage determined under
this subparagraph for the preceding year (determined
after the application of this subparagraph).

“(II) In the case of any calendar year after a positive
balance year which is not a positive balance year, this sub-
paragraph shall be applied by substituting ‘the second cal-
endar year preceding the most recent positive balance
year’ for ‘2015’ each place it appears in clause (iv).

“(iii) For purposes of clause (i), the maximum wage-
indexed benefit amount for any calendar year shall be
equal to the amount determined under this paragraph (de-
termined without regard to any reduction under this sub-
paragraph) for an individual with wages paid in and self-
employment income credited to each computation base
year in an amount equal to the contribution and benefit
base for each calendar year.

“(iv) For purposes of clause (i), the maximum CPI-
indexed benefit amount for any calendar year shall be an
amount equal to the amount determined under clause (iii)
for such year multiplied by a fraction—

“(I) the numerator of which is the ratio (rounded
to the nearest one-thousandth of 1 percent) of
the Consumer Price Index for the second preceding
year to such index for 2015; and

“(II) the denominator of which is the ratio
(rounded to the nearest one-thousandth of 1 per-
cent) of the national wage index (as defined in sec-
tion 209(k)(1)) for the second year preceding such
year to such index for 2015.
“(v)(I) For purposes of this subparagraph, a positive balance year is a calendar year following any calendar year after 2082 for which the Chief Actuary of the Social Security Administration certifies to the Secretary of the Treasury and the Congress that the combined balance ratio of the Federal Old-Age and Survivors Trust Fund and the Federal Disability Insurance Trust Fund is not less than 100 percent for such year.

“(II) For purposes of subclause (I), the combined balance ratio of the Federal Old-Age and Survivors Trust Fund and the Federal Disability Insurance Trust Fund for any calendar year is the ratio of the combined balance of such Trust Funds as of the last day of such calendar year (reduced by any transfer made pursuant to section 201(o) in such calendar year) to the amount estimated by the Commissioner of Social Security under section 201(l)(3)(B)(iii)(II) to be paid from such Trust Funds during the calendar year following such calendar year for all purposes authorized by section 201 (determined as if such following calendar year were a positive balance year).

“(D) For purposes of this paragraph, rules similar to the rules of subparagraphs (C) and (D) of paragraph (1) shall apply.
“(E) For purposes of this paragraph, the term ‘applicable benefit’ means any benefit under section 202 other than—

“(i) a child’s insurance benefit under section 202(d) with respect to a child of an individual who has died;

“(ii) a widow’s insurance benefit under section 202(e) with respect to a widow who has not attained age 60 and is under a disability (as defined in section 223(d)) which began before the end of the period specified in section 202(e)(4);

“(iii) a widower’s insurance benefit under section 202(f) with respect to a widower who has not attained age 60 and is under a disability (as defined in section 223(d)) which began before the end of the period specified in section 202(f)(4); and

“(iv) a mother’s and father’s insurance benefit under section 202(g).”.

(b) Treatment of Disabled Beneficiaries.—Section 215(a) of such Act (as amended by subsection (a)) is amended further by adding at the end the following new paragraph:

“(9)(A) Notwithstanding the preceding provisions of this subsection, in the case of an individual who has or has had a period of disability and who initially becomes
eligible for old-age insurance benefits or who dies (before becoming eligible for such benefits) in any calendar year in or after 2018, the primary insurance amount of such individual shall be the sum of—

“(i) the amount determined under subparagraph (B); and

“(ii) the product derived by multiplying—

“(I) the excess of the amount determined under subparagraph (C) over the amount determined under subparagraph (B), by

“(II) the adjustment factor for such individual determined under subparagraph (D).

“(B) The amount determined under this subparagraph is the amount of such individual’s primary insurance amount as determined under this section without regard to this paragraph.

“(C) The amount determined under this subparagraph is the amount of such individual’s primary insurance amount as determined under this section as in effect with respect to individuals becoming eligible for old-age or disability insurance benefits under section 202(a) on the date of the enactment of the Social Security Personal Savings Guarantee and Prosperity Act of 2010.
“(D) The adjustment factor determined under this subparagraph for any individual is the ratio (not greater than 1) of—

“(i) the total number of months during which such individual is under a disability (as defined in section 223(d)) during the period beginning on the date the individual attains age 22 and ending on the first day of such individual’s first month of eligibility for old-age insurance benefits under section 202(a) (or, if earlier, the month of such individual’s death), to

“(ii) the number of months during the period beginning on the date the individual attains age 22 and ending on the first day of such individual’s first month of eligibility for old-age insurance benefits under section 202(a) (or, if earlier, the month of such individual’s death).”.

(c) CONFORMING AMENDMENTS.—

(1) Subsections (e)(2)(B)(i)(I) and (f)(2)(B)(i)(I) of section 202 of the Social Security Act are each amended by inserting “or section 215(a)(2)(B)(iii)” after “section 215(a)(1)(B)(i) and (ii)”.

(2) Section 203(a)(10) of such Act is amend-

(B) in subparagraph (A)(ii), by striking “215(a)(2)(C)” and inserting “215(a)(3)(C)”;

and

(C) in subparagraph (B)(ii), by striking “215(a)(2)” and inserting “215(a)(3)”.

(3) Section 209(k)(1) of such Act is amended by inserting “215(a)(2)(B), 215(a)(2)(C),” after “215(a)(1)(D),”.

(4) Section 215(a) of such Act is amended—

(A) in paragraph (4)(A), as redesignated by paragraph (2), by striking “paragraph (4)” and inserting “paragraph (5)”;

(B) in paragraph (4)(B), as redesignated by paragraph (2), by striking “paragraph (2)(A)” and inserting “paragraph (3)(A)”;

(C) in paragraph (5), as redesignated by paragraph (2), by striking “paragraph (3)(A)” and inserting “paragraph (4)(A)”;

(D) in paragraph (6)(A), as redesignated by paragraph (2), by striking “paragraph (4)(B)” and inserting “paragraph (5)(B)”;

and
(E) in paragraph (8)(B)(ii)(I), as redesignated by paragraph (2), by striking “paragraph (3)(B)” and inserting “paragraph (4)(B)”.  

(5) Section 215(d)(3) of such Act is amended—
   (A) by striking “paragraph (4)(B)(ii)” and inserting “paragraph (5)(B)(ii)”;
   (B) by striking “subsection (a)(7)(C)” and inserting “subsection (a)(8)(C)”.

(6) Subsection 215(f) of such Act is amended—
   (A) in paragraph (2)(B), by striking “subsection (a)(4)(B)” and inserting “subsection (a)(5)(B)”;
   (B) in paragraph (7), by striking “subsection (a)(4)(B)” and inserting “subsection (a)(5)(B)”, and by striking “subsection (a)(6)” and inserting “subsection (a)(7)”;
   (C) in paragraph (9)(A)—
      (i) by striking “subsection (a)(7)(A)” and inserting “subsection (a)(8)(A)”;
      (ii) by striking “subsection (a)(7)(C)” and inserting “subsection (a)(8)(C)”;
   (D) in paragraph (9)(B), by striking “subsection (a)(7)” each place it appears and inserting “subsection (a)(8)”.
SEC. 409. ADJUSTMENTS TO SCHEDULE FOR INCREASES IN NORMAL RETIREMENT AGE.

(a) Completion of Phase-In of Normal Retirement Age to Age 67 by 2021.—

(1) In general.—Section 216(l) of the Social Security Act (42 U.S.C. 416(l)) is amended—

(A) in paragraph (1)(C), by striking “2017” and inserting “2016”;

(B) in paragraph (1)(D), by striking “2016” and inserting “2015”, and by striking “2022” and inserting “2021”;

(C) in paragraph (1)(E), by striking “2021” and inserting “2020”; and

(D) in paragraph (3)(B), by striking “2017” and inserting “2016”, by striking “2021” and inserting “2020”, and by striking “2017” and inserting “2016”.

(2) Maintenance of current law for individuals born prior to January 1, 1956.—Section 216(l)(3) of such Act (as amended by paragraph (1)(D)) is amended—

(A) by redesignating subparagraphs (A) and (B) as clauses (i) and (ii), respectively;

(B) by inserting “(A)” after “(3)”;

(C) by adding at the end the following new subparagraph:
“(B) Notwithstanding the preceding provisions of this subsection—

“(i) with respect to an individual who attains early retirement age after December 31, 2015, and before January 1, 2017, the age increase factor under subparagraph (A)(ii) shall not be applied; and

“(ii) with respect to an individual who attains early retirement age after December 31, 2016, and before January 1, 2018, the age increase factor under subparagraph (A)(ii) shall be 2 months.”.

(b) Adjustments to Normal Retirement Age After 2021.—Section 216(l) of such Act (as amended by subsection (a)) is amended—

(1) in paragraph (1)(E), by inserting “and before January 1, 2022,” after “2020,” and by striking “age.” and inserting “age; and” ;

(2) in paragraph (1), by adding after subparagraph (E) the following new subparagraph:

“(F) with respect to an individual who attains early retirement age after December 31, 2021, 67 years of age plus the number of months in the age increase factor (as determined under paragraph (3)) for the calendar year in which such individual attains early retirement age.”; and
(3) in paragraph (3), by adding at the end the following new subparagraph:

“(C) The Commissioner of Social Security shall determine (using reasonable actuarial assumptions) and publish on or before November 1 of each calendar year after 2020 the number of months (rounded, if not a multiple of one month, to the next lower multiple of one month) by which the life expectancy as of October 1 of such calendar year of an individual attaining early retirement age on such October 1 exceeds the life expectancy as of October 1, 2020, of an individual attaining early retirement age on October 1, 2020. With respect to an individual who attains early retirement age in the calendar year following any calendar year in which a determination is made under this subparagraph, the age increase factor shall be the number of months determined under this subparagraph as of October 1 of such calendar year in which such determination is made.”.

**TITLE V—SIMPLIFIED INCOME TAX**

**SEC. 501. SHORT TITLE.**

This title may be cited as the “Taxpayer Choice Act”.

•HR 4529 IH
SEC. 502. REPEAL OF ALTERNATIVE MINIMUM TAX FOR NONCORPORATE TAXPAYERS.

(a) In General.—Section 55(a) of the Internal Revenue Code of 1986 (relating to alternative minimum tax imposed) is amended by adding at the end the following new flush sentence:

“In the case of a taxpayer other than a corporation, no tax shall be imposed by this section for any taxable year beginning after December 31, 2010, and the tentative minimum tax of any taxpayer other than a corporation for any such taxable year shall be zero for purposes of this title.”.

(b) Conforming Amendments.—

(1) Section 26(c) of such Code is amended by striking “the term ‘tentative minimum tax’ means the amount determined under section 55(b)(1)” and inserting “the tentative minimum tax is zero.”.

(2) Section 911(f)(2) of such Code is amended to read as follows:

“(2) the tentative minimum tax under section 55 for the taxable year shall be zero.”.

(c) Effective Date.—The amendments made by this section shall apply to taxable years beginning after December 31, 2010.
SEC. 503. SIMPLIFIED INCOME TAX SYSTEM.

(a) In General.—Part I of subchapter A of chapter 1 of the Internal Revenue Code of 1986 (relating to tax on individuals) is amended by redesignating section 5 as section 6 and by inserting after section 4 the following new section:

“SEC. 5. SIMPLIFIED INCOME TAX SYSTEM.

“(a) Election.—

“(1) In General.—A taxpayer other than a corporation may elect in accordance with this subsection to be subject to the tax imposed by this section in lieu of the tax imposed by section 1 for a taxable year and all subsequent taxable years.

“(2) Effect of Election.—For purposes of this title, if an election is in effect under paragraph (1) for any taxable year, the tax imposed by this section shall be treated as the tax imposed by section 1 for the taxable year and, except as provided by sections 31 and 36, no amount shall be allowed as a credit against such tax for the taxable year.

“(3) Election.—

“(A) In General.—

“(i) In General.—Except as provided in clause (ii) of this subparagraph and clauses (ii) and (iii) of subparagraph (B), the election under paragraph (1) may
only be made with respect to any taxable year beginning before January 1, 2021, on a timely filed return for the first taxable year for which the election applies.

“(ii) NEW TAXPAYERS.—In the case of an individual with no tax liability under this title before January 1, 2021, the election under paragraph (1) may only be made for the first taxable year beginning after December 31, 2020, for which such individual has tax liability under this title.

“(B) EFFECT OF ELECTION.—

“(i) IN GENERAL.—Except as provided in clauses (ii) and (iii), the election under paragraph (1), once made, shall be irrevocable.

“(ii) ONE-TIME REVOCATION OF ELECTION.—A taxpayer may revoke an election under paragraph (1) for a taxable year and all subsequent taxable years. The preceding sentence shall not apply if the taxpayer has made a revocation under such sentence for any prior taxable year.

“(iii) FILING STATUS CHANGES DUE TO MAJOR LIFE EVENTS.—In the case of
any major life event described in clause (iv), a taxpayer may make an election under paragraph (1) or revoke such an election under clause (ii). Any such election or revocation shall apply for the taxable year for which made and all subsequent taxable years until the taxpayer makes an election under the preceding sentence for any subsequent (and all succeeding) taxable year.

“(iv) Major Life Event.—For purposes of clause (iii), a major life event described in this clause is marriage, divorce, and death.

“(b) Tax Imposed.—

“(1) Married Individuals and surviving spouses.—In the case of a taxpayer for whom an election under subsection (a) is in effect and who is a married individual (as defined in section 7703) who makes a single return jointly with his spouse under section 6013 or a surviving spouse (as defined in section 2(a)), there is hereby imposed on the alternative taxable income of such individual a tax determined in accordance with the following table:

<table>
<thead>
<tr>
<th>If taxable income is:</th>
<th>The tax is:</th>
</tr>
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<tbody>
<tr>
<td>Not over $100,000</td>
<td>10% of alternative taxable income.</td>
</tr>
</tbody>
</table>
“If taxable income is: The tax is:
Over $100,000 ........................................... $10,000, plus 25% of the excess over $100,000.

“(2) UNMARRIED INDIVIDUALS (OTHER THAN SURVIVING SPOUSES).—In the case of a taxpayer for whom an election under subsection (a) is in effect and who is not described in paragraph (1), there is hereby imposed on the alternative taxable income of such individual a tax determined in accordance with the following table:

“If taxable income is: The tax is:
Not over $50,000 ........................................... 10% of alternative taxable income.
Over $50,000 ........................................... $5,000, plus 25% of the excess over $50,000.

“(c) ALTERNATIVE TAXABLE INCOME.—For purposes of this section—

“(1) IN GENERAL.—The term ‘alternative taxable income’ means—

“(A) gross income,
“(B) the amount excluded from income under section 139C for capital gains, dividends, and interest, minus
“(C) the sum of—
“(i) the personal exemption,
“(ii) the dependent allowance, plus
“(iii) the alternative standard deduction.
“(2) PERSONAL EXEMPTION.—The personal exemption is—

“(A) 200 percent of the dollar amount in effect under subparagraph (B) in the case of—

“(i) a joint return, or

“(ii) a surviving spouse (as defined in section 2(a)), and

“(B) $3,500 in the case of an individual—

“(i) who is not married and is not a surviving spouse, or

“(ii) who is a married individual filing a separate return.

“(3) DEPENDENT ALLOWANCE.—The dependent allowance is $3,500 for each dependent (as defined in section 152).

“(4) ALTERNATIVE STANDARD DEDUCTION.—The alternative standard deduction means—

“(A) $25,000 in the case of—

“(i) a joint return, or

“(ii) a surviving spouse (as defined in section 2(a)), and

“(B) $12,500 in the case of an individual—

“(i) who is not married and is not a surviving spouse, or
“(ii) who is a married individual filing a separate return.

“(d) Inflation Adjustments.—

“(1) In general.—In the case of any taxable year beginning in a calendar year after 2011, each of the dollar amounts for the rate brackets in subsection (b) and each of the dollar amounts in subsection (d)(2)(B), (d)(3), and (d)(4) shall be increased by an amount equal to—

“(A) such dollar amount, multiplied by

“(B) the cost-of-living adjustment determined under section 1(f)(3) for the calendar year in which the taxable year begins, by substituting ‘calendar year 2010’ for ‘calendar year 1992’ in subparagraph (B) thereof.

“(2) Rounding.—If any amount as adjusted under clause (i) is not a multiple of $100, such amount shall be rounded to the nearest multiple of $100.”.

(b) Conforming Amendment.—The table of sections for part I of subchapter A of chapter 1 of such Code is amended by striking the item relating to section 5 and inserting after the item relating to section 4 the following:

“Sec. 5. Simplified income tax system.

“Sec. 6. Cross references relating to tax on individuals.”.
(c) Effective Date.—The amendments made by this section shall apply to taxable years beginning after December 31, 2010.

SEC. 504. EXCLUSION FOR CAPITAL GAINS, DIVIDENDS, AND INTEREST.

(a) In General.—Part III of subchapter B of chapter 1 of the Internal Revenue Code of 1986 (relating to items specifically excluded from gross income) is amended by inserting after section 139C the following new section:

"SEC. 139D. CAPITAL GAINS, DIVIDENDS, AND INTEREST.

"(a) Exclusion.—Gross income does not include amounts received by an individual as net capital gains, qualified dividends, and interest.

"(b) Qualified Dividends.—For purposes of this section—

"(1) In General.—The term ‘qualified dividends’ means dividends received during the taxable year from—

"(A) domestic corporations, and

"(B) qualified foreign corporations.

"(2) Qualified Foreign Corporations.—

"(A) In General.—Except as otherwise provided in this paragraph, the term ‘qualified foreign corporation’ means any foreign corporation if—
“(i) such corporation is incorporated in a possession of the United States, or

“(ii) such corporation is eligible for benefits of a comprehensive income tax treaty with the United States which the Secretary determines is satisfactory for purposes of this paragraph and which includes an exchange of information program.

“(B) Dividends on stock readily tradable on United States securities market.—A foreign corporation not otherwise treated as a qualified foreign corporation under subparagraph (A) shall be so treated with respect to any dividend paid by such corporation if the stock with respect to which such dividend is paid is readily tradable on an established securities market in the United States.

“(C) Exclusion of dividends of certain foreign corporations.—Such term shall not include any foreign corporation which for the taxable year of the corporation in which the dividend was paid, or the preceding taxable year, is a passive foreign investment company (as defined in section 1297).
“(3) SPECIAL RULE.—If a taxpayer to whom this section applies receives, with respect to any share of stock, qualified dividend income from 1 or more dividends which are extraordinary dividends (within the meaning of section 1059(c)), any loss on the sale or exchange of such share shall, to the extent of such dividends, be treated as long-term capital loss.

“(c) INTEREST.—For purposes of this section, the term ‘interest’ means—

“(1) interest on deposits with a bank (as defined in section 581),

“(2) amounts (whether or not designated as interest) paid, in respect to deposits, investment certificates, or withdrawable or repurchasable shares, by—

“(A) a mutual savings bank, cooperative bank, domestic building and loan association, industrial loan association or bank, or credit union, or

“(B) any other savings or thrift institution, which is chartered and supervised under Federal or State law,
the deposits or accounts in which are insured under Federal or State law or which are protected and guaranteed under State law,

“(3) interest on—

“(A) evidences of indebtedness (including bonds, debentures, notes, and certificates) issued by a domestic corporation in registered form, and

“(B) to the extent provided in regulations prescribed by the Secretary, other evidences of indebtedness issued by a domestic corporation of a type offered by corporations to the public,

“(4) interest on obligations of the United States, a State, or a political subdivision of a State (not excluded from gross income of the taxpayer under any other provision of law), and

“(5) interest attributable to participation shares in a trust established and maintained by a corporation established pursuant to Federal law.

“(d) CERTAIN NONRESIDENT ALIENS INELIGIBLE FOR EXCLUSION.—In the case of a nonresident alien individual, subsection (a) shall apply only—

“(1) in determining the tax imposed for the taxable year pursuant to section 871(b)(1) and only in respect to dividends and interest which are effec-
tively connected with the conduct of a trade or busi-
ness within the United States, or

“(2) in determining the tax imposed for the
taxable year pursuant to section 877(b).”.

(b) CONFORMING AMENDMENT.—Section 1 of such
Code is amended by striking subsection (h).

(e) CLERICAL AMENDMENT.—The table of sections
for such part III is amended by inserting after the item
relating to section 139C the following new item:

“Sec. 139D. Capital gains, dividends, and interest.”.

(d) EFFECTIVE DATE.—The amendments made by
this section shall apply to taxable years beginning after
December 31, 2010.

SEC. 505. REPEAL OF ESTATE AND GIFT TAXES.

(a) IN GENERAL.—Subtitle B of the Internal Rev-

(b) EFFECTIVE DATE.—The repeal made by sub-

(C) EFFECTIVE DATE.—Section 1 of such
Code is amended by striking subsection (h).

(e) CLERICAL AMENDMENT.—The table of sections
for such part III is amended by inserting after the item
relating to section 139C the following new item:

“Sec. 139D. Capital gains, dividends, and interest.”.

(d) EFFECTIVE DATE.—The amendments made by
this section shall apply to taxable years beginning after
December 31, 2010.

TITLE VI—BUSINESS
CONSUMPTION TAX

SEC. 601. SHORT TITLE.

This title may be cited as the “Competitive American
Business Tax”.
SEC. 602. REPEAL OF CORPORATE INCOME TAX; NEW TAX PAID BY CORPORATIONS AND OTHER BUSINESSES.

(a) In General.—Chapter 2 of the Internal Revenue Code is renumbered chapter 3 and the following new chapter is inserted after chapter 1:

“CHAPTER 2—COMPETITIVE AMERICAN BUSINESS TAX

“SUBCHAPTER A. IMPOSITION OF TAX

“SUBCHAPTER B. BASIC RULES FOR BUSINESS CONSUMPTION TAX

“SUBCHAPTER C. CAPITAL CONTRIBUTIONS, MERGERS, ACQUISITIONS, AND DISTRIBUTIONS

“SUBCHAPTER D. ACCOUNTING METHOD RULES

“SUBCHAPTER E. LAND AND RENTAL PROPERTY

“SUBCHAPTER F. INSURANCE AND FINANCIAL PRODUCTS

“SUBCHAPTER G. TAX-EXEMPT ORGANIZATIONS

“SUBCHAPTER H. COOPERATIVES

“SUBCHAPTER I. SOURCING RULES

“SUBCHAPTER J. BUSINESS CONDUCTED IN A POSSESSION

“SUBCHAPTER K. IMPORT TAX

“SUBCATEGORY L. TRANSITION RULES

“SUBCHAPTER M. RULES FOR ADMINISTRATION, CONSOLIDATED RETURNS

“SUBCHAPTER N. DEFINITIONS AND RULES OF APPLICATION

“Subchapter A—Imposition of Tax

“Sec. 201. Tax imposed.
“SEC. 201. TAX IMPOSED.

“(a) Taxable Business Activity.—A business consumption tax is imposed on the sale of goods and services in the United States by a business entity.

“(b) Business Consumption Tax Imposed.—‘Business consumption tax’ is 8.5 percent of the gross profits of the business entity for the taxable year.

“(c) Import Tax.—For rules relating to the import tax imposed by this chapter, see subchapter K (sections 281 through 283).

“Subchapter B—Basic Rules for Business Consumption Tax


Sec. 203. Taxable receipts.

Sec. 204. Deductible amounts.

Sec. 205. Cost of business purchases.

Sec. 206. Business entity and business activity.

Sec. 207. Loss carryover deduction.

“SEC. 202. GROSS PROFITS.

‘Gross profits’ means for a taxable year of a business entity the amount by which—

“(1) the taxable receipts of the business entity for the taxable year exceed,

“(2) the deductible amounts for the business entity for the taxable year.
"SEC. 203. TAXABLE RECEIPTS.

(a) In General.—‘Taxable receipts’ means all receipts from the sale of property, use of property, and performance of services in the United States.

(b) Games of Chance.—Amounts received for playing games of chance by business entities engaging in the activity of providing such games shall be treated as receipts from the sale of property or services.

(c) In-Kind Receipts.—The taxable receipts attributable to the receipt of property, use of property or services in whole or partial exchange for property, use of property or services equal the fair market value of the services or property received.

(d) Taxes.—Taxable receipts do not include any excise tax, sales tax, custom duty, or other separately stated levy imposed by a Federal, State, or local government received by a business entity in connection with the sale of property or services or the use of property.

(e) Financial Receipts.—

(1) In General.—Taxable receipts do not include financial receipts.

(2) Financial Receipts.—‘Financial receipts’ include—

(A) interest,

(B) dividends and other distributions by a business entity,
“(C) proceeds from the sale of stock, other ownership interests in business entities, or other financial instruments,

“(D) proceeds from life insurance policies,

“(E) proceeds from annuities,

“(F) proceeds from currency hedging or exchanges, and

“(G) proceeds from other financial transactions.

“(3) FINANCIAL INSTRUMENT.—‘Financial instrument’ means any—

“(A) share of stock in a corporation,

“(B) equity ownership in any widely held or publicly traded partnership, trust, or other business entity,

“(C) note, bond, debenture, or other evidence of indebtedness,

“(D) interest rate, currency, or equity notional principal contract,

“(E) evidence or interest in, or a derivative financial instrument in, any financial instrument described in subparagraph (A), (B), (C), or (D), or any currency, including any option, forward contract, short position, and any simi-
lar financial instrument in such a financial instrument or currency, and

“(F) a position which—

“(i) is not a financial instrument described in subparagraph (A), (B), (C), (D) or (E),

“(ii) is a hedge with respect to such a financial instrument, and

“(iii) is clearly identified in the dealer’s records as being described in this subparagraph before the close of the day on which it was acquired or entered into.

“(f) Cross References.—

“(1) Exports, sales in the United States.—See subchapter I for the exclusion from gross receipts for export sales and for rules on sales of property and services in the United States.

“(2) Land.—See subchapter E for rules relating to certain sales of land.

“Sec. 204. Deductible Amounts.

‘Deductible amounts’ for a business entity in a taxable year include—

“(1) the cost of business purchases in the taxable year (as determined under section 205),
“(2) the cost of employer-provided health insurance for which the employee, members of his family, or persons designated by him or members of his family are the beneficiaries,

“(3) such entity’s loss carryover deduction (as determined under section 207), and

“(4) the transition basis deduction (as determined under section 290).

“SEC. 205. COST OF BUSINESS PURCHASES.

“(a) BUSINESS PURCHASES.—

“(1) IN GENERAL.—‘Business purchases’ means the acquisition of—

“(A) property,

“(B) the use of property, or

“(C) services

in the United States for use in a business activity.

“(2) EXAMPLES.—Business purchases include (without limitation) the—

“(A) purchase or rental of real property,

“(B) purchase or rental of capital equipment,

“(C) purchase of supplies and inventory,

“(D) purchase of services from independent contractors, and

“(E) imports for use in a business activity.
“(3) Exclusions.—Business purchases do not include—

“(A) payments for use of money or capital, such as interest or dividends (except to the extent that a portion so paid is a fee for financial intermediation services),

“(B) premiums for life insurance,

“(C) the acquisition of savings assets or other financial instruments (as defined in section 203(e)(3)).

“(D) property acquired outside the United States (but such property shall be taken into account as an import if imported),

“(E) services performed outside the United States (unless treated as imported into the United States),

“(F) compensation expenses for an individual (other than amounts paid to an individual in his capacity as a business entity), or

“(G) taxes (except as provided in subsection (b)(2) relating to product taxes).

“(4) Compensation expenses.—‘Compensation expenses’ means—

“(A) wages, salaries or other cash payable for services,
“(B) any taxes imposed on the recipient that are withheld by the business entity,

“(C) the cost of property purchased to provide employees with compensation (other than property incidental to the provision of fringe benefits that are excluded from income under the individual tax),

“(D) the cost of fringe benefits which are includible in an employee’s, partner’s, or proprietor’s income under the business consumption tax (or are excluded solely because they constitute employee savings), including (without limitation)—

“(i) contributions to retirement and severance benefit plans,

“(ii) premiums for the cost of life, accident, disability and other insurance policies for which the employee, members of his family, or persons designated by him or members of his family are the beneficiaries,

“(iii) rental of parking spaces or parking fees (unless the parking space is used for a vehicle that is regularly used in a business activity);
“(iv) employer paid educational benefits;

“(v) employer paid housing (other than housing provided for the convenience of the employer); and

“(vi) employer paid meals (other than meals provided for the convenience of the employer).

“(b) Cost of Business Purchases.—

“(1) In general.—The ‘cost of a business purchase’ is the amount paid or to be paid for the business purchase.

“(2) Taxes.—

“(A) In general.—The ‘cost of business purchases’ includes any product taxes paid with respect to the property or services purchased.

“(B) Product tax.—‘Product tax’ means any excise tax, sales or use tax, custom duty, or other separately stated levy imposed by a Federal, State, or local government on the production, severance or consumption of property or on the provision of services, whether or not separately stated, and including any such taxes that are technically imposed on the seller of property or services.
“(C) Taxes not product taxes.—Product taxes do not include—

“(i) the import tax,

“(ii) state and local property taxes,

“(iii) franchise or income taxes,

“(iv) payroll taxes and self-employment taxes, or

“(v) the business consumption tax.

“(3) Imports.—In the case of an import by a business entity, the cost of the import is the import price for purposes of the import tax. The import tax is not part of the cost of the import.

“(c) Property and Services Acquired for Property.—If a business entity receives property or services from a business entity in whole or partial exchange for property or services, the property or services acquired shall be treated as if they were purchased for an amount equal to the fair market value of the services or property received. For purposes of this section, property includes stock and other equity interests in business other than stock or an equity interest in the business entity acquiring the property or services. See section 210(b) for rules on property or services received in exchange for an equity interest in the recipient.
“(d) Gambling Payments.—In the case of a business involving gambling, lotteries, or other games of chance, business purchases include amounts paid to winners.

“(e) Savings Assets.—‘Savings assets’ means stocks, bonds, securities, certificates of deposits, investments in partnerships and limited liability companies, shares of mutual funds, life insurance policies, annuities, and other similar savings or investment assets.

“(f) Cross References.—

“(1) Land.—For special rules relating to the acquisition of land, see subchapter E.

“(2) Rental Real Estate.—For special rules relating to the rental of real estate previously occupied by an owner of the real estate, see section 232.

“(3) Outside the United States.—For special rules relating to services performed outside the United States but used inside the United States and international services, see subchapter I.


“(a) Business Entity.—For purposes of the business consumption tax, ‘business entity’ means any corporation, unincorporated association, partnership, limited liability company, proprietorship, independent contractor, individual, or any other person engaging in business activ-
ity in the United States. An individual shall be considered a business entity only with respect to the individual’s business activities.

“(b) BUSINESS ACTIVITY.—‘Business activity’ means the sale of property or services, the leasing of property, the development of property or services for subsequent sale or use in producing property or services for subsequent sale. ‘Business activity’ does not include casual or occasional sales of property used by an individual (other than in a business activity), such as the sale by an individual of a vehicle used by the individual.

“(c) EXCEPTION FOR CERTAIN EMPLOYEES.—

“(1) IN GENERAL.—‘Business activity’ does not include—

“(A) the performance of services by an employee for an employer that is a business entity with respect to the activity in which the employee is engaged, or

“(B) the performance of regular domestic household services (including babysitting, housecleaning, and lawn cutting) by an employee of an employer that is an individual or family.

“(2) EMPLOYEE DEFINED.—For purposes of this subsection, ‘employee’ includes an individual
partner who provides services to a partnership or an individual member who provides services to a limited liability company, or a proprietor with respect to compensation for services from his proprietorship.

**SEC. 207. LOSS CARRYOVER DEDUCTION.**

“(a) DEDUCTION.—The ‘loss carryover deduction’ for a taxable year is the lesser of—

“(1) the business entity’s gross profits for the taxable year (determined without the loss carryover deduction), or

“(2) the amount of the loss carryover to the taxable year.

“(b) LOSS CARRYOVER.—

“(1) GENERAL RULE.—A loss for any taxable year shall be a loss carryover to each of the 15 taxable years following the taxable year of the loss.

“(2) LOSS CARRYOVERS TO A TAXABLE YEAR.—The loss carryover to a taxable year is the sum of the loss carryovers from all prior taxable years beginning on or after January 1, 2011, that can be carried over to the taxable year.

“(3) REDUCTION OF LOSS CARRYOVERS AS A RESULT OF THE DEDUCTION.—A business entity’s loss carryovers shall be reduced each year by the amount of the loss carryover deduction for the year.
Loss carryovers shall be reduced in the order that they arose.

“(c) LOSS FOR TAXABLE YEAR.—A business entity’s loss (if any) for the taxable year equals the excess (if any) of—

“(1) the sum of—

“(A) the cost of business purchases for the taxable year, and

“(B) the transition basis adjustment for the taxable year, over

“(2) taxable receipts for the taxable year.

“(d) SPECIAL RULES.—

“(1) CONSOLIDATED RETURNS.—In the case of a consolidated return, the loss for a taxable year shall be determined on a consolidated group basis. In the case of a deconsolidation, the loss carryovers from the consolidated group shall be allocated in accordance with rules to be prescribed by the Secretary.

“(2) LOSS CARRYOVERS OF ACQUIRED BUSINESS ENTITY.—

“(A) IN GENERAL.—If a business entity acquires another business entity in a transaction that is considered the acquisition of a business entity and the two entities file a con-
solidated return or if two business entities merge, the loss carryovers will survive and can be applied against the taxable receipts attributable to the business activities carried on (or in the case of a merger formerly carried on) by either entity.

“(B) Asset Acquisition.—If a business entity acquires all or substantially all of the assets of another entity in a transaction that is considered an asset acquisition rather than the acquisition of a business entity, the acquirer will be treated as if it acquired the loss carryovers of the selling entity. For purposes of this rule, the assets of a business entity include ownership interests in other business entities.

“(C) Substantially All.—For purposes of this paragraph ‘substantially all’ means more than 80 percent of the fair market value of a business entity’s net assets. Under rules prescribed by the Secretary, the parties to a transaction may elect to treat acquisitions in excess of 70 percent of the fair market value of a business entity’s net assets as acquisitions of ‘substantially all’ of a business entity’s net assets.
“Subchapter C—Capital Contributions, Mergers, Acquisitions, and Distributions

Sec. 211. Distributions of property.
Sec. 212. Asset acquisitions.
Sec. 213. Mergers and stock acquisitions.
Sec. 214. Spin-offs, split-off, etc.
Sec. 215. Allocation of certain tax attributes.

“Sec. 210. CONTRIBUTIONS TO A BUSINESS ENTITY.

“(a) By Business Entity.—

“(1) Cash.—If a business entity contributes cash to a business entity of which it is or becomes a partial or full owner, the amount contributed is not a deductible amount to the contributor or a taxable receipt to the recipient.

“(2) Property or Services.—If a business entity contributes property or services to a business entity of which it is or becomes a partial or full owner, the transaction will not result in taxable receipts to the contributor or a deduction for a business purchase for the recipient and will not constitute a sale resulting in taxable receipts to the contributor.

“(b) By Individual.—

“(1) Cash.—If an individual contributes cash to a business entity, the cash received is not a taxable receipt.
“(2) NEW PROPERTY.—If an individual contributes to a business entity property that the individual purchased for the business entity but which was not used by any person after its purchase, the property shall be considered purchased by such business entity from the person from which the individual purchased the property.

“(3) PERSONAL USE PROPERTY.—

“(A) IN GENERAL.—If an individual contributes personal use property to a business entity in which the individual has an ownership interest or for which the individual receives an ownership interest, the business entity shall not be permitted to deduct the value of the property received as a business expense. The business entity will have a tax basis in the contributed property equal to the contributor’s basis.

“(B) PERSONAL USE PROPERTY.—‘Personal use property’ means any property used by an individual at any time other than in a business activity.

“(4) SERVICES.—If an individual contributes services to a business entity in which the individual has an ownership interest or receives an ownership interest, the business entity shall not be permitted to
deduct the value of the services received (or the value of the equity interest provided to the services provider).

“SEC. 211. DISTRIBUTIONS OF PROPERTY.

“(a) Distributions Other Than to Controlling Business.—If a business entity distributes all or a portion of its assets to its owners (other than a controlling business entity), the business entity will be treated as if it sold the assets to its owners at fair market value. The fair market value will be determined by the distributing corporation and those determinations, unless unreasonable, will be binding on the recipients.

“(b) Distributions to a Controlling Business.—If a business entity distributes all or a portion of its assets to a controlling business, the controlling business will assume the distributing entity’s tax attributes with respect to the assets and neither entity will have taxable receipts or a deduction as a result of the transaction.

“(c) Distribution of Personal Use Property.—If personal use property is distributed to the individual who contributed the personal use property to a business entity, the fair market value of the property for purposes of paragraph (a) shall equal the basis of the property plus any enhancement in value of the property attributable to business purchases with respect to the property.
“(d) Controlling Business Entity.—A business entity is a ‘controlling business entity’ with respect to another business entity if it owns directly or indirectly more than 50 percent of the profits or capital interest in the other business entity.

“(e) Application of This Section.—This section applies to both liquidating and nonliquidating distributions. Property shall be treated as distributed if the property is used for a nonbusiness purpose or used as nonrental property (as defined in section 232) for more than an insubstantial period of time during a taxable year. See section 232 for rules relating to certain rental property.

“Sec. 212. Asset Acquisitions.

“(a) In General.—If a business entity transfers some or all of its assets, the consideration received for such assets shall be allocated among the assets transferred in the same manner as was required by section 1060 of the Internal Revenue Code of 1986. If the transferee and transferor agree in writing on the allocation of any consideration, or as to the fair market value of any of the assets, such agreement shall be binding on both the transferor and transferee unless the Secretary determines that such allocation (or fair market value) is not appropriate.

“(b) Tax Consequences.—The tax consequences of an asset acquisition shall be determined in accordance
with the rules of this chapter and shall be dependent upon allocations made under subsection (a). In general, consideration allocable to savings assets, such as stock in another business entity, would not be included in taxable receipts of the transferor and would not be a business purchase of the purchaser, but consideration allocable to the sale of tangible property and intangible property (other than savings assets) will constitute taxable receipts of the seller and a business purchase of the purchaser.

“(c) Election To Treat Asset Acquisition As a Stock Acquisition.—In the case of the sale of substantially all of the assets of a business entity or substantially all of the assets of a line of business or a separately standing business of a business entity, the transferee and transferor can jointly elect to treat the acquisition as if it were an acquisition of the stock of a business entity holding the assets so transferred. In such case, the rules of section 213 shall apply.

“(d) Authority To Require Allocation Agreement and Notice to the Secretary.—If the Secretary determines that certain types of asset acquisitions have significant possibilities of tax avoidance, the Secretary may require—

“(1) parties to such types of acquisitions to enter into agreements allocating consideration,
“(2) parties to acquisitions involving certain kinds of assets to enter into agreements allocating part of the consideration to those assets, or

“(3) parties to certain acquisitions to report information to the Secretary.

“(e) Asset Acquisition Rules Do Not Apply If Consideration Includes Equity in Purchaser.—

“(1) In general.—If a business entity issues its own equity or equity in a subsidiary or other controlled entity as part of the consideration for the transfer of assets to it, the transaction shall be treated as a business purchase and not as an asset acquisition, and the taxpayer shall not be entitled to a loss carryover for any unused deduction attributable to the equity portion of such transfer.

“(2) Equity.—For purposes of this subsection, equity means—

“(A) stock, in the case of a corporation,

“(B) partnership or similar interest, in the case of a partnership or limited liability company, and

“(C) an ownership interest or interest in profits in the case of any other business entity.
SEC. 213. MERGERS AND STOCK ACQUISITIONS.

(a) MERGERS.—A merger of one business entity into another or two businesses entities into a third business entity or any other similar transaction shall have no direct consequences under the business consumption tax. The surviving entity shall assume the tax attributes of the merged corporations, including any loss carryovers and credit carryovers.

(b) STOCK ACQUISITION.—The acquisition of all or substantially all of the ownership interest in one business entity either for cash or in exchange for ownership in the acquiring entity or an entity controlled by the acquired entity shall have no direct consequences under the business consumption tax.

SEC. 214. SPIN-OFFS, SPLIT-OFFS, ETC.

A spin-off, split-off or split-up of a business entity shall have no direct tax consequences under the business consumption tax.

SEC. 215. ALLOCATION OF CERTAIN TAX ATTRIBUTES.

The Secretary shall prescribe rules for allocation of loss carryovers in cases of substantial shifts of assets from one business entity to another business entity. Under such rules, a portion of a business entity’s carryovers may be deemed transferred when assets are transferred.

Subchapter D—Accounting Method Rules

Sec. 220. General accounting rules.
"SEC. 220. GENERAL ACCOUNTING RULES.

“(a) In General.—Except as provided in section 221, a business entity shall use an accrual method of accounting for purposes of determining the timing of recognition of taxable receipts and deduction of business purchases. All business purchases shall be deducted when incurred (in the case of a business entity using the accrual method of accounting) or when paid (in case of a business entity using the cash method of accounting) without regard to whether the business purchases are for or relate to—

“(1) inventory,

“(2) assets with a useful life of more than one year, or

“(3) property that will be used to produce other property.

“(b) Economic Performance.—For purposes of determining whether an amount has been incurred, the all events test shall not be treated as met any earlier than when economic performance with respect to such item occurs.
“(c) CONSISTENT ACCOUNTING METHODS.—Except as otherwise expressly provided in this chapter, a business entity shall secure the consent of the Secretary before changing the method of accounting by which it determines gross profits. This provision shall not apply to changes required by the adoption of the business consumption tax.

“SEC. 221. USE OF THE CASH METHOD OF ACCOUNTING.

“(a) IN GENERAL.—A business entity that was permitted to use and used the cash method of accounting under the Internal Revenue Code of 1986 shall be permitted to continue to use the cash method of accounting.

“(b) NEW BUSINESS ENTITIES.—A new business entity shall be permitted to use the cash method of accounting if permitted to under regulations prescribed by the Secretary.

“(c) CHANGE OR EXPANSION OF BUSINESS.—Subsection (a) shall cease to apply to a business entity that changes or expands its business such that under regulations prescribed by the Secretary it is no longer eligible to use the cash method of accounting.

“(d) REGULATIONS.—

“(1) USE OF CASH METHOD.—The Secretary shall prescribe regulations defining which business entities may use the cash method of accounting. In general, those regulations shall be consistent with
the rules under sections 447 and 448 of the Internal
Revenue Code of 1986. The regulations shall not re-require a business entity described in subsection (a) to convert to the accrual method prior to January 1, 2012.

“(2) Change in accounting method.—The Secretary shall prescribe regulations to prevent dou-
ble counting of taxable receipts and deductible ex-
penses in the case of a change in accounting method.

“SEC. 222. TAXABLE YEAR.

“(a) Computation of gross profits.—Gross profits shall be computed on the basis of a business enti-
ty’s taxable year.

“(b) Taxable year.—‘Taxable year’ means—

“(1) the taxpayer’s annual accounting period, if it is a calendar year or a fiscal year;

“(2) the calendar year, if subsection (g) applies;

or

“(3) the period for which the return is made if the return is made for a period of less than 12 months.

“(c) Annual accounting period.—‘Annual ac-
counting period’ means the annual period on the basis of which the business entity regularly keeps its books.
“(d) Calendar Year.—‘Calendar year’ means a period of 12 months ending on December 31.

“(e) Fiscal Year.—‘Fiscal year’ means a period of 12 months ending on the last day of any month other than December. In the case of any business entity that has made the election provided by subsection (f), the term means the annual period (varying from 52 to 53 weeks) so elected.

“(f) Election of 52–53 Week Year.—

“(1) General rule.—A business entity which, in keeping its books, regularly computes its income or profits on a basis of an annual period which varies from 52 to 53 weeks and ends always on the same day of the week and ends always—

“(A) on whatever date such same day of the week last occurs in a calendar month, or

“(B) on whatever date such same day of the week falls which is nearest to the last day of a calendar month, may elect to compute its gross profits on the basis of such annual period.

“(2) Regulations.—The Secretary shall prescribe such regulations as he deems necessary for the application of this subsection, including regulations relating to the application of effective dates to taxpayers using a 52–53 week year.
“(g) **Calendar Year Required.**—

“(1) **No Accounting Period.**—A business entity’s taxable year shall be the calendar year if the business entity does not have an annual accounting period or has an annual accounting period that does not qualify as a fiscal year.

“(2) **New Business Entity.**—The taxable year of a business entity that begins business activity after December 31, 2010, shall be the calendar year (or a 52–53 week fiscal year ending in December) unless the business entity can demonstrate a business reason for selecting an accounting period other than the calendar year.

“(h) **Transition Rule for Business Entities With a Fiscal Year.**—

“(1) **In General.**—A business entity with a taxable year that is not the calendar year shall have a short taxable year ending on December 31, 2010, and a subsequent taxable year beginning on January 1, 2011, and ending on the day immediately preceding the beginning of the business entity’s next fiscal year.

“(2) **Business Entities with 52–53 Week Year Ending in December.**—
“(A) IN GENERAL.—If a business entity has a 52–53 week taxable year (under the Internal Revenue Code of 1986) that ends in December 2010, it may elect to begin its first taxable year for the business consumption tax on the first day immediately following the last day of such taxable year.

“(B) NO ELECTION.—If a business entity that has a 52–53 week taxable year that ends in December 2010, does not make the election under subparagraph (A) or is prohibited from making such election by subparagraph (C), the business entity’s taxable year under the Internal Revenue Code of 1986 that would end in December 2010 shall end on December 31, 2010.

“(C) ANTI-ABUSE RULE.—Subparagraph (A) shall not apply to any taxpayer that enters into business transactions in 2010 following the scheduled end of its fiscal year with business entities that are not subject to the business consumption tax at the time of such transactions if such transactions deviate from the normal course of business in order to achieve some tax benefit.
“SEC. 223. LONG-TERM CONTRACTS.

“(a) In General.—In the case of a long-term contract—

“(1) Contractor Expenses.—The contractor shall be entitled to deduct its business purchases when paid or incurred.

“(2) Contractor Receipts.—The contractor shall recognize taxable receipts—

“(A) in the case of a project in which the acquirer has no ownership interest in the project until delivery—

“(i) upon delivery of the project, in the case of an accrual basis contractor, or

“(ii) upon the later of delivery of the project or the receipt of payment, in the case of cash-basis contractor.

“(B) in the case of a project in which the acquirer obtains an ownership interest as the project is constructed—

“(i) when the contractor has the right to payments, in the case of an accrual basis contractor, or

“(ii) upon the later of when the contractor receives the cash or has the right to payments, in the case of a cash basis contractor.
“(3) ACQUERER EXPENSES.—The acquirer that is a business entity shall be entitled to deduct its costs of the business purchase—

“(A) in the case of a cash-basis acquirer, at such time as a cash basis contractor would be required to treat the amounts paid as taxable receipts, or

“(B) in the case of an accrual-basis acquirer, at such time as an accrual basis contractor would be required to treat the amounts paid or due as taxable receipts.

“(b) RIGHT TO PAYMENTS.—

“(1) IN GENERAL.—A contractor shall be treated as having a right to payments with respect to a project at any time to the extent that the contractor would not be required to return payments received (or would be entitled to collect payments not yet received) if the project were terminated at such time by the contractor.

“(2) CONTRACTUAL PROVISIONS.—If a long-term contract includes a procedure for paying the contractor as work is completed (for example, by reason of a draw down from a trust account), the contractual provisions shall generally govern when a contractor has a right to payment.
“(3) Percentage completion method of accounting.—If a long-term contract does not include a mechanism for paying the contractor as work is completed, the percentage-of-completion method of accounting shall be used to determine the timing of taxable receipts of the contractor and business purchases of the acquirer.

“(c) Long-Term Contract.—

“(1) In general.—‘Long-term contract’ means—

“(A) any contract that covers service or production through parts of two different calendar years if the contract includes a formal deposit and draw-down mechanism, and

“(B) any contract for the manufacture, building, installation, or construction of property if such contract is not completed within the taxable year of the contractor in which such contract is entered into.

“(2) Exception.—A contract for the manufacture of property shall not be treated as a long-term contract unless such contract involves the manufacture of—
“(A) any unique item of a type which is not normally included in the finished goods inventory of the taxpayer, or

“(B) any item which normally requires more than 12 calendar months to complete.

“(d) CONSISTENCY.—The Secretary may require business entities to file statements containing such information with respect to long-term contracts as the Secretary may prescribe to ensure consistency in reporting.

“(e) FOREIGN CONTRACTS.—This section shall not be construed to permit a deduction for a business purchase for the cost of property produced outside the United States pursuant to a long-term contract at any time prior to the import of such property into the United States.

“SEC. 224. POST-SALE PRICE ADJUSTMENTS AND REFUNDS.

“(a) RECEIPT OF PRICE ADJUSTMENT.—In the case of a post-sale price adjustment attributable to a business purchase which was taken into account in computing gross profits for a prior taxable year, the amount of such adjustment shall be treated as a reduction or increase, as the case may be, in the cost of business purchases for the taxable year in which the adjustment is made or incurred.

“(b) ISSUANCE OF PRICE ADJUSTMENT.—In the case of a post-sale price adjustment attributable to a sale the receipts from which were taken into account in deter-
mining taxable receipts for a prior taxable year, the amount of such adjustment shall be treated as a reduction or increase, as the case may be, in taxable receipts for the taxable year in which the adjustment is made or incurred.

“(c) Post-Sale Price Adjustment.—‘Post-sale price adjustment’ means a refund, rebate, or other price allowance attributable to a sale of property or services or an upward adjustment in price that was not previously taken into account under the business entity’s method of accounting.

“SEC. 225. BAD DEBTS.

“(a) Seller.—If an amount owed to an accrual basis business entity for property or services sold—

“(1) was taken into account as a taxable receipt in a prior taxable year, and

“(2) becomes wholly or partially uncollectible during the taxable year, then the seller shall treat the amount as a reduction in taxable receipts for the taxable year in which it becomes wholly or partially uncollectible.

“(b) Notice Requirement.—No reduction shall be allowed under subsection (a) unless the seller notifies the purchaser of the amount which the seller has treated as wholly or partially uncollectible.
“(c) Subsequent Collection.—If an amount which was treated as uncollectible under subsection (a) is subsequently collected, it shall be treated as a taxable receipt when collected.

“(d) Purchaser.—If a purchaser receives notice under subsection (b) from a seller and the purchaser has treated the amount labeled uncollectible as a business purchase in a prior taxable year, then the purchaser shall treat such amount as a reduction in the cost of business purchases in the taxable year to which the notice relates. If the purchaser subsequently repays such amount, the repayment shall constitute the cost of a business purchase.


“(a) No Double Deductions.—A business entity shall not be entitled to treat as a ‘cost of business purchase’ any amount that the business entity deducted in computing taxable income under the income tax in effect prior the effective date of the business consumption tax.

“(b) No Double Inclusion.—A business entity shall not be required to include in taxable receipts any receipt that the business entity took into account in computing taxable income under the income tax in effect prior to the effect date of the business consumption tax.

“(c) No Loss of Deduction.—An expense which—
“(1) a business entity would have been able to
deduct as a cost of a business purchase in an ac-
counting period before the effective date of the busi-
ness consumption tax if the business consumption
tax had been in effect in such period, and

“(2) the business entity would have been able to
deduct as an expense in computing taxable income
in a period after the business consumption tax is ef-
fective if the income tax had continued in effect,

shall be treated as a cost of a business purchase incurred
or paid at the time that it would have been paid or in-
curred under the income tax if the income tax had contin-
ued in effect. This subsection shall not apply to any
amount which is to be taken into account under sub-
chapter L (relating to transition rules), any amounts
which would have been deducted under the income tax
through loss carryover deductions, or any deductions de-
ferred by the uniform capitalization rules under section

“(d) All Taxable Receipts Taxed.—A receipt
which—

“(1) a business entity would have been required
to treat as a taxable receipt in an accounting period
before the effective date of the business consumption
tax if the business consumption tax had been in effect in such period, and

“(2) the business entity would have been required to include in gross income in a period after the business consumption tax is effective if the income tax had continued in effect,

shall be treated as a taxable receipt at the time that it would have been included in income if the income tax had continued in effect.

“Subchapter E—Land and Rental Property

“Sec. 230. No deduction for land purchased for nonbusiness use.
“Sec. 231. Taxable receipts for land held for nonbusiness use.
“Sec. 232. Certain rental property.

“SEC. 230. NO DEDUCTION FOR LAND PURCHASED FOR NONBUSINESS USE.

“(a) IN GENERAL.—The acquisition of unimproved land shall not constitute a business purchase if the unimproved land is not acquired to be used in a business activity or if the land is acquired for—

“(1) speculation,

“(2) development (including subdivision), or

“(3) temporary leasing or other use not commensurate with the value of the land,

“(4) indefinite future use in a business activity,

or

“(5) use in compensating employees.
“(b) Future Use in Business Activity.—Unimproved land will not be considered held for ‘indefinite future use in a business activity’ if promptly upon acquisition, the purchaser or the lessee begins construction of improvements on the land (other than improvements, such as paving or sewage lines, intended for indefinite future development) that will be used in a business activity. Such improvement must be commensurate with the value of the land.

“(c) Unimproved Land.—‘Unimproved land’ means—

“(1) land with no buildings on it,

“(2) land with improvements if the value of the improvements is relatively small in comparison to the value of the land and it is anticipated that the improvements will be demolished and not used,

“(3) land in excess of the amount reasonably needed for the buildings located on it.

“(d) Conversion to Business Use.—If the acquisition of land is not treated as a business purchase by reason of subsection (a) and the land is subsequently used in a manner for which it could have been treated as a business purchase, the cost of the land will be treated as a business purchase when the improvements on the land
are placed in service (or in the case of construction for
sale, substantially completed and advertised for sale).

“SEC. 231. TAXABLE RECEIPTS FROM SALE OF LAND HELD
FOR NONBUSINESS USE.

“(a) Tax Basis.—A business entity shall have a tax
basis in land equal to the cost of the land if such cost
is not deductible by reason of section 230(a) and the land
has not been converted to business use for purposes of
section 230(d).

“(b) Taxable Receipts of a Land Sale.—The
taxable receipts from the sale of land (or portion thereof)
in which a business entity has a tax basis by reason of
subsection (a) shall be the amount by which the proceeds
exceed the basis of such land (or portion thereof).

“SEC. 232. CERTAIN RENTAL PROPERTY.

“(a) In General.—Except as provided in subsection
(b), the activity of rental of real estate is a business activ-
ity to which the business consumption tax applies.

“(b) Not Rental Property.—Subsection (a) shall
not apply—

“(1) to property used on more than 14 days
during the taxable year for nonbusiness purposes, or

“(2) to property rented for no more than 14
days during the taxable year and the total rental re-
ceived with respect to such property does not exceed $10,000.

“(c) Rental Property Becomes Nonrental Property.—If property which is considered rental property for purposes of subsection (a) in one taxable year ceases to be rental property (by reason of subsection (b)) in the following taxable year, the property (and any associated debt) shall be treated as distributed by the business entity to its owners. Section 211(a) shall apply to such distribution.

“Subchapter F—Insurance and Financial Products


“(a) Taxable Receipts.—Taxable receipts do not include financial receipts (as defined in section 203(e)(2)).

“(b) Business Purchases.—Business purchases do not include the cost of financial instruments (as defined in section 203(e)(3)) or payments for use of money or capital.

“Subchapter G—Tax-exempt Organizations

“Sec. 251. Exemption for governmental entities.

“Sec. 252. Taxable activity of governmental entities.

“Sec. 253. Tax-exempt organizations.

“Sec. 254. Special rules for (c)(3) organizations.

“Sec. 255. Tax on unrelated business activity.

“Sec. 256. Unrelated business activity.
“SEC. 251. EXEMPTION FOR GOVERNMENTAL ENTITIES.

“(a) STATES.—Except as provided in section 252, a state, political subdivision thereof and the District of Columbia shall be exempt from taxation under this chapter on any gross profits derived from the exercise of any essential governmental function.

“(b) POSSESSIONS.—The government of any possession of the United States shall be exempt from taxation under this chapter on any gross profits earned by the possession.

“SEC. 252. TAXABLE ACTIVITY OF GOVERNMENTAL ENTITIES.

“(a) CERTAIN ACTIVITIES TAXABLE.—A governmental entity shall be considered a business and subject to tax on any business activity of a type frequently provided by business entities subject to tax under this chapter.

“(b) CERTAIN ACTIVITIES TREATED AS ESSENTIAL GOVERNMENT FUNCTIONS.—Subsection (a) shall not apply to the following activities, which shall be treated as essential government functions:

“(1) Provision of mass transportation services.

“(2) Provision of public utility services.
“SEC. 253. TAX-EXEMPT ORGANIZATIONS.

“(a) Exemption from Taxation.—An organization described in subsection (c) or (d) shall be exempt from taxation under this chapter.

“(b) Tax on Unrelated Business Activity.—An organization exempt from taxation under subsection (a) shall be subject to tax to the extent provided in sections 255 and 256, but shall be considered a tax-exempt organization for purposes of any law that refers to tax-exempt organizations.

“(c) List of Exempt Organizations.—The following organizations are referred to in subsection (a):

“(1) Instrumentality of the United States.—Any corporation organized under Act of Congress which is an instrumentality of the United States but only if such corporation—

“(A) is exempt from Federal income taxes—

“(i) under such Act as amended and supplemented before July 18, 1984, or

“(ii) under this title without regard to any provision of law which is not contained in this title and which is not contained in a revenue Act, or

“(B) is described in subsection (h).
“(2) Title holding companies.—Corporations organized for the exclusive purpose of holding title to property, collecting income therefrom, and turning over the entire amount thereof, less expenses, to an organization which itself is exempt under this section. Rules similar to the rules of subparagraph (G) of paragraph (25) shall apply for purposes of this paragraph.

“(3) Charitable, educational and religious organizations.—Corporations, and any community chest, fund, or foundation, organized and operated exclusively for religious, charitable, scientific, testing for public safety, literary, or educational purposes, or to foster national or international amateur sports competition (but only if no part of its activities involve the provision of athletic facilities or equipment), or for the prevention of cruelty to children or animals, no part of the net earnings of which inures to the benefit of any private shareholder or individual, no substantial part of the activities of which is carrying on propaganda, or otherwise attempting, to influence legislation (except as otherwise provided in subsection (g)), and which does not participate in, or intervene in (including the publishing or distributing of statements), any polit-
ical campaign on behalf of (or in opposition to) any
candidate for public office.

“(4) Social welfare organizations, etc.—

“(A) Civic leagues or organizations not or-
ganized for profit but operated exclusively for
the promotion of social welfare, or local associa-
tions of employees, the membership of which is
limited to the employees of a designated person
or persons in a particular municipality, and the
net earnings of which are devoted exclusively to
charitable, educational, or recreational pur-
poses.

“(B) Subparagraph (A) shall not apply to
an entity unless no part of the net earnings of
such entity inures to the benefit of any private
shareholder or individual.

“(5) Labor and agricultural organizations.—Labor, agricultural, or horticultural organi-
izations.

“(6) Trade associations.—Business leagues,
chambers of commerce, real-estate boards, boards of
trade, or professional football leagues (whether or
not administering a pension fund for football play-
ers) not organized for profit and no part of the net
earnings of which inures to the benefit of any private shareholder or individual.

“(7) SOCIAL CLUBS.—Clubs organized for pleasure, recreation, and other nonprofitable purposes, substantially all of the activities of which are for such purposes and no part of the net earnings of which inures to the benefit of any private shareholder.

“(8) CERTAIN FRATERNAL SOCIETIES.—Fraternal beneficiary societies, orders, or associations—

“(A) operating under the lodge system or for the exclusive benefit of the members of a fraternity itself operating under the lodge system, and

“(B) providing for the payment of life, sick, accident, or other benefits to the members of such society, order, or association or their dependents.

“(9) VEBAS.—Voluntary employees’ beneficiary associations providing for the payment of life, sick, accident, or other benefits to the members of such association or their dependents or designated beneficiaries, if no part of the net earnings of such association inures (other than through such payments)
to the benefit of any private shareholder or individual.

“(10) Other Fraternal Organizations.— Domestic fraternal societies, orders, or associations, operating under the lodge system—

“(A) the net earnings of which are devoted exclusively to religious, charitable, scientific, literary, educational, and fraternal purposes, and

“(B) which do not provide for the payment of life, sick, accident, or other benefits.

“(11) Local Teachers’ Retirement Funds.— Teachers’ retirement fund associations of a purely local character, if—

“(A) no part of their net earnings inures (other than through payment of retirement benefits) to the benefit of any private shareholder or individual, and

“(B) the income consists solely of amounts received from public taxation, amounts received from assessments on the teaching salaries of members, and income in respect of investments.

“(12) Certain Cooperatives.—

“(A) Benevolent life insurance associations of a purely local character, mutual ditch or irrigation companies, mutual or cooperative tele-
phone companies, or like organizations; but only if 85 percent or more of the income consists of amounts collected from members for the sole purpose of meeting losses and expenses.

“(B) In the case of a mutual or cooperative telephone company, subparagraph (A) shall be applied without taking into account any income received or accrued—

“(i) from a nonmember telephone company for the performance of communication services which involve members of the mutual or cooperative telephone company,

“(ii) from qualified pole rentals,

“(iii) from the sale of display listings in a directory furnished to the members of the mutual or cooperative telephone company, or

“(iv) from the prepayment of a loan under section 306A, 306B, or 311 of the Rural Electrification Act of 1936 (as in effect on January 1, 1987).

“(C) In the case of a mutual or cooperative electric company, subparagraph (A) shall be ap-
plied without taking into account any income
received or accrued—

“(i) from qualified pole rentals, or

“(ii) from the prepayment of a loan
under section 306A, 306B, or 311 of the
Rural Electrification Act of 1936 (as in ef-
fect on January 1, 1987).

“(D) For purposes of this paragraph, the
term ‘qualified pole rental’ means any rental of
a pole (or other structure used to support
wires) if such pole (or other structure)—

“(i) is used by the telephone or elec-
tric company to support one or more wires
which are used by such company in pro-
viding telephone or electric services to its
members, and

“(ii) is used pursuant to the rental to
support one or more wires (in addition to
the wires described in clause (i)) for use in
connection with the transmission by wire
of electricity or of telephone or other com-
munications.

For purposes of the preceding sentence, the
term ‘rental’ includes any sale of the right to
use the pole (or other structure).
“(13) Nonprofit Cemeteries.—Cemetery companies owned and operated exclusively for the benefit of their members or which are not operated for profit; and any corporation chartered solely for the purpose of the disposal of bodies by burial or cremation which is not permitted by its charter to engage in any business not necessarily incident to that purpose and no part of the net earnings of which inures to the benefit of any private shareholder or individual.

“(14) Grandfathered Mutual Financial Institutions.—

“(A) Credit unions without capital stock organized and operated for mutual purposes and without profit.

“(B) Certain corporations or associations organized before September 1, 1957, and described in subparagraphs (B) or (C) of section 501(c)(14) of the Internal Revenue Code of 1986.

“(15) Grandfathered Small Insurance Companies.—Insurance companies described in section 501(c)(15) of the Internal Revenue Code of 1986.
“(16) Crop financing associations.—Cor-
porations organized by an association subject to part
IV of this subchapter or members thereof, for the
purpose of financing the ordinary crop operations of
such members or other producers, and operated in
conjunction with such association. Exemption shall
not be denied any such corporation because it has
capital stock, if the dividend rate of such stock is
fixed at not to exceed the legal rate of interest in the
State of incorporation or 8 percent per annum,
whichever is greater, on the value of the consider-
ation for which the stock was issued, and if substan-
tially all such stock (other than nonvoting preferred
stock, the owners of which are not entitled or per-
mitted to participate, directly or indirectly, in the
profits of the corporation, on dissolution or other-
wise, beyond the fixed dividends) is owned by such
association, or members thereof; nor shall exemption
be denied any such corporation because there is ac-
cumulated and maintained by it a reserve required
by State law or a reasonable reserve for any nece-
sary purpose.

“(17) Supplemental employment benefit
trust.—
“(A) A trust or trusts forming part of a plan providing for the payment of supplemental unemployment compensation benefits, if—

“(i) under the plan, it is impossible, at any time prior to the satisfaction of all liabilities, with respect to employees under the plan, for any part of the corpus or income to be (within the taxable year or thereafter) used for, or diverted to, any purpose other than the providing of supplemental unemployment compensation benefits,

“(ii) such benefits are payable to employees under a classification which is set forth in the plan and which is found by the Secretary not to be discriminatory in favor of employees who are highly compensated employees (within the meaning of section 414(q)), and

“(iii) such benefits do not discriminate in favor of employees who are highly compensated employees (within the meaning of section 414(q)). A plan shall not be considered discriminatory within the meaning of this clause merely because the bene-
fits received under the plan bear a uniform relationship to the total compensation, or the basic or regular rate of compensation, of the employees covered by the plan.

“(B) Rules similar to those contained in subparagraphs (B) through (E) of section 501(c)(7) of the Internal Revenue Code of 1986 shall apply to subparagraph (A).

“(18) GRANDFATHERED TRUSTS.—A trust or trusts created before June 25, 1959, and described in section 501(c)(18) of the Internal Revenue Code of 1986.

“(19) CERTAIN VETERANS’ ORGANIZATIONS.—A post or organization of past or present members of the Armed Forces of the United States, or an auxiliary unit or society of, or a trust or foundation for, any such post or organization—

“(A) organized in the United States or any of its possessions,

“(B) at least 75 percent of the members of which are past or present members of the Armed Forces of the United States and substantially all of the other members of which are individuals who are cadets or are spouses, widows, or widowers of past or present members of
the Armed Forces of the United States or of
cadets, and

“(C) no part of the net earnings of which
inures to the benefit of any private shareholder
or individual.

“(20) LEGAL SERVICE PLAN TRUSTS.—An or-
ganization or trust created or organized in the
United States, the exclusive function of which is to
form part of a qualified group legal services plan or
plans.

“(21) BLACK LUNG ACT TRUSTS.—A trust or
trusts established in writing, created or organized in
the United States, and contributed to by any person
(except an insurance company) if—

“(A) the purpose of such trust or trusts is
exclusively—

“(i) to satisfy, in whole or in part, the
liability of such person for, or with respect
to, claims for compensation for disability
or death due to pneumoconiosis under
Black Lung Acts,

“(ii) to pay premiums for insurance
exclusively covering such liability,

“(iii) to pay administrative and other
incidental expenses of such trust in connec-
tion with the operation of the trust and the processing of claims against such person under Black Lung Acts, and

“(iv) to pay accident or health benefits for retired miners and their spouses and dependents (including administrative and other incidental expenses of such trust in connection therewith) or premiums for insurance exclusively covering such benefits; and

“(B) such trusts meets requirements similar to those contained in section 501(c)(21) of the Internal Revenue Code of 1986.

“(22) MULTIEMPLOYER ERISA TRUST.—A trust created or organized in the United States and established in writing by the plan sponsors of multiemployer plans if—

“(A) the purpose of such trust is exclusively—

“(i) to pay any amount described in section 4223(c) or (h) of the Employee Retirement Income Security Act of 1974, and

“(ii) to pay reasonable and necessary administrative expenses in connection with the establishment and operation of the
trust and the processing of claims against
the trust,

“(B) no part of the assets of the trust may
be used for, or diverted to, any purpose other
than—

“(i) the purposes described in sub-
paragraph (A), or

“(ii) prudent investment in securities,
obligations, or time or demand deposits,

“(C) such trust meets the requirements of
paragraphs (2), (3), and (4) of section 4223(b),
4223(h), or, if applicable, section 4223(c) of the
Employee Retirement Income Security Act of
1974, and

“(D) the trust instrument provides that,
on dissolution of the trust, assets of the trust
may not be paid other than to plans which have
participated in the plan or, in the case of a
trust established under section 4223(h) of such
Act, to plans with respect to which employers
have participated in the fund.

“(23) GRANDFATHERED VETERANS’ INSURANCE
ORGANIZATION.—Any association organized before
1880 more than 75 percent of the members of which
are present or past members of the Armed Forces
and a principal purpose of which is to provide insurance and other benefits to veterans or their dependents.


“(25) Real Title Holding Corporation or Trust.—

“(A) Any corporation or trust which—

“(i) has no more than 35 shareholders or beneficiaries,

“(ii) has only 1 class of stock or beneficial interest, and

“(iii) is organized for the exclusive purposes of—

“(I) acquiring real property and holding title to, and collecting income from, such property, and

“(II) remitting the entire amount of income from such property (less expenses) to 1 or more organizations described in subparagraph (C) which are
shareholders of such corporation or
beneficiaries of such trust.

For purposes of clause (iii), the term ‘real prop-
erty’ shall not include any interest as a tenant
in common (or similar interest) and shall not
include any indirect interest.

“(B) A corporation or trust shall be de-
scribed in subparagraph (A) without regard to
whether the corporation or trust is organized by
1 or more organizations described in subpara-
graph (C).

“(C) An organization is described in this
subparagraph if such organization is—

“(i) a qualified pension, profit shar-
ing, or stock bonus plan that meets the re-
quirements of section 401(a),

“(ii) a governmental plan (within the
meaning of section 414(d)),

“(iii) the United States, any State or
political subdivision thereof, or any agency
or instrumentality of any of the foregoing,
or

“(iv) any organization described in
paragraph (3).
“(D) A corporation or trust shall in no event be treated as described in subparagraph (A) unless such corporation or trust permits its shareholders or beneficiaries—

“(i) to dismiss the corporation’s or trust’s investment adviser, following reasonable notice, upon a vote of the shareholders or beneficiaries holding a majority of interest in the corporation or trust, and

“(ii) to terminate their interest in the corporation or trust by either, or both, of the following alternatives, as determined by the corporation or trust:

“(I) by selling or exchanging their stock in the corporation or interest in the trust (subject to any Federal or State securities law) to any organization described in subparagraph (C) so long as the sale or exchange does not increase the number of shareholders or beneficiaries in such corporation or trust above 35, or

“(II) by having their stock or interest redeemed by the corporation or trust after the shareholder or bene-
ficiary has provided 90 days notice to such corporation or trust.

“(E)(i) For purposes of this paragraph—

“(I) a corporation which is a qualified subsidiary shall not be treated as a separate corporation, and

“(II) all assets, liabilities, and items of income, deduction, and credit of a qualified subsidiary shall be treated as assets, liabilities, and such items (as the case may be) of the corporation or trust described in subparagraph (A).

“(ii) For purposes of this subparagraph, the term ‘qualified subsidiary’ means any corporation if, at all times during the period such corporation was in existence, 100 percent of the stock of such corporation is held by the corporation or trust described in subparagraph (A).

“(iii) For purposes of this subtitle, if any corporation which was a qualified subsidiary ceases to meet the requirements of clause (ii), such corporation shall be treated as a new corporation acquiring all of its assets (and assuming all of its liabilities) immediately before such
cession from the corporation or trust described in subparagraph (A) in exchange for its stock.

“(F) For purposes of subparagraph (A), the term ‘real property’ includes any personal property which is leased under, or in connection with, a lease of real property, but only if the rent attributable to such personal property for the taxable year does not exceed 15 percent of the total rent for the taxable year attributable to both the real and personal property leased under, or in connection with, such lease.

“(G)(i) An organization shall not be treated as failing to be described in this paragraph merely by reason of the receipt of any otherwise disqualifying income which is incidentally derived from the holding of real property.

“(ii) Clause (i) shall not apply if the amount of gross income described in such clause exceeds 10 percent of the organization’s gross income for the taxable year unless the organization establishes to the satisfaction of the Secretary that the receipt of gross income described in clause (i) in excess of such limitation was inadvertent and reasonable steps are being
taken to correct the circumstances giving rise to such income.

“(26) STATE ESTABLISHED MEDICAL CARE INSURER.—Any membership organization if—

“(A) such organization is established by a State exclusively to provide coverage for medical care on a not-for-profit basis to individuals described in subparagraph (B) through—

“(i) insurance issued by the organization, or

“(ii) a health maintenance organization under an arrangement with the organization,

“(B) the only individuals receiving such coverage through the organization are individuals—

“(i) who are residents of such State, and

“(ii) who, by reason of the existence or history of a medical condition—

“(I) are unable to acquire medical care coverage for such condition through insurance or from a health maintenance organization, or
“(II) are able to acquire such coverage only at a rate which is substantially in excess of the rate for such coverage through the membership organization,

“(C) the composition of the membership in such organization is specified by such State, and

“(D) no part of the net earnings of the organization inures to the benefit of any private shareholder or individual. A spouse and any qualifying child) of an individual described in subparagraph (B) (without regard to this sentence) shall be treated as described in subparagraph (B).

“(27) GRANDFATHERED WORKERS COMPENSATION ORGANIZATION.—Any membership organization established before June 1, 1996, by a State exclusively to reimburse its members for losses arising under workmen’s compensation acts, and described in section 501(c)(27) of the Internal Revenue Code of 1986.

“(d) RELIGIOUS AND APOSTOLIC ORGANIZATIONS.—

The following organizations are referred to in subsection (a): Religious or apostolic associations or corporations, if
such associations or corporations have a common treasury
or community treasury, even if such associations or cor-
porations engage in business for the common benefit of
the members, but only if such activity is treated as unre-
lated business activity.

“(e) COOPERATIVE HOSPITAL SERVICE ORGANIZA-
tions.—For purposes of this chapter, an organization
shall be treated as an organization organized and operated
exclusively for charitable purposes, if—

“(1) such organization is organized and oper-
ated solely—

“(A) to perform, on a centralized basis,
one or more of the following services which, if
performed on its own behalf by a hospital which
is an organization described in subsection (c)(3)
and exempt from taxation under subsection (a),
would constitute activities in exercising or per-
forming the purpose or function constituting
the basis for its exemption: data processing,
purchasing (including the purchasing of insur-
ance on a group basis), warehousing, billing
and collection, food, clinical, industrial engi-
neering, laboratory, printing, communications,
record center, and personnel (including selec-
tion, testing, training, and education of personnel) services; and

“(B) to perform such services solely for two or more hospitals each of which is—

“(i) an organization described in subsection (c)(3) which is exempt from taxation under subsection (a),

“(ii) a constituent part of an organization described in subsection (c)(3) which is exempt from taxation under subsection (a) and which, if organized and operated as a separate entity, would constitute an organization described in subsection (c)(3), or

“(iii) owned and operated by the United States, a State, the District of Columbia, or a possession of the United States, or a political subdivision or an agency or instrumentality of any of the foregoing;

“(2) such organization is organized and operated on a cooperative basis and allocates or pays, within 8½ months after the close of its taxable year, all net earnings to patrons on the basis of services performed for them; and
“(3) if such organization has capital stock, all
of such stock outstanding is owned by its patrons.
For purposes of this title, any organization which, by rea-
son of the preceding sentence, is an organization described
in subsection (c)(3) and exempt from taxation under sub-
section (a), shall be treated as a hospital and as an organi-
zation the principal purpose or functions of which are the
providing of medical or hospital care or medical education
or medical research, if the organization is a hospital, or
if the organization is a medical research organization di-
rectly engaged in the continuous active conduct of medical
research in conjunction with a hospital.
“(f) COOPERATIVE SERVICE ORGANIZATIONS OF OP-
erating Educational Organizations.—For purposes
of this chapter—
“(1) If an organization is—
“(A) organized and operated solely to hold,
commingle, and collectively invest and reinvest
(including arranging for and supervising the
performance by independent contractors of in-
vestment services related thereto) in stocks and
securities, the moneys contributed thereto by
each of the members of such organization, and
to collect income therefrom and turn over the
entire amount thereof, less expenses, to such members,

“(B) organized and controlled by one or more such members, and

“(C) comprised solely of members that are organizations described in paragraph (2) or (3)—

“(i) which are exempt from taxation under subsection (a), or

“(ii) the gross profits of which are excluded from taxation under section 251(a),

then such organization shall be treated as an organization organized and operated exclusively for charitable purposes.

“(2) An organization is described in this paragraph if the organization is an educational organization which normally maintains a regular faculty and curriculum and normally has a regularly enrolled body of pupils or students in attendance at the place where its educational activities are regularly carried on.

“(3) An organization is described in this paragraph if the organization is an organization which normally receives a substantial part of its support (exclusive of income received in the exercise or per-
formance by such organization of its charitable, educational, or other purpose or function constituting the basis for its exemption under section 253(a)) from the United States or any State or political subdivision thereof or from direct or indirect contributions from the general public, and which is organized and operated exclusively to receive, hold, invest, and administer property and to make expenditures to or for the benefit of a college or university which is an organization referred to in clause (ii) of this subparagraph and which is an agency or instrumentality of a State or political subdivision thereof, or which is owned or operated by a State or political subdivision thereof or by an agency or instrumentality of one or more States or political subdivisions.

“(g) Expenditures by Public Charities to Influence Legislation.—

“(1) General rule.—In the case of an organization to which this subsection applies, exemption from taxation under subsection (a) shall be denied because a substantial part of the activities of such organization consists of carrying on propaganda, or otherwise attempting, to influence legislation, but only if such organization normally—
“(A) makes lobbying expenditures in excess of the lobbying ceiling amount for such organization for each taxable year, or

“(B) makes grass roots expenditures in excess of the grass roots ceiling amount for such organization for each taxable year.

“(2) DEFINITIONS.—For purposes of this subsection—

“(A) LOBBYING EXPENDITURES.—‘Lobbying expenditures’ means expenditures for the purpose of influencing legislation (as defined in section 4911(d)).

“(B) LOBBYING CEILING AMOUNT.—The lobbying ceiling amount for any organization for any taxable year is 150 percent of the lobbying nontaxable amount for such organization for such taxable year, determined under section 4911.

“(C) GRASS ROOTS EXPENDITURES.—‘Grass roots expenditures’ means expenditures for the purpose of influencing legislation (as defined in section 4911(d) without regard to paragraph (1)(B) thereof).

“(D) GRASS ROOTS CEILING AMOUNT.—The grass roots ceiling amount for any organi-
zation for any taxable year is 150 percent of
the grass roots nontaxable amount for such or-
ganization for such taxable year, determined
under section 4911.

“(3) Organizations to which this sub-
section applies.—This subsection shall apply to
any organization which has elected (in such manner
and at such time as the Secretary may prescribe) to
have the provisions of this subsection apply to such
organization and which, for the taxable year which
includes the date the election is made, is described
in subsection (c)(3) and is not described in para-
graph (4) and is not a private foundation.

“(4) Disqualified organizations.—This
subsection does not apply to—

“(A) a church,

“(B) an integrated auxiliary of a church or
of a convention or association of churches, or

“(C) a member of an affiliated group of or-
ganizations (within the meaning of section
4911(f)(2)) if one or more members of such
group is described in subparagraph (A) or (B).

“(5) Years for which election is effec-
tive.—An election by an organization under this
subsection shall be effective for all taxable years of such organization which—

“(A) end after the date the election is made, and

“(B) begin before the date the election is revoked by such organization (under regulations prescribed by the Secretary).

“(6) No effect on certain organizations.—With respect to any organization for a taxable year for which—

“(A) such organization is described in paragraph (5), or

“(B) an election under this subsection is not in effect for such organization, nothing in this subsection or in section 4911 shall be construed to affect the interpretation of the phrase, ‘no substantial part of the activities of which is carrying on propaganda, or otherwise attempting, to influence legislation,’ under subsection (c)(3).

“(h) Government Corporations Exempt Under Subsection (c)(1).—For purposes of subsection (c)(1), the following organizations are described in this subsection:
“(1) The Central Liquidity Facility established under title III of the Federal Credit Union Act (12 U.S.C. 1795 et seq.).


“(3) The Resolution Funding Corporation established under section 21B of the Federal Home Loan Bank Act.

“(i) CERTAIN EDUCATIONAL ORGANIZATIONS.—An organization shall not be eligible for exemption as an educational organization under subsection (c)(3) if a substantial amount of its activities and funds are devoted to—

“(1) conducting seminars and other similar programs,

“(2) conducting research to educate Congress or the general public about public policy issues,

“(3) producing books and pamphlets, or

“(4) a combination of the foregoing.

“SEC. 254. SPECIAL RULES FOR (c)(3) ORGANIZATIONS.

“(a) NEW ORGANIZATIONS MUST NOTIFY SECRETARY.—Except as provided in subsection (c), an organization shall not be treated as an organization described in section 253(c)(3)—
“(1) unless that it has given notice to the Sec-
retary, in such manner as the Secretary may pre-
scribe, that it is applying for recognition of such sta-
tus, or

“(2) for any period before giving of such notice,
if such notice is given after the time prescribed by
the Secretary by regulations for giving notice under
this subsection.

“(b) Presumption That Organizations Are Pri-
vate Foundations.—Except as provided in subsection
(c), any organization described in section 253(e)(3) and
which does not notify the Secretary, at such time and in
such manner as the Secretary may by regulations pre-
scribe, that it is not a private foundation shall be pre-
sumed to be a private foundation.

“(c) Exceptions.—Subsections (a) and (b) shall not
apply to—

“(1) organizations organized before October 10,
1969;

“(2) organizations which obtained recognition
of tax-exempt status under section 501(c)(3) of the
Internal Revenue Code of 1986 (in the case of sub-
section (a) only);
“(3) organizations which were determined not to be private foundations under the Internal Revenue Code of 1986;

“(4) churches, their integrated auxiliaries, and conventions and associations of churches;

“(5) any organization that is not a private foundation and the gross receipts of which in each taxable year are not more than $25,000, or

“(6) such other classes of organizations which the Secretary may exempt.

“SEC. 255. TAX ON UNRELATED BUSINESS ACTIVITY.

“(a) IN GENERAL.—Each organization described in subsection (b) shall be subject to the Competitive American Business Tax for businesses under section 201 on its gross profits from its unrelated business activity.

“(b) ORGANIZATIONS SUBJECT TO TAX.—This section shall apply to—

“(1) organizations exempt from the business consumption tax under section 253(a), other than instrumentalities of the United States described in section 253(c)(1).

“(2) colleges and universities which are instrumentalities of any government and corporations owned by one or more such colleges or universities.
“SEC. 256. UNRELATED BUSINESS ACTIVITY.

“(a) IN GENERAL.—‘Unrelated business activity’ means any trade or business the conduct of which is not substantially related (aside from the need of such organization for income or funds or the use it makes of the profits derived) to the exercise or performance by such organization of its charitable, educational, or other purpose or function constituting the basis for its exemption under section 253, except that such term does not include any trade or business—

“(1) in which substantially all the work in carrying on such trade or business is performed for the organization without compensation; or

“(2) which is carried on, in the case of an organization described in section 253(c)(3) or in the case of a college or university described in section 255(b), by the organization primarily for the convenience of its members, students, patients, officers, or employees, which is the selling by the organization of items of work-related clothes and equipment and items normally sold through vending machines, through food dispensing facilities, or by snack bars, for the convenience of its members at their usual places of employment; or
“(3) which is the selling of merchandise, substantially all of which has been received by the organization as gifts or contributions.

“(b) ADVERTISING, ETC., ACTIVITIES.—For purposes of this section, ‘trade or business’ includes any activity which is carried on for the production of income from the sale of goods or the performance of services. For purposes of the preceding sentence, an activity does not lose identity as a trade or business merely because it is carried on within a larger aggregate of similar activities or within a larger complex of other endeavors which may, or may not, be related to the exempt purposes of the organization. Where an activity carried on for profit constitutes an unrelated trade or business, no part of such trade or business shall be excluded from such classification merely because it does not result in profit.

“(c) TRADE OR BUSINESS.—

“(1) CERTAIN BUSINESS ACTIVITIES.—An activity shall not be considered a ‘trade or business’ solely because the activity is a business activity (such as certain passive rental activity) that would be subject to the business consumption tax if conducted by a business entity other than a tax-exempt organization.
“(2) REGULATIONS.—The Secretary shall prescribe regulations defining a ‘trade or business’. Such regulations shall be consistent with the provisions under sections 511 through 513 of the Internal Revenue Code of 1986, except to the extent such provisions are inconsistent with other principles of the business consumption tax. The regulations shall include exclusions from the definition of ‘trade or business’ similar to those contained in section 513 of the Internal Revenue Code for—

“(A) certain bingo games,
“(B) certain hospital services, and
“(C) certain public entertainment activity at fairs and expositions by an organization which regularly conducts, as one of its substantial exempt purposes, an agricultural or educational fair or exhibition.

“(3) TRADE SHOWS.—The conduct of trade shows and conventions shall not be excluded from the definition of trade or business.

“Subchapter H—Cooperatives

“Sec. 260. Patronage dividends of cooperatives.

“SEC. 260. PATRONAGE DIVIDENDS OF COOPERATIVES.

“(a) PATRONAGE DIVIDENDS PAID BY SUPPLY CO-OPERATIVES.—A qualified patronage dividend paid by a
supply cooperative to a patron shall be treated as if it is a refund of a portion of the amounts paid by the patron for goods, services, or use of capital. In general, if the supply cooperative included the amount received from the patron in taxable receipts, the dividend shall reduce taxable receipts in the year incurred. If the recipient of the dividend is a business entity which deducted the cost of business purchases to which the dividend related, the recipient will reduce its cost of business purchases by the amount of the dividend in the year the dividend is paid or incurred.

“(b) Patronage Dividends Paid by Marketing Cooperatives.—A qualified patronage dividend paid to a patron by a marketing cooperative shall be treated as an upward price adjustment in the amount received by the patron for its goods marketed by the cooperative. In general, the cooperative will increase its cost of business purchases by the amount of the qualified patronage dividend and the recipient will increase its taxable receipts by the amount of the qualified patronage dividend.

“(c) Dividend Treatment.—Only the portion of a patronage dividend that is not a qualified patronage dividend shall be treated as a dividend under this chapter and chapter 2.

“(d) Definitions.—
“(1) **Qualified Patronage Dividend.**—A ‘qualified patronage dividend’ is that part of a patronage dividend that is attributable to the patron’s allocable share of patronage earnings of a marketing cooperative or a supply cooperative.

“(2) **Supply Cooperative.**—A ‘supply cooperative’ is a cooperative that sells goods or service to patrons and provided patronage dividends with respect to the quantity of purchases of the patrons.

“(3) **Marketing Cooperative.**—A ‘marketing cooperative’ is a cooperative that sells goods produced by its members and provides patronage dividends to the members based on the quantities of goods sold or provided for sale.

“(e) **Special Rules.**—

“(1) **Notices of Allocation and Per-Unit Retain Certificates.**—Except as provided in paragraph (2), a notice of allocation, per-unit retain certificate, or other similar document shall not be treated as a patronage dividend until it is redeemed in cash or property.

“(2) **Opportunity to Receive Cash.**—If a patron is given an opportunity to receive a patronage dividend in cash, but instead chooses to accept a per-unit retain certificate or a qualified notice of
allocation, the patron will be treated as receiving

cash and simultaneously contributing to the capital

of the cooperative.

“(3) Application limited to qualified co-

operatives.—Under rules to be prescribed by the

Secretary, this section shall apply only to coopera-
tives to which one of the following provisions of the

Internal Revenue Code of 1986 would have applied:

“(A) Section 501(c)(12) (relating to coop-
erative telephone companies and similar organi-
zations).

“(B) Section 501(c)(14) (relating to cer-
tain cooperative banks).

“(C) Section 521 (relating to farm co-

operatives).

“(D) Section 1381 (relating to coopera-
tives generally).

“(4) Regulations.—The Secretary shall pre-
scribe regulations for the application of this section.
The regulations shall generally be consistent with
subchapter T of chapter 1 of the Internal Revenue
Code of 1986 except to the extent that such rules
are inconsistent with provisions of this chapter.

“Subchapter I—Sourcing Rules

Sec. 265. Exports of property or services.

Sec. 266. Imports of property or services.

Sec. 267. Import or export of services.
“SEC. 265. EXPORTS OF PROPERTY OR SERVICES.

“(a) GENERAL RULE.—Taxable receipts do not include amounts received by the exporter thereof for property or services exported from the United States for use or consumption outside the United States.

“(b) EXPORT THROUGH NONBUSINESS ENTITY.—For purposes of subsection (a), if property or services are sold to a governmental entity or a tax-exempt organization for export and are exported other than in an activity of such entity which is subject to the business consumption tax, then the seller of such property or services is deemed to be the exporter thereof.

“(c) EXPORT OF SERVICES.—See section 267 for rules for determining whether services are exported or imported.

“SEC. 266. IMPORTS OF PROPERTY OR SERVICES.

“(a) IN GENERAL.—The import of property or services for consumption in the United States shall constitute a business purchase if such property or service is to be used in a business activity in the United States. Property being held for sale or retail by a business entity that is in the business of selling goods shall be considered held for ‘use in a business activity’.
“(b) Amount of Business Purchase.—

“(1) In General.—The cost of business purchases with respect to the import of property or services for use or consumption in the United States is the customs value, price or other amount used for purposes of determining the import tax under section 281 or section 282.

“(2) Import Tax.—The cost of business purchases does not include any import tax paid. No deduction shall be allowed with respect to property or service imported by a business entity unless the import tax is paid with respect to such import.

“SEC. 267. Import or Export of Services.

“(a) In General.—Except as otherwise provided in this subchapter, services shall not be treated as imported or exported from the location in which they are performed.

“(b) Import of Services.—A business entity shall be treated as importing a service if—

“(1) the entire benefit of the service will be realized in the United States, and

“(2) the benefit will be realized in connection with the United States business activities of the business entity.

“(c) Export of Services.—A business will be treated as exporting a service if—
“(1) the entire benefit of the service will be realized outside of the United States, and

“(2) the benefit will be realized solely in connection with the activities of the purchaser occurring outside the United States.

“(d) SERVICES ACQUIRED FROM SERVICE PROVIDER THAT PROVIDES SERVICES IN AND OUTSIDE THE UNITED STATES.—

“(1) IN GENERAL.—If a business entity acquires services from a service provider that provides services both in and outside the United States and the service provider shows on the invoice where the services are provided—

“(A) the business entity shall treat the services as provided where stated on the invoice, and

“(B) the service provider shall treat as taxable receipts any services listed as provided in the United States.

“(2) NO INVOICE.—If a business entity acquires services from a service provider that provides services both in and outside the United States and the service provider does not show on an invoice where such services are provided—
“(A) the business entity shall treat the services as if provided in the location to which payment is sent, and

“(B) the service provider shall treat as taxable receipts any payments received in the United States.

“(e) Special Rules Prevail.—See sections 268 and 269 for special rule relating to transportation and communication services.

“SEC. 268. INTERNATIONAL TRANSPORTATION SERVICES.

“(a) Transportation of Property.—

“(1) Taxable Receipts.—

“(A) Exports.—Taxable receipts do not include receipts from the transportation of property exported from the United States.

“(B) Imports.—Taxable receipts include receipts from transportation of property imported into the United States only if such costs are not taken into account in determining the import tax.

“(C) Presumptions.—The Secretary shall prescribe regulations describing situations in which a transporter of property must presume that no import tax has been paid on the cost of its services.
“(2) Business purchases.—

“(A) Exports.—Business purchases do not include amounts paid or incurred for the cost of transportation of property exported from the United States.

“(B) Imports.—Amounts paid or incurred for transportation of goods imported into the United States, shall constitute a cost of business purchase only to the extent that they are taken into account in determining the customs value for purposes of section 281(a) (relating to the import tax).

“(b) Transportation of Passengers.—

“(1) Taxable receipts.—Taxable receipts—

“(A) include receipts from the transportation of passengers from the United States to a destination outside the United States, but

“(B) do not include receipts from the transportation of passengers from outside the United States to a destination in the United States.

“(2) Business purchases.—Business purchases—

“(A) include amounts paid or incurred in a business activity for the transportation of
passengers from the United States to a destination outside the United States, but

“(B) do not include amounts paid or incurred for transportation of passengers from outside the United States to a destination in the United States.

“(3) SIMPLIFYING RULES.—The Secretary may provide rules that simplify this subsection, including rules under which—

“(A) half of receipts attributable to transportation to or from the United States are treated as taxable receipts,

“(B) half of the cost for business trips to and from the United States are treated as business purchases, and

“(C) all transportation expenses of a business entity that has no regular business outside the United States are treated as business purchases.

“SEC. 269. INTERNATIONAL COMMUNICATIONS.

“(a) IN GENERAL.—For purposes of section 266, communications services shall be treated as provided at the point of origin of the communications and shall not be treated as imported or exported.
“(b) COMMUNICATIONS SERVICES.—Communications services include—

“(1) internet services,

“(2) telephone and electronic email communications services,

“(3) courier services (except in the case of transportation of property that is imported or exported),

“(4) satellite transmission services,

“(5) telegraph services,

“(6) facsimile transmission services, and

“(7) other similar services.

“SEC. 270. INSURANCE.

“(a) IN GENERAL.—Insurance services will be treated as provided at the location of the insurance company providing the services. Except as the Secretary may prescribe by regulations, insurance companies will be treated as providing services at the location to which insurance payments are made.

“(b) INSURED RISKS IN THE UNITED STATES.—If insurance services are provided outside the United States and the insured risk is located in the United States—

“(1) the insurance service shall be treated as imported,
“(2) the insurance premiums shall be subject to the import tax, and
“(3) payments of insurance benefits shall not be treated as imported.
“(c) INSURED RISK OUTSIDE THE UNITED STATES.—If insurance services are provided inside the United States and the insured risk is located outside the United States—
“(1) insurance services shall be treated as exported,
“(2) payments of insurance benefits shall be treated as payments for services outside the United States, and shall not be deducted as business purchases.
“(d) INSURANCE SERVICES.—Insurance services means the provision of insurance and services related to insurance other than insurance that is treated as a savings asset.

“SEC. 271. BANKING SERVICES.
“The Secretary shall prescribe regulations on the location of banking services and the extent to which such services are to be treated as imported or exported.

“Subchapter J—Business Conducted in a Possession

“Sec. 276. Treatment of possessions.
“SEC. 276. TREATMENT OF POSSESSIONS.

“(a) In General.—For purposes of the business consumption tax imposed by this chapter, the U.S. possessions shall not be treated as part of the United States.

“(b) Possession.—For purposes of this subchapter, ‘U.S. possession’ or ‘possession’ means a possession of the United States and includes the Commonwealth of Puerto Rico and the Virgin Islands.

“Subchapter K—Import Tax

“Sec. 281. Imposition of tax on property.
“Sec. 282. Imposition of tax on import of services.
“Sec. 283. General rules for the import tax.

“SEC. 281. IMPOSITION OF TAX ON PROPERTY.

“(a) General Rule.—There is hereby imposed a tax equal to 8.5 percent of the customs value of all property entered into the United States for consumption, use or warehousing.

“(b) Liability for Tax.—The tax imposed on the import of property by subsection (a) shall be paid by the person entering the property into the United States for consumption, use or warehousing. Such tax shall be due and payable at the time of import.

“(c) Imports of Previously Exported Property.—In the case of any article that is classified under a heading or subheading of subchapter I or II of chapter 98 of the Tariff Schedules of the United States, the tax under this section shall be imposed only on that portion
of the customs value of such article that is dutiable under
such heading or subheading.

“(d) Imports for Personal Consumption.—The
import tax imposed by this section shall not apply to any
article entered into the United States duty free under sub-
chapters I through VII of chapter 98 of the Tariff Sched-
ules of the United States.

“(e) Exception for Certain Commodities and
Products.—The import tax imposed by this section shall
not apply to petroleum, petroleum products or such com-
modities or products as the President shall by Executive
Order determine to be in short supply and vital to national
security.

“SEC. 282. Imposition of Tax on Import of Services.

“(a) General Rule.—There is hereby imposed a
tax equal to 8.5 percent of the cost of all services treated
as imported into the United States during the taxable year
of the service recipient.

“(b) Liability for the Tax.—The tax on the im-
port of services imposed by subsection (a) shall be paid
by the person who receives the imported services. The tax
shall be payable as if it were an addition to the business
consumption tax imposed by section 201.

“(c) Imported Services.—For purposes of this sec-
tion, services shall be treated as imported if they are treat-
ed as imported under section 267 (general rules on import
or export of services) or section 270 (related to insurance).

“(d) Special Rule for Insurance.—The seller of
insurance that is treated as imported under section 270
shall be liable for the collection of the tax imposed by sub-
section (a) on the insurance and for paying such tax to
the Secretary. The first sentence of subsection (b) (relat-
ing to the person liable for the tax) shall apply to insur-
ance only to the extent that the seller of the insurance
services does not collect such tax.


‘Import tax’ means the tax imposed by section 281
on the import of property and the tax imposed by section
282 on the import of services.

“Subchapter L—Transition Rules

“Sec. 290. Amortization of transition basis.

“SEC. 290. Amortization of Transition Basis.

“(a) Transition Basis Deduction.—The ‘transition
basis deduction’ for a taxable year is the sum of the
amortization allowance determined under this section for
the taxable year.

“(b) Treatment of Interest Flows.—Interest
flows between non-financial businesses shall be treated as
under current law, phased out over 5 years.
“(c) Amortization Rules.—The amortization allowance to all property placed in service before the effective date of this section shall be the lesser of—

“(1) the amortization period under current law remaining on such date, or

“(2) a 5-year ratable period beginning on such date.

Subchapter M—Rules for Administration,
Consolidated Returns

Sec. 301. Returns, due dates, etc.

Sec. 302. Consolidated returns.

“SEC. 301. RETURNS, DUE DATES, ETC.

“(a) In General.—Until subtitle F is amended to reflect the adoption of this chapter, the rules of subtitle F relating to C corporations shall apply to business entities with respect to—

“(1) returns and records;

“(2) time and place for paying tax;

“(3) assessment of taxes;

“(4) collections and liens;

“(5) abatements, credits, and refunds;

“(6) interest on underpayments and overpayments;

“(7) additions to tax and penalties;

“(8) closing agreements and compromises;

“(9) crimes;
“(10) judicial proceedings;
“(11) discovery of liability and enforcement;
and
“(12) estimated taxes.
“(b) INDIVIDUALS ENGAGING IN BUSINESS ACTIVITIES.—Under rules prescribed by the Secretary, individuals engaging in business activities on their own or with their spouses shall be permitted to file their business consumption tax returns with their individual tax returns and shall be subject to estimated tax rules for individual income tax returns. Such rules shall include rules to prevent the avoidance or abuse of this chapter and chapter 1.

“SEC. 302. CONSOLIDATED RETURNS.
“(a) IN GENERAL.—Business entities may file consolidated returns of business consumption tax if they would have been permitted to file consolidated returns under section 1501 of the Internal Revenue Code and such section were applied by treating each business entity as a corporation and its owners or partners as shareholders.
“(b) FINANCIAL INSTITUTIONS.—Financial intermediation businesses may be included in consolidated returns.
“(c) INTERCOMPANY TRANSACTIONS.—In computing the gross profits of a consolidated group, intercompany transactions can be taken into account, or at the election
of the filer, be disregarded (except in the case of trans-
actions with financial intermediation businesses).

“Subchapter N—Definitions and Rules of
Application

“Sec. 310. Definitions.
Sec. 311. Rules of application.

“SEC. 310. DEFINITIONS.

“When used in this chapter, where not otherwise dis-
tinctly expressed or manifestly incompatible with the in-
tent thereof—

“(1) INTERNAL REVENUE CODE OF 1986.—‘In-
ternal Revenue Code of 1986’ means the Internal
Revenue Code of 1986 as in effect immediately be-
fore the enactment of the Competitive American
Business Tax.

“(2) UNITED STATES.—‘United States’ means
the States and the District of Columbia.

“SEC. 311. RULES OF APPLICATION.

“(a) DEFINITIONS.—Any definition included in this
chapter shall apply for all purposes of this chapter un-
less—

“(1) such definition is limited to the purposes
of a particular chapter, section, or subsection, or
“(2) the definition clearly would not be applica-
ble in a particular context.
“(b) INTERPRETATIONS CONSISTENT WITH INTERNAL REVENUE CODE OF 1986.—Terms not defined in this chapter or elsewhere in this title, but defined in the Internal Revenue Code of 1986, shall be interpreted in a manner consistent with the Internal Revenue Code of 1986, except to the extent such interpretation would be inconsistent with the principles and purposes of this chapter.”.

(b) The amendments made by this section shall be effective on January 1, 2011, except to the extent otherwise specifically provided in the text of such amendments.

SEC. 603. REPEAL OF CHAPTER 6.

Chapter 6 of the Code (relating to consolidated returns) is repealed as of January 1, 2011.

TITLE VII—JOB TRAINING RESULTS ACT OF 2010

SEC. 701. SHORT TITLE.

This title may be cited as the “Job Training Results Act of 2010”.

SEC. 702. PURPOSE.

The purpose of this title is to ensure accountability and job training results in Federal job training programs.
SEC. 703. IMPROVEMENT OF JOB TRAINING PROGRAMS; PERFORMANCE METRICS FOR WIA JOB TRAINING PROGRAMS.

Title V of the Workforce Investment Act of 1998 (20 U.S.C. 9271 et seq.) is amended—

(1) by redesignating section 507 as section 510; and

(2) by inserting after section 506, the following:

“SEC. 507. IMPROVEMENT OF JOB TRAINING PROGRAMS.

“(a) General Rules.—

“(1) Grant Competition.—In order to encourage competition under the grant programs for providers of job training programs authorized under this Act, any grants under such grant programs shall be awarded on a competitive basis.

“(2) Priority.—In awarding grants under this Act, the Secretary shall give priority to applicants that leverage private resources.

“(3) Grant Renewal.—

“(A) Threshold Determination.—The Secretary shall not renew a grant for a provider of a training program under this Act that fails to demonstrate, in accordance with the performance measures described section 508(b), that at least 50 percent of the participants of such program were employed for at least 1 year in an
occupation related to the training provided under the program.

“(B) PRIORITY.—In renewing grants for providers who meet the requirement described in subparagraph (A), the Secretary shall give priority to those providers that have the greatest percentage of participants who—

“(i) were employment for at least 1 year in an occupation related to the training provided under the program; and

“(ii) as a result of the training provided under the program—

“(I) have the highest income levels; and

“(II) the lowest percentage of participants receiving Federal assistance.

“(b) EXCEPTIONS.—Subsection (a) shall not apply to State allotments made under sections 127 and 132.

“(c) ENROLLMENT PROHIBITION AND REQUIREMENT.—

“(1) PROHIBITION.—A provider of a job training program under this Act may not in any way limit recruitment for, or enrollment in, such program to individuals who are more likely to be suc-
successful in obtaining employment or earning a higher income after the completion of the program, as compared to other individuals.

“(2) REQUIREMENT.—An individual who participates in, or receives any service under, a training program shall be considered to be enrolled as a participant in the program.

“(d) DEFINITIONS.—For purposes of this section and section 508:

“(1) FEDERAL ASSISTANCE.—

“(A) IN GENERAL.—The term ‘Federal assistance’ includes—

“(i) supplemental nutrition assistance authorized under the Food and Nutrition Act of 2008 (7 U.S.C. 2011 et seq.);

“(ii) the case where a participant’s adjusted gross income (or, if greater, earned income) for the most recently ended taxable year exceeds the amount of adjusted gross income, or earned income, as the case may be, which would cause the credit allowable to the participant for such taxable year under paragraph (1) of section 32(a) of the Internal Revenue Code of
1986 to be reduced by reason of paragraph
(2) of such section;

“(iii) supplemental security income
benefits under title XVI of the Social Secu-
rit y Act (42 U.S.C. 1382 et seq.);}

“(iv) assistance under the State med-
icaid program under title XIX of the Social
Security Act (42 U.S.C. 1396 et seq.); and

“(v) benefits under the temporary as-
assistance for needy families program funded
under part A of title IV of the Social Secu-
rit y Act (42 U.S.C. 601 et seq.).

“(B) DEFINED TERMS.—The terms ‘ad-
justed gross income’, ‘earned income’, and
‘phaseout amount’ shall have the respective
meanings given such terms by section 32 of the

“(2) JOB TRAINING PROGRAM.—The term ‘job
training program’ includes the following programs:

“(A) Programs for migrant youth author-
ized under section 127.

“(B) Native American Programs author-
ized under section 166.

“(C) Migrant and seasonal farm workers
programs authorized under section 167.
“(D) Youth Opportunity Grant authorized under section 169.

“(E) Grants to States for Incarcerated Youth Offenders authorized under section 171.

“(F) Programs for the reintegration of ex-offenders authorized under section 171.

“(G) Responsible Reintegration of Youth Offenders program authorized under section 171.

“(H) Program of Competitive Grants for Worker Training and Placement in High Growth and Emerging Industry Sectors authorized under section 171.

“(I) Energy Efficiency and Renewable Worker Training Programs authorized under section 171(e).

“(J) Youthbuild Program authorized under section 173A.

“(K) Veterans’ Workforce Investment Program authorized under section 168.

“(L) The program of workforce investment activities for youth authorized under chapter 4 of subtitle B of title I.
“(M) The program of workforce investment activities for adults authorized under chapter 5 of subtitle B of title I.

“(N) The program of workforce investment activities for dislocated workers under chapter 5 of subtitle B of title I.

“(O) Job Corps program authorized under subtitle C of title I.

“(P) The Adult Education and Family Literacy Act authorized under title II.

“(3) PARTICIPANT.—The term ‘participant’ means an individual who participated in, or received a service under, a job training program that is funded under this Act.

“(4) PROVIDER.—The term ‘provider’—

“(A) has the meaning given the term ‘eligible provider’ in section 101(12);

“(B) has the meaning given the term ‘service provider’ in section 142(10); and

“(C) means any other agency, entity, or provider that is responsible for administering, or carrying out, a job training program under this Act.
"SEC. 508. PERFORMANCE MEASURES FOR JOB TRAINING PROGRAMS.

(a) In General.—Notwithstanding any other provision of law, each provider of a job training program under this Act shall, annually—

"(1) use the performance measures described in subsection (b) to assess the effectiveness of such job training program; and

"(2) submit the results of such assessment to the Secretary.

(b) Performance Measures.—In carrying out the assessment described in subsection (a), a provider of a job training program shall include the following performance measures in the assessment:

"(1) The type of job training each participant received under the program and the program costs (such as tuition and fees) for each participant.

"(2) The employment status of each participant—

"(A) 1 year after the participant completes the program;

"(B) 3 years after the participant completes the program; and

"(C) 5 years after the participant completes the program."
“(3) The percentage and number of participants who obtained employment after the completion of the program in an occupation related to the training provided under the program.

“(4) The income level of each participant—

“(A) 2 years prior to participating in the program; and

“(B) every year, up to 5 years, after participation in the program.

“(5) The percentage and number of participants receiving Federal assistance—

“(A) prior to participating in the program; and

“(B) every year, up to 5 years, after participation in the program.

“(c) RULE OF CONSTRUCTION.—Nothing in this section shall be construed to prohibit a provider of a job training program from assessing the program by using (in addition to the performance measures described in subsection (b)) a performance measure—

“(1) not described in subsection (b); or

“(2) that was being used by the provider on the day before the date of the enactment of this section.

“(d) AUDITS.—
“(1) IN GENERAL.—The Inspector General of the Department of Labor and the Comptroller General of the United States shall conduct periodic audits to ensure that providers of job training programs are—

“(A) accurately assessing the programs, including the outcomes of all participants of such programs, using the performance measures required under this section; and

“(B) in compliance with section 507(c).

“(2) REQUIREMENTS.—

“(A) IN GENERAL.—In carrying out any audit under this section (other than any initial audit survey or any audit investigating possible criminal or fraudulent conduct), either directly or through grant or contract, the Inspector General of the Department of Labor and the Comptroller General of the United States shall furnish to the providers of job training programs, or other entity to be audited, advance notification of the overall objectives and purposes of the audit, and any extensive record-keeping or data requirements to be met, not later than 14 days (or as soon as practicable), prior to the commencement of the audit.
“(B) Notification requirement.—If the scope, objectives, or purposes of the audit change substantially during the course of the audit, the entity being audited shall be notified of the change as soon as practicable.

“(C) Additional requirement.—The reports on the results of such audits shall cite the law, regulation, policy, or other criteria applicable to any finding contained in the reports.

“(D) Rule of construction.—Nothing contained in this title shall be construed so as to be inconsistent with the Inspector General Act of 1978 (5 U.S.C. App.) or government auditing standards issued by the Comptroller General of the United States.”.

SEC. 704. OTHER JOB TRAINING PROGRAMS.

(a) In general.—The appropriate Secretaries shall—

(1) require that the providers of job training programs, as such term is defined by such Secretaries, under the programs described in subsection (b), conduct an annual assessment of the programs in accordance with section 508(b) of the Workforce Investment Act of 1998; and
(2) award grants under the programs described in subsection (b) on a competitive basis.

(b) JOB TRAINING PROGRAMS.—Subsection (a) shall apply to the following programs:

(1) The Disabled Veterans Outreach Program authorized under section 4103A of title 38, United States Code.

(2) The Local Veterans’ Employment Representative Program authorized under section 4104 of title 38, United States Code.

(3) The Homeless Veterans’ Reintegration Program authorized under section 2021 of title 38, United States Code.

(4) Vocational Rehabilitation for Disabled Veterans authorized under chapter 31 of title 38, United States Code.


(6) The Older American Community Service Program authorized under title V of the Older Americans Act of 1965 (42 U.S.C. 3056 et seq.).

(7) The Native American Vocational and Technical Education Program authorized under section


(14) Vocational Rehabilitation Services authorized under title I of the Rehabilitation Act of 1973 (29 U.S.C. 720 et seq.).


(17) Programs authorized under the Community Services Block Grant Act (42 U.S.C. 9901 et seq.).

(18) The Tribal Work Grants program authorized under section 412(a)(2) of Social Security Act (42 U.S.C. 612(a)(2)).

(19) Job training grants authorized under section 414(c) of the American Competitiveness and Workforce Improvement Act of 1998 (29 U.S.C. 2916a).

(20) Indian Employment, Job Placement Assistance, and Vocational Training programs authorized under the Indian Self-Determination Act (25 U.S.C. 450 et seq.).
(21) Programs authorized under part A of title IV of the Social Security Act (42 U.S.C. 601 et seq.).

(22) Refugee assistance programs authorized under chapter 2 of title IV of the Immigration and Nationality Act (8 U.S.C. 1521 et seq.).

(23) Targeted assistance programs for refugees and entrants authorized under chapter 2 of title IV of the Immigration and Nationality Act (8 U.S.C. 1521 et seq.).

(24) Programs authorized under section 16(h) of the Food and Nutrition Act of 2008 (7 U.S.C. 2025(h)).

(25) The Federal Prisoner Reentry Initiative authorized under section 231(i) of Second Chance Act of 2007 (42 U.S.C. 17541(i)).

(26) Employment services authorized under the Wagner-Peyser Act of 1933 (29 U.S.C. 49 et seq.).


(e) DEFINITION.—The term “appropriate Secretary” means the head of the Federal agency who exercises ad-
ministrative authority over a program described in sub-
section (b).

SEC. 705. TRANSPARENCY.

Section 136(d)(3)(A) of the Workforce Investment
Act of 1998 (29 U.S.C. 2871) is amended to read as fol-
lows:

“(A) shall make available to the general
public the information contained in such reports
and the results of an assessment using the per-
formance measures described in section 508(b)
with respect to the workforce investment activi-
ties authorized under this subtitle—

“(i) through publication; and

“(ii) by posting such information and
results on the Internet website of the De-
partment of Labor in a format and lan-
guage understandable by the general pub-
lic.”.

SEC. 706. EVALUATIONS.

(a) EVALUATIONS.—Section 172 of the Workforce
Investment Act of 1998 (29 U.S.C. 2917) is amended—
(1) in subsection (a)—

(A) in the matter preceding paragraph
(1)—
(i) by inserting “impact” after “continuing”; and

(ii) by inserting “impact” after “Such”; and

(B) in paragraph (1)—

(i) by striking “the general effectiveness” and inserting “outcomes measuring of the effectiveness”;

(ii) in subparagraph (A), by striking “and” after the semicolon;

(iii) in subparagraph (B)—

(I) by striking “to the extent feasible,”; and

(II) by inserting “and” after the semicolon; and

(iv) by adding at the end the following:

“(C) increase the incomes and hourly wages of participants in comparison to similarly situated individuals who did not participate in such programs and activities.”;

(2) in subsection (b), by inserting “impact” after “conduct”;

(3) in subsection (c)—
(A) by striking “Evaluations” and inserting “Impact evaluations”;

(B) by inserting “intervention and” after “, including the use of”;

(C) by inserting “The Secretary for each impact evaluation shall fulfill all the notification and reporting requirements under subsections (d), (e), and (f).” after “assignment methodologies.”; and

(D) by striking “by the end of fiscal year 2005” and inserting “not later than 3 years after the date of the enactment of the Job Training Results Act of 2010”;

(4) by redesignating subsections (c) through (f), as subsections (d) through (g), respectively; and

(5) by inserting after subsection (c), the following:

“(a) Notification of Impact Evaluation Progress.—

“(1) Reports to Congress.—Not later than 1 year after the date of the enactment of the Job Training Results Act of 2010, and annually thereafter, the Secretary shall transmit to the Committee on Education and the Labor, and the Committee on the Budget, of the House of Representatives and the
Committee on Health, Education, Labor, and Pensions, and the Committee on Budget, of the Senate a report on the progress the Secretary is making in evaluating the programs and activities carried out under this section.

“(2) AVAILABILITY TO GENERAL PUBLIC.—Not later than 1 year after the date of the enactment of the Job Training Results Act of 2010, and annually thereafter not later than 30 days after the transmission of an annual report under paragraph (1), the Secretary shall make available the reports to the general public on the Internet website of the Department of Labor.”;

(6) by amending subsection (e) (as so redesignated), by inserting “impact” after “carrying out an”;

(7) by amending subsection (f) (as so redesignated)—

(A) by striking “Workforce” and inserting “, Labor and the Committee on the Budget,”; 

(B) by striking “Committee on Labor and Human Resources” and inserting “Committee on Health, Education, Labor, and Pensions, and the Committee on Budget,”;
(C) by striking “30 days” and inserting “60 days”; and

(D) by inserting the following: “All reports transmitted under this subsection shall be made available to the general public on the Internet website of the Department of Labor.”; and

(8) by adding at the end the following:

“(h) GAO REPORT.—Not later than 3 years after the date of the enactment of the Job Training Results Act of 2010, and every 3 years thereafter, the Comptroller General of the United States shall conduct a study and submit a report to Congress that evaluates—

“(1) the effectiveness of the impact evaluations conducted under this section; and

“(2) the impact of such evaluations on the assessments conducted under section 508(b) with respect to the programs and activities carried out under this title.

“(i) DEFINITIONS.—In this section:

“(1) IMPACT EVALUATION.—The term ‘impact evaluation’ means an evaluative study that evaluates, in accordance with subsection (a), the outcomes of programs and activities carried out under this title, including the impact on social conditions such programs and activities are intended to improve.
“(2) **Scientific random assignment methodologies.**—The term ‘scientific random assignment methodologies’ means research designs conducted in program settings in which intervention and control groups are—

“(A) formed by random assignment; and

“(B) compared on the basis of outcome measures for the purpose of determining the impact of the programs and activities carried out under this title on participants.

“(3) **Control group.**—The term ‘control group’ means a group of individuals—

“(A) who did not participate in the programs and activities carried out under this title; and

“(B) whose outcome measures are compared to the outcome measures of individuals in an intervention group.

“(4) **Intervention group.**—The term ‘intervention group’ means a group of individuals—

“(A) who participated in the programs and activities carried out under this title; and

“(B) whose outcome measures are compared to the outcome measures of individuals in a control group.”.
SEC. 707. ENCOURAGING INNOVATION.

(a) STATE BLOCK GRANT.—Section 192 (29 U.S.C. 2942) is amended to read as follows:

"SEC. 192. JOB TRAINING IMPROVEMENT PLAN.

“(a) STATE BLOCK GRANT.—

“(1) IN GENERAL.—Not earlier than 1 year of the date of the enactment of the ‘Job Training Results Act of 2010’, a State may submit to the Secretary, and the Secretary (in cooperation with the appropriate Secretaries) may approve a Job Training Improvement Plan (in this section referred to as a ‘Plan’) submitted by a State pursuant to subsection (d) under which the State is authorized to—

“(A) integrate any of the funds that the State is eligible to receive under the job training programs described in subsection (g) to improve job training results in the State; and

“(B) waive, in accordance with the Plan and except as otherwise indicated in this subsection, any of the statutory and regulatory requirements—

“(i) applicable under this title to local areas; and

“(ii) applicable under the programs described in subsection (g), the funds of
which will be integrated under a Plan submitted under this section.

“(2) ELIGIBILITY.—In order for a State’s Plan to be approved under this section, the providers of training programs in the State shall have carried out at least 1 assessment pursuant to section 508 with respect to such programs.

“(b) PERIODS.—

“(1) IN GENERAL.—The Secretary (in cooperation with other appropriate Secretaries) may—

“(A) approve a State’s Plan under this section for a period of not more than 3 years; and

“(B) renew a State’s Plan under this section for additional 3-year periods if the State demonstrates a significant improvement in job training results at the end of the preceding 3-year period.

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

“(1) JOB TRAINING RESULTS.—

“(A) IN GENERAL.—The term ‘job training results’ means an improvement in the assessment carried out pursuant to section 508 with respect to the job training programs conducted in a State, as compared to the assessment of
such programs carried out in the most recent preceding fiscal year.

“(B) IMPROVEMENTS.—An improvement in an assessment described in subparagraph (A) shall include—

“(i) an increase in the percentage of participants—

“(I) who were employed for at least 1 year in an occupation related to the training provided under the program;

“(II) who are employed at higher income levels; and

“(ii) a decrease in the percentage of participants who are receiving Federal assistance

“(2) APPROPRIATE SECRETARY.—The term ‘appropriate Secretary’ means the head of the Federal agency who exercises administrative authority over a program described in subsection (g).

“(d) CONTENTS OF PLAN.—To have a Plan approved under this subsection, a State, after consultation with State and local workforce investment boards, shall submit a Plan to the Secretary at such time, in such manner,
and containing such information as the Secretary may re-
quire, including—

“(1) identification of the funds the State is eli-
gible to receive under the job training programs de-
scribed in subsection (g) that will be integrated;

“(2) a description of how the Plan, including
how the integration of funds under the Plan will re-
sult in a significant improvement in job training re-
sults in the State;

“(3) a description of how the State will main-
tain accurate records of the performance measures
for the assessments required pursuant to section
508;

“(4) assurances that in carrying out the Plan—

“(A) the State will serve populations con-
sistent with the populations served by the funds
which are being integrated, and will provide
such populations universal access to work ready
services as described in section 134(d)(2) of
this Act;

“(B) of the funds expended under the plan
each fiscal year, not more than 10 percent of
such funds will be expended on the costs of ad-
ministration (as defined by the Secretary); and
“(C) the State will comply with requirements under this title and the programs to be integrated relating to wage and labor standards (including nondisplacement provisions), grievance procedures and judicial review, and nondiscrimination;

“(5) identification of private resources that will be used to assist in improving job training results; and

“(6) a description of the job training awareness campaign that the State will carry out as part of such Plan.

“(e) INTEGRATION OF JOB TRAINING PROGRAMS AUTHORIZED.—

“(1) AUTHORIZATION FOR INTEGRATION.—In carrying out this subsection, the Secretary, in cooperation with the appropriate Secretaries, shall, upon the approval of the Plan submitted under subsection (d), authorize a State to integrate, as described in paragraph (2) the portion of the funds the State is eligible to receive under the programs described in subsection (g) to assist in implementing such Plan.
“(2) INTEGRATION.—The authorization shall give the State the authority to integrate, in accord-
ance with the State’s Plan, funds the State—

“(A) is eligible to receive under the pro-
grams described in subsection (g); and

“(B) has identified under the Plan as
funds to be integrated.

“(f) EFFECT ON PROGRAM REQUIREMENTS.—The State may use the integrated funds used to carry out any of the activities authorized under any of the programs de-
scribed in subsection (g), but shall not be required to carry out any requirements of the statutes authorizing the pro-
grams, except as otherwise specified in this section.

“(g) JOB TRAINING PROGRAMS.—Funds that shall be made available for integration under an approved Plan are funds provided under the following programs:

“(1) Programs for migrant youth authorized under section 127.

“(2) Native American Programs authorized under section 166.

“(3) Migrant and seasonal farm workers pro-
grams authorized under section 167.

“(4) Youth Opportunity Grant authorized under section 169.
“(5) Grants to States for Incarcerated Youth Offenders authorized under section 171.

“(6) Programs for the reintegration of ex-offenders authorized under section 171.

“(7) Responsible Reintegration of Youth Offenders program authorized under section 171.

“(8) Program of Competitive Grants for Worker Training and Placement in High Growth and Emerging Industry Sectors authorized under section 171.

“(9) Energy Efficiency and Renewable Worker Training Programs authorized under section 171(e).

“(10) Youthbuild Program authorized under section 173A.

“(11) Veterans’ Workforce Investment Program authorized under section 168.

“(12) The program of workforce investment activities for youth authorized under chapter 4 of subtitle B of title I.

“(13) The program of workforce investment activities for adults authorized under chapter 5 of subtitle B of title I.

“(14) The program of workforce investment activities for dislocated workers under chapter 5 of subtitle B of title I.
“(15) The Adult Education and Family Literacy Act authorized under title II.

“(16) The Disabled Veterans Outreach Program authorized under section 4103A of title 38, United States Code.

“(17) The Local Veterans’ Employment Representative Program authorized under section 4104 of title 38, United States Code.


“(19) Vocational Rehabilitation for Disabled Veterans authorized under chapter 31 of title 38, United States Code.


“(21) The Older American Community Service Program authorized under title V of the Older Americans Act of 1965 (42 U.S.C. 3056 et seq.).


“(29) Vocational Rehabilitation Services authorized under title I of the Rehabilitation Act of 1973 (29 U.S.C. 720 et seq.).


“(32) Programs authorized under the Community Services Block Grant Act (42 U.S.C. 9901 et seq.).

“(33) The Tribal Work Grants program authorized under section 412(a)(2) of Social Security Act (42 U.S.C. 612(a)(2)).

“(34) Job training grants authorized under section 414(c) of the American Competitiveness and Workforce Improvement Act of 1998 (29 U.S.C. 2916a).

“(35) Indian Employment, Job Placement Assistance, and Vocational Training programs authorized under the Indian Self-Determination Act (25 U.S.C. 450 et seq.).
“(36) Programs authorized under part A of title IV of the Social Security Act (42 U.S.C. 601 et seq.).

“(37) Refugee assistance programs authorized under chapter 2 of title IV of the Immigration and Nationality Act (8 U.S.C. 1521 et seq.).

“(38) Targeted assistance programs for refugees and entrants authorized under chapter 2 of title IV of the Immigration and Nationality Act (8 U.S.C. 1521 et seq.).

“(39) Programs authorized under section 16(h) of the Food and Nutrition Act of 2008 (7 U.S.C. 2025(h)).

“(40) The Federal Prisoner Reentry Initiative authorized under section 231(i) of Second Chance Act of 2007 (42 U.S.C. 17541(i)).

“(41) Employment services authorized under the Wagner-Peyser Act of 1933 (29 U.S.C. 49 et seq.).


“(h) PERFORMANCE MEASURES AND REPORTING.—
“(1) Performance Measures.—Each State with an approved Plan under this section shall carry out an assessment pursuant to section 508 of all the job training programs conducted in such State that receive funding under the Plan for each fiscal year the Plan is approved under this section.

“(2) Reporting.—Each State with an approved Plan under this section shall ensure that records are maintained and reports are submitted, in such form and containing such information, as the Secretary may require regarding the performance of job training programs funded pursuant to this section.

“(i) Technical Assistance and Evaluation.—

“(1) Technical Assistance.—The Secretary shall provide such staff training, technical assistance, and other activities as the Secretary deems appropriate to support the implementation of this section.

“(2) Evaluation.—The Secretary may require that States with an approved Plan under this section participate in an evaluation of job training programs funded pursuant to this subsection, including an evaluation using the techniques described in section 172(e).
“(j) Plan Review.—

“(1) In general.—Upon receipt of a Plan from the Governor, the Secretary shall consult with the appropriate Secretaries in reviewing and approving such plan. Such plan shall be approved if it meets the requirements described in subsection (d).

“(2) Plan approval.—

“(A) 90-day period.—Subject to subparagraph (B), a Plan that is submitted to the Secretary under this section shall be considered to be approved by the Secretary at the end of the 90-day period beginning on the day the Secretary receives the Plan, unless the Secretary denies the Plan during the 90-day period.

“(B) 30-day extensions.—If the Secretary is in good faith negotiations with a State with respect to the State’s Plan—

“(i) at the end of the 90-day period described in subparagraph (A), the Secretary may have an additional 30 days to determine whether to approve the Plan; or

“(ii) at the end of the 30 days described in clause (i), the Secretary may have an additional 30 days to determine whether to approve the Plan.
“(3) PLAN DENIAL.—In the case where the Secretary denies a Plan submitted by a State under this section, the Secretary shall—

“(A) provide a written explanation to the State for the denial of the Plan; and

“(B) make such written explanation accessible to the general public.

“(k) FEDERAL RESPONSIBILITIES.—

“(1) INTERAGENCY MEMORANDUM OF UNDERSTANDING.—Within 90 days following the date of enactment of this section, the Secretary and the appropriate Secretaries shall enter into an interdepartmental memorandum of agreement providing for the implementation of the Plans with respect to the integration of funds administered by each Secretary.

“(2) INTERAGENCY FUNDS TRANSFERS AUTHORIZED.—The Secretary and the appropriate Secretaries responsible for the programs that are included in a Plan approved are authorized to take such action as may be necessary to provide for intra-agency or interagency transfers of funds otherwise available to a State in order to further the purposes of this section.”.
SEC. 708. MAKING WIA TRAINING VOUCHERS MORE ACCESSIBLE AND FLEXIBLE.

(a) USE OF FUNDS FOR EMPLOYMENT AND TRAINING ACTIVITIES.—

(1) WORK READY SERVICES.—Section 134(d)(2) (29 U.S.C. 2864(c)(2)) is amended—

(A) in the heading, by striking “CORE SERVICES” and inserting “WORK READY SERVICES”;

(B) by striking “core services” and inserting “work ready services”;

(C) by striking “paragraph (1)(A)” and inserting “paragraph (1)(A)(i)”;

(D) by striking “who are adults or dislocated workers”;

(E) in subparagraph (A), by inserting “and assistance in obtaining eligibility determinations under the other one-stop partner programs through such activities as assisting in the submission of applications, the provision of information on the results of such applications, the provision of intake services and information, and, where appropriate and consistent with the authorizing statute of the one-stop partner program, determinations of eligibility” after “sub-
(F) by amending subparagraph (D) to read as follows:

“(D) labor exchange services, including—

“(i) job search and placement assistance, and where appropriate career counseling;

“(ii) appropriate recruitment services for employers, including small employers, in the local area, which may include services described in this subsection, including information and referral to specialized business services not traditionally offered through the one-stop delivery system; and

“(iii) reemployment services provided to unemployment claimants, including claimants identified as in need of such services under the worker profiling system established under section 303(j) of the Social Security Act (42 U.S.C. 503(j));”;

(G) in subparagraph (I), by inserting “and the administration of the work test for the unemployment compensation system” after “compensation”; and

(H) by striking subparagraph (H) and inserting the following:
“(H) provision of accurate information, in formats that are usable and understandable to all one-stop center customers, relating to the availability of supportive services or assistance, including child care, child support, medical or child health assistance under title XIX or XXI of the Social Security Act (42 U.S.C. 1396 et seq. and 1397aa et seq.), benefits under the Food Stamp Act of 1977 (7 U.S.C. 2011 et seq.), the earned income tax credit under section 32 of the Internal Revenue Code of 1986, and assistance under a State program funded under part A of title IV of the Social Security Act (42 U.S.C. 601 et seq.) and other supportive services and transportation provided through funds made available under such part, available in the local area, and referral to such services or assistance as appropriate;”; and

(I) by amending subparagraph (J) to read as follows:

“(J) assistance in establishing eligibility for programs of financial aid assistance for training and education programs that are not funded under this Act and are available in the local area; and”; and
(J) by redesignating subparagraph (K) as subparagraph (M); and

(K) by inserting the following new subparagraphs after subparagraph (J):

“(K) the provision of information from official publications of the Internal Revenue Service, regarding Federal tax credits available to individuals relating to education, job training and employment, including the Hope Scholarship Credit and the Lifetime Learning Credit (26 U.S.C. 25A), and the Earned Income Tax Credit (26 U.S.C. 32);

“(L) services relating to the Work Opportunity Tax Credit (26 U.S.C. 51);

“(M) comprehensive and specialized assessments of the skill levels and service needs of adults and dislocated workers, which may include—

“(i) diagnostic testing and use of other assessment tools; and

“(ii) in-depth interviewing and evaluation to identify employment barriers and appropriate employment goals;

“(N) development of an individual employment plan, to identify the employment goals,
appropriate achievement objectives, and appropriate combination of services for the participation to achieve the employment goals;

“(O) group counseling;

“(P) individual counseling and career planning;

“(Q) case management;

“(R) short-term prevocational services, including development of learning skills, communications skills, interviewing skills, punctuality, personal maintenance skills, and professional conduct, to prepare individuals for unsubsidized employment or training;

“(S) internships and work experience;

“(T) literacy activities relating to basic work readiness, information and communication technology literacy activities, and financial literacy activities, if such activities are not available to participants in the local area under programs administered under the Adult Education and Family Literacy Act (20 U.S.C. 2901 et seq.); and

“(U) out-of-area job search assistance and relocation assistance.”.
(L) Delivery of services.—Section 134(c)(3) (29 U.S.C. 2864(c)(3)) is amended to read as follows:

“(3) Delivery of services.—The work ready services described in paragraph (M) through (U) shall be provided through the one-stop delivery system and may be provided through contracts with public, private for-profit, and private nonprofit service providers, approved by the local board.”.

(M) Training services.—Section 134(c)(4) is amended—

(i) by amending subparagraph (A) to read as follows:

“(A) In general.—Funds allocated to a local area under section 133(b) shall be used to provide training services to adults who—

“(i) after an interview, evaluation, or assessment, and case management, have been determined by a one-stop operator or one-stop partner, as appropriate, to—

“(I) be in need of training services to obtain or retain suitable employment; and

“(II) have the skills and qualifications to successfully participate in
the selected program of training services;

“(ii) select programs of training services that are directly linked to the employment opportunities in the local area involved or in another area in which the adults receiving such services are willing to commute or relocate;

“(iii) who meet the requirements of subparagraph (B); and

“(iv) who are determined eligible in accordance with the priority system in effect under subparagraph (E).”;

(ii) in subparagraph (B)(i), by striking “Except” and inserting “Notwithstanding section 479B of the Higher Education Act of 1965 (20 U.S.C. 1087uu) and except”;

(iii) by amending subparagraph (D) to read as follows:

“(D) TRAINING SERVICES.—Training services authorized under this paragraph may include—

“(i) occupational skills training;

“(ii) on-the-job training;
“(iii) skill upgrading and retraining;
“(iv) entrepreneurial training;
“(v) education activities leading to a high school diploma or its equivalent, including a General Educational Development credential, in combination with, concurrently or subsequently, occupational skills training;
“(vi) adult education and literacy activities provided in conjunction with other training authorized under this subparagraph;
“(vii) workplace training combined with related instruction; and
“(viii) occupational skills training that incorporates English language acquisition.”;

(iv) by amending subparagraph (E) to read as follows:
“(E) Priority.—
“(i) In general.—A priority shall be given to dislocated workers or workers who are in danger of being dislocated for the provision of intensive and training services under this subsection.
“(ii) DETERMINATIONS.—The Governor and the appropriate local board shall direct the one-stop operators in the local area with regard to making determinations with respect to the priority of service under this subparagraph.”;

(v) in subparagraph (F), by striking clause (iii) and inserting the following:

“(iii) ENHANCED INDIVIDUAL TRAINING ACCOUNTS.—An individual who seeks training services and who is eligible pursuant to subparagraph (A), may, in consultation with a case manager, select an eligible provider of training services from the list or identifying information for providers described in clause (ii)(I). Upon such selection, the one-stop operator involved shall, to the extent practicable, refer such individual to the eligible provider of training services, and arrange for payment for such services through a enhanced individual training account.

“(iv) COORDINATION.—Each local board may, through one-stop centers, coordinate enhanced individual training ac-
counts with other Federal, State, local, or private job training programs or sources to assist the individual in obtaining training services.

“(v) Enhanced Individual Training Accounts.—Each local board may, through one-stop centers, assist individuals receiving enhanced individual training accounts through the establishment of such accounts that include, in addition to the funds provided under this paragraph, funds from other programs and sources that will assist the individual in obtaining training services.”; and

(vi) in subparagraph (G)—

(I) in the subparagraph heading, by striking “INDIVIDUAL TRAINING ACCOUNTS” and inserting “ENHANCED INDIVIDUAL TRAINING ACCOUNTS”;

(II) in clause (i) by striking “individual training accounts” and inserting “enhanced individual training accounts”; and

(III) in clause (ii)—
(aa) by striking “an individual training account” and inserting “an enhanced individual training account”;

(bb) in subclause (II), by striking “individual training accounts” and inserting “enhanced individual training accounts”;

(cc) in subclause (II) by striking “or” after the semicolon;

(dd) in subclause (III) by striking the period and inserting “; or”; and

(ee) by adding at the end of the following:

“(IV) The local board determines that it would be most appropriate to award a contract to an institution of higher education in order to facilitate the training of multiple individuals in high-demand occupations, if such contract does not limit customer choice.”.

(IV) in clause (iv)—

(aa) by redesignating subclause (IV) as subclause (V) and
inserting after subclause (III) the following:

“(IV) Individuals with disabilities.”.

(2) PERMISSIBLE ACTIVITIES.—Section 134(c) is amended by amending paragraph (1) to read as follows:

“(1) DISCRETIONARY ONE-STOP DELIVERY ACTIVITIES.—

“(A) IN GENERAL.—Funds allocated to a local area under section 133(b) may be used to provide, through the one-stop delivery system—

“(i) customized screening and referral of qualified participants in training services to employers;

“(ii) customized employment-related services to employers on a fee-for-service basis;

“(iii) customer support to navigate among multiple services and activities for special participant populations that face multiple barriers to employment, including individuals with disabilities;

“(iv) employment and training assistance provided in coordination with child
support enforcement activities of the State agency carrying out subtitle D of title IV of the Social Security Act (42 U.S.C. 651 et seq.);

“(v) activities to improve services to local employers, including small employers in the local area, and increase linkages between the local workforce investment system and employers;

“(vi) activities to facilitate remote access to services provided through a one-stop delivery system, including facilitating access through the use of technology; and

“(vii) activities to carry out business services and strategies that meet the workforce investment needs of local area employers, as determined by the local board, consistent with the local plan under section 118, which services—

“(I) may be provided through effective business intermediaries working in conjunction with the local board, and may also be provided on a fee-for-service basis or through the leveraging of economic development
and other resources as determined appropria-
te by the local board; and

“(II) may include—

“(aa) identifying and dis-
seminating to business, edu-
cators, and job seekers, informa-
tion related to the workforce, eco-
omic and community develop-
ment needs, and opportunities of
the local economy;

“(bb) development and deliv-
ery of innovative workforce in-
vestment services and strategies
for area businesses, which may
include sectoral, industry cluster,
regional skills alliances, career
ladder, skills upgrading, skill
standard development and certifi-
cation, apprenticeship, and other
effective initiatives for meeting
the workforce investment needs
of area employers and workers;

“(cc) participation in semi-
nars and classes offered in part-
nership with relevant organiza-
tions focusing on the workforce-related needs of area employers and job seekers;

“(dd) training consulting, needs analysis, and brokering services for area businesses, including the organization and aggregation of training (which may be paid for with funds other than those provided under this title), for individual employers and coalitions of employers with similar interests, products, or workforce needs;

“(ee) assistance to area employers in the aversion of layoffs and in managing reductions in force in coordination with rapid response activities;

“(ff) the marketing of business services offered under this title, to appropriate area employers, including small and mid-sized employers;
“(gg) information referral on concerns affecting local employers; and

“(hh) other business services and strategies designed to better engage employers in workforce investment activities and to make the workforce investment system more relevant to the workforce investment needs of area businesses, as determined by the local board to be consistent with the objectives of this title.”.

SEC. 709. LIFE LONG LEARNING AWARENESS CAMPAIGNS.

(a) FEDERAL COMMUNICATIONS COMMISSION.—

(1) IN GENERAL.—The Federal Communications Commission shall require that each licensed broadcaster keep a record of the number and duration of public service announcements voluntarily broadcast with respect to the job training opportunities and services described in section 509 of the Workforce Investment Act of 1998.

(2) DEADLINE.—Not later than 90 days after the date of the enactment of this Act, the Federal Communications Commission shall take all actions
necessary to adopt a regulation to implement paragraph (1).

(3) REQUIREMENT.—The Federal Communications Commission shall consider the voluntary broadcast of any public service announcement described in paragraph (1) as—

(A) fulfilling part of a broadcaster’s obligation to serve the public interest; and

(B) demonstrating such service for the purposes of license renewal.

(b) JOB TRAINING PROVIDERS.—Title V of the Workforce Investment Act of 1998 (20 U.S.C. 9271 et seq.) is further amended by adding at the end the following:

“SEC. 509. PUBLIC SERVICE ANNOUNCEMENTS.

“(a) IN GENERAL.—Each provider of a job training program shall make periodic public service announcements to inform the general public about job training opportunities and services, including—

“(1) the availability of job training opportunities under the program;


“(3) the Job Corps centers;
“(4) the one-stop delivery systems; and
“(5) community colleges.
“(b) REGULATIONS.—The Secretary shall promul-
gate regulations to assist providers of job training pro-
grams in carrying out the requirements described in sub-
section (a). In promulgating such regulations, the Sec-
retary shall consider whether the requirements may be sat-
isfied by—
“(1) posting the required information on an
Internet Web site;
“(2) publishing the required information in a
newspaper; or
“(3) making an announcement containing the
required information on the television or radio.
“(c) DEFINITION.—The term ‘job training program’
has the meaning given such term in section 507(d).”.

SEC. 710. GAO REPORTS.

(a) IDENTIFYING DUPLICATION.—Not later than 1
year after the date of the enactment of this Act, the Com-
troller General of the United States shall conduct a study
and submit a report to Congress on job training programs
that—
(1) identifies duplications among such pro-
grams; and
(2) if applicable, recommends the consolidation of such programs.

(b) Effectiveness of Programs.—Not later than 2 years after the date of the enactment of this Act, and every 2 years thereafter, the Comptroller General of the United States shall conduct a study and submit a report to Congress that evaluates the effectiveness of job training programs based on the assessments of such programs carried out under section 508(b) of the Workforce Investment Act of 1998 (as amended by this Act).

c) Definition.—For purposes of this section, the term “job training program” has the meaning given such term in 507(d) of the Workforce Investment Act of 1998 (as amended by this Act).

TITLE VIII—SPENDING LIMITS AND DEFICIT CONTROL

SEC. 800. SHORT TITLE.

This title may be cited as the “Spending Enforcement and Control Act of 2010”.

Subtitle A—Spending Limits and Deficit Control

SEC. 801. DISCRETIONARY SPENDING LIMITS.

(a) Discretionary Spending Limits.—Section 251 of the Balanced Budget and Emergency Deficit Control of Act of 1985 is amended to read as follows:
“(a) DISCRETIONARY SPENDING LIMITS.—The fiscal years for the discretionary spending limits shall be as follows:

“(1) Fiscal year 2011: $1,203,000,000,000 in outlays.

“(2) Fiscal year 2012: $1,144,000,000,000 in outlays.

“(3) Fiscal year 2013: $1,143,000,000,000 in outlays.

“(4) Fiscal year 2014: $1,143,000,000,000 in outlays.

“(5) Fiscal year 2015: $1,149,000,000,000 in outlays.

“(6) Fiscal year 2016: $1,165,000,000,000 in outlays.

“(7) Fiscal year 2017: $1,176,000,000,000 in outlays.

“(8) Fiscal year 2018: $1,184,000,000,000 in outlays.

“(9) Fiscal year 2019: $1,202,000,000,000 in outlays.

“(b) SPENDING REDUCTION ORDER.—A spending reduction ordered shall be implemented using the procedures set forth in section 256.”.
(b) **CONFORMING AMENDMENT.**—The item relating to section 251 in the table of contents set forth in 250(e) of the Balanced Budget and Emergency Deficit Control Act of 1985 is amended to read as follows:

"Sec. 251. Discretionary spending limits."

**SEC. 802. TOTAL SPENDING LIMITS.**

(a) **TOTAL SPENDING LIMITS.**—After section 252 of the Balanced Budget and Emergency Deficit Control Act of 1985, add the following new section:

"**SEC. 252A. TOTAL SPENDING LIMITS.**"

"(a) **PROJECTIONS.**—"

"(1) **OMB REPORT.**—OMB shall prepare a report comparing projected total spending under section 257 and the total spending limits in subsection (d), and include such report in the budget as submitted by the President annually under section 1105(a) of title 31, United States Code.

"(2) **CBO REPORT.**—CBO shall prepare a report comparing projected total spending under section 257 and the total spending limits in subsection (d) and include such report in the CBO annual baseline and reestimate of the President’s budget.

"(3) **INCLUSION IN SPENDING REDUCTION ORDERS.**—Reports prepared pursuant to this subsection shall be included in the spending reduction report."
“(b) Spending Reduction Order.—A spending reduction order shall be implemented using the procedures set forth in section 256.

“(c) Fiscal Years of the Total Spending Period.—The fiscal years within the total spending period shall be as follows:

“(1) Fiscal year 2011: 22.8 percent.
“(2) Fiscal year 2012: 21.6 percent.
“(3) Fiscal year 2013: 21.8 percent.
“(4) Fiscal year 2014: 21.9 percent.
“(5) Fiscal year 2015: 21.7 percent.
“(6) Fiscal year 2016: 22.0 percent.
“(9) Fiscal year 2019: 22.3 percent.
“(10) Fiscal year 2020: 22.3 percent.
“(11) Fiscal year 2021: 22.4 percent.
“(12) Fiscal year 2022: 22.6 percent.
“(13) Fiscal year 2023: 22.8 percent.
“(14) Fiscal year 2024: 22.9 percent.
“(15) Fiscal year 2025: 22.9 percent.
“(16) Fiscal year 2026: 23.2 percent.
“(17) Fiscal year 2027: 23.5 percent.
“(18) Fiscal year 2028: 23.6 percent.
“(19) Fiscal year 2029: 23.7 percent.
‘‘(20) Fiscal year 2030: 23.8 percent.

‘‘(21) Fiscal year 2031: 23.9 percent.

‘‘(22) Fiscal year 2032: 24.0 percent.

‘‘(23) Fiscal year 2033: 24.1 percent.

‘‘(24) Fiscal year 2034: 24.1 percent.


‘‘(26) Fiscal year 2036: 24.1 percent.

‘‘(27) Fiscal year 2037: 24.1 percent.

‘‘(28) Fiscal year 2038: 23.9 percent.

‘‘(29) Fiscal year 2039: 23.7 percent.

‘‘(30) Fiscal year 2040: 23.5 percent.

‘‘(31) Fiscal year 2041: 23.5 percent.

‘‘(32) Fiscal year 2042: 23.4 percent.

‘‘(33) Fiscal year 2043: 23.1 percent.

‘‘(34) Fiscal year 2044: 23.0 percent.

‘‘(35) Fiscal year 2045: 22.7 percent.

‘‘(36) Fiscal year 2046: 22.4 percent.

‘‘(37) Fiscal year 2047: 22.2 percent.

‘‘(38) Fiscal year 2048: 21.9 percent.

‘‘(39) Fiscal year 2049: 21.7 percent.

‘‘(40) Fiscal year 2050: 21.6 percent.

‘‘(41) Fiscal year 2051: 21.4 percent.

‘‘(42) Fiscal year 2052: 21.2 percent.

‘‘(43) Fiscal year 2053: 20.9 percent.

‘‘(44) Fiscal year 2054: 20.9 percent.
“(45) Fiscal year 2055: 20.6 percent.
“(46) Fiscal year 2056: 20.3 percent.
“(47) Fiscal year 2057: 20.1 percent.
“(48) Fiscal year 2058: 20.0 percent.
“(49) Fiscal year 2059: 19.7 percent.
“(50) Fiscal year 2060: 19.6 percent.
“(51) Fiscal year 2061: 19.4 percent.
“(52) Fiscal year 2062: 19.2 percent.
“(53) Fiscal year 2063: 18.9 percent.
“(54) Fiscal year 2064: 18.8 percent.
“(55) Fiscal year 2065: 18.4 percent.
“(56) Fiscal year 2066: 18.2 percent.
“(57) Fiscal year 2067: 18.1 percent.
“(58) Fiscal year 2068: 17.6 percent.
“(59) Fiscal year 2069: 17.5 percent.
“(60) Fiscal year 2070: 17.1 percent.
“(61) Fiscal year 2071: 16.8 percent.
“(62) Fiscal year 2072: 16.6 percent.
“(63) Fiscal year 2073: 16.2 percent.
“(64) Fiscal year 2074: 16.0 percent.
“(65) Fiscal year 2075: 15.6 percent.
“(66) Fiscal year 2076: 15.4 percent.
“(67) Fiscal year 2077: 15.0 percent.
“(68) Fiscal year 2078: 14.7 percent.
“(69) Fiscal year 2079: 14.3 percent.
“(70) Fiscal year 2080: 14.0 percent.
“(71) Fiscal year 2081: 13.6 percent.
“(72) Fiscal year 2082: 13.4 percent.
“(73) Fiscal year 2083: 13.0 percent.”.

(b) DEFINITIONS.—Section 3 of the Congressional Budget and Impoundment Control Act of 1974 (2 U.S.C. 622) is amended by adding at the end the following new paragraph:

“(11) The term ‘total spending’ means all outlays of the Federal Government including those from off-budget entities and budget authority and outlays flowing therefrom, as applicable, designated as emergencies.”.

(e) CONFORMING AMENDMENT.—The table of contents set forth in 250(c) of the Balanced Budget and Emergency Deficit Control Act of 1985 is amended by inserting after the item relating to section 252A the following new item:

“Sec. 252A. Total spending limits.”.

Subtitle B—Reports and Orders

SEC. 811. REPORTS AND ORDERS.

Section 254 of the Balanced Budget and Emergency Deficit Control Act of 1985 is amended to read as follows:

“SEC. 254. REPORTS AND ORDERS.

“(a) TIMETABLE.—

“Date: Action to be completed:

•HR 4529 IH
5 days before the President’s budget submission.
CBO sequestration preview report.

President’s budget submission ...
OMB sequestration preview report.

August 10 ..............................
CBO sequestration update report.

August 20 ..............................
OMB sequestration update report.

10 days after end of session ..... CBO sequestration final report.

15 days after end of session ..... OMB sequestration final report; Presidential order.

“(b) Submission and Availability of Reports.—

Each report required by this section shall be submitted to the Committees on the Budget of the House of Representatives and the Senate. On the following day a notice of the report shall be printed in the Federal Register.

“(c) Sequestration Preview Report.—

“(1) Reporting requirement.—On the dates specified in subsection (a), OMB and CBO shall issue a preview report regarding discretionary limits and total spending limits, sequestration based on laws enacted through those dates.

“(2) Discretionary Spending Limit Sequestration Report.—The preview report shall set forth for the current year and the budget year the following:

“(A) The discretionary spending limit;

“(B) The estimated discretionary spending amount; and

“(C) The amount of reductions required under section 251.
“(3) Total spending limit sequestration report.—The preview reports shall set forth for the budget year estimates for the following:

“(A) The total spending limit;

“(B) The estimated total spending amount; and

“(C) The amount of reductions required under section 252A.

“(4) Explanation of differences.—The OMB reports shall explain the differences between OMB and CBO estimates for each item set forth in this subsection.

“(d) Sequestration update report.—On the dates specified in subsection (a), OMB and CBO shall issue a sequestration update report, reflecting laws enacted through those dates, containing all of the information required in the sequestration preview report.

“(e) Sequestration final report.—

“(1) Reporting requirement.—On the dates specified in subsection (a), OMB and CBO shall issue a sequestration final report, reflecting laws enacted through those dates, containing all of the information required in the sequestration preview report.
“(2) PRESIDENTIAL ORDER.—On the date specified in subsection (a), if in its sequestration final report OMB estimates that any sequestration is required, the President shall issue an order fully implementing without change all sequestrations required by the OMB calculations set forth in that report. This order shall be effective on issuance.

“(f) GAO COMPLIANCE REPORT.—Upon request of the Committee on the Budget of the House of Representatives or the Senate, the Comptroller General shall submit to the Congress and the President a report on—

“(1) the extent to which each order issued by the President under this section complies with all of the requirements contained in this part, either certifying that the order fully and accurately complies with such requirements or indicating the respects in which it does not; and

“(2) the extent to which each report issued by OMB or CBO under this section complies with all of the requirements contained in this part, either certifying that the report fully and accurately complies with such requirements or indicating the respects in which it does not.

“(g) LOW-GROWTH REPORT.—At any time, CBO and OMB shall notify the Congress if—
“(1) during the period consisting of the quarter during which such notification is given, the quarter preceding such notification, and the 4 quarters following such notification, CBO or OMB has determined that real economic growth is projected or estimated to be less than zero with respect to each of any 2 consecutive quarters within such period; or

“(2) the most recent of the Department of Commerce’s advance preliminary or final reports of actual real economic growth indicate that the rate of real economic growth for each of the most recently reported quarter and the immediately preceding quarter is less than one percent.

“(h) ECONOMIC AND TECHNICAL ASSUMPTIONS.—In all reports required by this section, OMB shall use the same economic and technical assumptions as used in the most recent budget submitted by the President under section 1105(a) of title 31, United States Code”.

SEC. 812. SPENDING LIMITS ENFORCEMENT.

(a) CONFORMING AMENDMENTS TO SECTION 312.—

Section 312 of the Congressional Budget Act of 1974 is amended—

(1) by striking subsection (a) and inserting the following:
“(a) Budget Committee Determinations.—For purposes of this title, the levels of new budget authority, outlays, direct spending, deficits, revenues, and debt, or the increases or decreases of such levels for purpose of section 303, shall be determined on the basis of estimates made by the Committee on the Budget of the House of Representatives or the Senate, as applicable.”.

(2) by striking subsections (b) and (c) and redesignating subsections (d), (e), and (f) as (g), (h), and (i), respectively.

(b) Enforcement Amendments to Section 312.—Section 312 of the Congressional Budget Act of 1974 is further amended by adding the following new subsections:

“(b) Discretionary Spending Limit Point of Order.—It shall not be in order in the House of Representatives or the Senate to consider any bill, joint resolution, amendment, or conference report that—

“(1) causes the discretionary spending limits for the budget year to be breached; or

“(2) increases the discretionary spending limits for the budget year or any ensuing fiscal year.

“(c) Total Spending Limit Point of Order.—It shall not be in order in the House of Representatives
or the Senate to consider any bill, joint resolution, amendment, or conference report that—

“(1) causes the total spending limits for the budget year, as a percentage of gross domestic product, to be breached; or

“(2) increases the total spending limits for the budget year or any ensuing fiscal year after the budget year, as a percentage of gross domestic product.

“(d) REVENUE LIMIT POINT OF ORDER.—It shall not be in order in the House of Representatives or the Senate to consider any bill, joint resolution, amendment, or conference report that increases levels of revenue above 19 percent of gross domestic product, as estimated by the Committee on the Budget of the applicable House.

“(e) WAIVER OR SUSPENSION.—The provisions of this section may be waived or suspended:

“(1) IN THE SENATE.—In the Senate only by the affirmative vote of three-fifths of the Members, duly chosen and sworn.

“(2) IN THE HOUSE OF REPRESENTATIVES.—In the House of Representatives:

“(A) Only by a rule or order proposing only to waive such provisions by an affirmative
vote of two-thirds of the Members, duly chosen
and sworn.

“(B) It shall not be in order to consider a
rule or order that waives the application of sub-
paragraph (A).

“(C) It shall not be in order for the Speak-
er to entertain a motion to suspend the applica-
tion of this section under clause 1 of rule XV
of the Rules of the House of Representatives.”.

SEC. 813. SPENDING REDUCTION ORDERS.

(a) In General.—Section 256 of the Balanced
Budget and Emergency Deficit Control Act of 1985 is
amended to read as follows:

“SEC. 256. SPENDING REDUCTION ORDER.

“(a) General Rules.—

“(1) Calculation of spending reduction
percentage.—OMB shall include in its final
spending sequestration report a requirement that
each nonexempt spending account shall be reduced
by an amount of budget authority calculated by mul-
tiplying the baseline level of budgetary resources in
that account at that time by the uniform percentage
necessary to reduce outlays sufficient to eliminate an
excess spending amount.
“(2) EXEMPTIONS.—The following shall be exempt from reduction under any order issued under this part:

“(A) Payments for net interest.

“(B) Benefits payable under the old-age, survivors, and disability insurance program established under title II of the Social Security Act if—

“(i) OASDI Trust Funds are actuarially solvent in the 75-year period utilized in the most recent annual report of the Board of Trustees provided pursuant to section 201(C)(2) of the Social Security Act; and

“(ii) OASDI Trust Funds have not run a cash deficit in the fiscal year prior to the transmittal of the most recent Sequestration Preview Report.

“(C) Benefits provided to veterans defined as direct spending payable by the Department of Veterans Affairs.

“(D) Obligated balances of budget authority carried over from prior fiscal years.

“(E) Any obligations of the Federal Government required to be paid under the United
States Constitution or legally contractual obligations.

“(F) Any program whose growth in the budget year is equal to or less than the consumer price index.

“(G) Intergovernmental transfers.

“(3) ONE-PERCENT REDUCTION LIMITATION.—No program shall be subject to a spending reduction of more than one percent of its budgetary resources.

“(4) CALCULATION OF SPENDING REDUCTION.—The percentage required to produce a spending reduction, as ordered by a spending reduction order, shall be calculated by OMB by adding all budgetary resources of the Government, and reducing that amount by an amount sufficient to reduce the total amount of outlays of the Government to equal, or lower, a level of outlays than the amount set forth in the guideline period.

“(5) APPLICATION.—Once issued, a spending reduction shall be applied to nonexempt programs as follows:

“(A) Budgetary resources subject to a spending reduction to any discretionary account shall be permanently canceled.
“(B) The same percentage spending reduction shall apply to all programs, projects, and activities within a budget account (with programs, projects, and activities as delineated in the appropriation Act or accompanying report for the relevant fiscal year covering that account, or for accounts not included in appropriation Acts, as delineated in the most recently submitted President’s budget).

“(C) Administrative regulations implementing a spending reduction shall be made within 120 days of the issue of a spending reduction order.

“(6) OASDI SPECIAL PROCEDURES.—If the OASDI Trust Funds are subject to sequestration, then payments from such Trust Funds shall be treated the same as other programs, except—

“(A) reductions from such Trust Funds shall not exceed one percent of the 75-year unfunded liability set forth in the most current Social Security Trustees Report;

“(B) reduction in individual benefits shall be implemented by increasing the Normal Retirement Age (NRA) by an amount certified by the Social Security Office of the Chief Actuary;
“(C) the increase in the NRA shall not be applied to any beneficiary born in a year 55 years or before—

“(i) the year of the enactment of the Roadmap for America’s Future Act of 2010; or

“(ii) the year in which the final spending sequestration report is issued; and

“(D) no change in the NRA shall be made before it is fully phased-in under the Social Security Act as in effect before the date of enactment of the Roadmap for America’s Future Act of 2010.

“(b) EMERGENCIES.—No program shall be subject to sequestration or counted for purposes of calculating a sequester if it is designated as an emergency under this section and so designated by the President.”.

(b) LOW-GROWTH AMENDMENT.—Section 258(b) of the Balanced Budget and Emergency Deficit Control Act of 1985 is amended to read as follows:

“(b) SUSPENSION OF SEQUESTRATION PROCEDURES.—Upon the enactment of a declaration of war or a joint resolution described in subsection (a)—
“(1) the subsequent issuance of any sequestration report to enforce the spending limits in sections 251 and 252A order is precluded;

“(2) sections 302(f), 310(d), and 311(a), of the Congressional Budget Act of 1974 are suspended; and

“(3) section 1103 of title 31, United States Code, is suspended.”.

(e) TECHNICAL AND CONFORMING AMENDMENTS.—

(1) REPEALS.—Sections 255 and 275 of the Balanced Budget and Emergency Deficit Control Act of 1985 are repealed.

(2) CONFORMING AMENDMENT.—The item relating to section 256 in the table of contents set forth in section 250(a) of the Balanced Budget and Emergency Deficit Control Act of 1985 is amended to read as follows:

“Sec. 256. Spending reduction order.”.

SEC. 814. ALTERNATE SPENDING REDUCTION LEGISLATION IN THE HOUSE OF REPRESENTATIVES.

(a) INTRODUCTION OF JOINT RESOLUTION.—At any time after the Director of OMB issues a final order for a fiscal year, but before the end of the session of Congress in session on the date of the issuance of such order, the majority leader of the House of Representatives may introduce a joint resolution which contains provisions direct-
ing the President to modify the most recent final order
issued pursuant to this title, or provide an alternative to
eliminate the spending excess for such fiscal year or years.

After the introduction of the first such joint resolution in
either House of Congress in any calendar year, then no
other joint resolution introduced pursuant to this section
shall be subject to the procedures set forth in this section.

(b) Procedures for Consideration of Joint
Resolutions.—

(1) Any committee of the House of Representa-
tives to which an alternative spending compliance
measure is referred shall report it to the House
without amendment not later than the seventh legis-
lative day after the date of its introduction. If a
committee fails to report the bill within that period
or the House has adopted a concurrent resolution
providing for adjournment sine die at the end of a
Congress, it shall be in order to move that the
House discharge the committee from further consid-
eration of the bill. Such a motion shall be in order
only at a time designated by the Speaker in the leg-
islative schedule within two legislative days after the
day on which the proponent announces his intention
to offer the motion. Such a motion shall not be in
order after a committee has reported a spending
compliance measure with respect to that special mes-

sage or after the House has disposed of a motion to
discharge with respect to that special message. The
previous question shall be considered as ordered on
the motion to its adoption without intervening mo-
tion except twenty minutes of debate equally divided
and controlled by the proponent and an opponent. If
such a motion is adopted, the House shall proceed
immediately to consider the spending compliance
measure bill in accordance with paragraph (3). A
motion to reconsider the vote by which the motion
is disposed of shall not be in order.

(2) After a spending compliance measure is re-
ported or a committee has been discharged from fur-
ther consideration, or the House has adopted a con-
current resolution providing for adjournment sine
die at the end of a Congress, it shall be in order to
move to proceed to consider the spending compliance
measure in the House. Such a motion shall be in
order only at a time designated by the Speaker in
the legislative schedule within two legislative days
after the day on which the proponent announces his
intention to offer the motion. Such a motion shall
not be in order after the House has disposed of a
motion to proceed with respect to that special mes-
sage. The previous question shall be considered as ordered on the motion to its adoption without intervening motion. A motion to reconsider the vote by which the motion is disposed of shall not be in order.

(3) The spending compliance measure shall be considered as read. All points of order against an approval bill and against its consideration are waived. The previous question shall be considered as ordered on an approval bill to its passage without intervening motion except five hours of debate equally divided and controlled by the proponent and an opponent and one motion to limit debate on the bill. A motion to reconsider the vote on passage of the bill shall not be in order.

(4) A spending compliance measure received from the Senate shall not be referred to committee.

(c) VOTING.—The vote on final passage of a joint resolution or conference report thereon referred to in paragraph (1) shall require approval of not less than three-fifths of the Members of the House of Representatives.

SEC. 815. ALTERNATE SPENDING REDUCTION LEGISLATION IN THE SENATE.

(a) INTRODUCTION OF JOINT RESOLUTION.—At any time after OMB issues a final order for a fiscal year, but before the end of the session of Congress in session on
the date of the issuance of such order, the majority leader
of either House of Congress may introduce a joint resolu-
tion which contains provisions directing the President to
modify the most recent final order provide an alternative
to eliminate the spending excess for such fiscal year or
years. After the introduction of the first such joint resolu-
tion in either House of Congress in any calendar year,
then no other joint resolution introduced in such House
in such calendar year shall be subject to the procedures
set forth in this section.

(b) Procedures for Consideration of Joint Resolutions.—

(1) Referral to Committee.—A joint resolu-
tion introduced in the Senate under subsection (a)
shall not be referred to a committee of the Senate
and shall be placed on the calendar pending disposi-
tion of such joint resolution in accordance with this
subsection.

(2) Consideration in the Senate.—On or
after the third calendar day (excluding Saturdays,
Sundays, and legal holidays) beginning after a joint
resolution is introduced under subsection (a), not-
withstanding any rule or precedent of the Senate, in-
cluding rule XXII of the Standing Rules of the Sen-
ate, it is in order (even though a previous motion to
the same effect has been disagreed to) for any Mem-
ber of the Senate to move to proceed to the consider-
ation of the joint resolution. The motion is not in
order after the eighth calendar day (excluding Sat-
urdays, Sundays, and legal holidays) beginning after
a joint resolution (to which the motion applies) is in-
troduced. The joint resolution is privileged in the
Senate. A motion to reconsider the vote by which the
motion is agreed to or disagreed to shall not be in
order. If a motion to proceed to the consideration of
the joint resolution is agreed to, the Senate shall im-
mEDIATELY proceed to consideration of the joint reso-
lution without intervening motion, order, or other
business, and the joint resolution shall remain the
unfinished business of the Senate until disposed of.

(3) DEBATE IN THE SENATE.—

(A) In the Senate, debate on a joint resolu-
tion introduced under subsection (a), amend-
ments thereto, and all debatable motions and
appeals in connection therewith shall be limited
to not more than 10 hours, which shall be di-
vided equally between the majority leader and
the minority leader (or their designees).

(B) A motion to postpone, or a motion to
proceed to the consideration of other business is
not in order. A motion to reconsider the vote by which the joint resolution is agreed to or dis-agreed to is not in order, and a motion to re-commit the joint resolution is not in order.

(C)(i) No amendment that is not germane to the provisions of the joint resolution shall be in order in the Senate. In the Senate, an amendment, any amendment to an amendment, or any debatable motion or appeal is debatable for not to exceed 30 minutes to be equally di-vided between, and controlled by, the mover and the majority leader (or their designees), except that in the event that the majority leader favors the amendment, motion, or appeal, the minority leader (or the minority leader’s designee) shall control the time in opposition to the amend-ment, motion, or appeal.

(ii) In the Senate, an amendment that is otherwise in order shall be in order notwith-standing the fact that it amends the joint reso-lution in more than one place or amends lan-guage previously amended. It shall not be in order in the Senate to vote on the question of agreeing to such a joint resolution or any amendment thereto unless the figures then con-
tained in such joint resolution or amendment
are mathematically consistent.

(4) Vote on Final Passage.—Immediately
following the conclusion of the debate on a joint res-
olution introduced under subsection (a), a single
quorum call at the conclusion of the debate if re-
quested in accordance with the rules of the Senate,
and the disposition of any pending amendments
under paragraph (3), the vote on final passage of
the joint resolution shall occur.

(5) Appeals.—Appeals from the decisions of
the Chair shall be decided without debate.

(6) Conference Reports.—In the Senate,
points of order under titles III and IV of the Con-
gressional Budget Act of 1974 are applicable to a
conference report on the joint resolution or any
amendments in disagreement thereto.

(7) Resolution from Other House.—If, be-
fore the passage by the Senate of a joint resolution
of the Senate introduced under subsection (a), the
Senate receives from the House of Representatives a
joint resolution introduced under subsection (a),
then the following procedures shall apply:
(A) The joint resolution of the House of Representatives shall not be referred to a committee and shall be placed on the calendar.

(B) With respect to a joint resolution introduced under subsection (a) in the Senate—

(i) the procedure in the Senate shall be the same as if no joint resolution had been received from the House; but

(ii)(I) the vote on final passage shall be on the joint resolution of the House if it is identical to the joint resolution then pending for passage in the Senate; or

(II) if the joint resolution from the House is not identical to the joint resolution then pending for passage in the Senate and the Senate then passes the Senate joint resolution, the Senate shall be considered to have passed the House joint resolution as amended by the text of the Senate joint resolution.

(C) Upon disposition of the joint resolution received from the House, it shall no longer be in order to consider the resolution originated in the Senate.
(8) **Senate action on house resolution.**—

If the Senate receives from the House of Representa-
tives a joint resolution introduced pursuant to this
section after the Senate has disposed of a Senate
originated resolution which is identical to the House
passed joint resolution, the action of the Senate with
regard to the disposition of the Senate originated
joint resolution shall be deemed to be the action of
the Senate with regard to the House originated joint
resolution. If it is not identical to the House passed
joint resolution, then the Senate shall be considered
to have passed the joint resolution of the House as
amended by the text of the Senate joint resolution.

(9) The vote on final passage of a joint resolu-
tion or conference report thereon referred to in para-
graph (1) shall require approval of not less than
three-fifths of the Members of the Senate.

**Subtitle C—Long-Term Budgeting**

**SEC. 821. CBO AND OMB PROJECTIONS.**

(a) **Congressional Budget Office.**—At the end
of section 308 of the Congressional Budget Act of 1974,
add the following:

“(d) **Long-Term Projections.**—Not later than
February 15 of each calendar year after the date of enact-
ment of this subsection, the Director of the Congressional
Budget Office shall issue a report projecting total spending, revenue, deficits, and debt for 75 years beginning with such fiscal year as a percentage of gross domestic product annually based on current law levels as modified to maintain current policy.

“(e) CBO Spending Review Report Issuance.—

As a component of the report required by subsection (d), the Congressional Budget Office shall issue a Spending Review Report and transmit such report to the Committees on the Budget of the House of Representatives and the Senate.

“(f) Content of Spending Review Report.—The content of the Spending Review Report referred to in subsection (e) shall include analyses of the following:

“(1) OASDI.—The solvency of the Old-Age, Survivors, and Disability Insurance Trust Fund.

“(2) Medicare.—The long-range sustainability of the spending levels of Medicare.

“(3) Medicaid.—The long-range sustainability of the spending levels of Medicaid.

“(4) Other Direct Spending.—The long-range sustainability of spending levels of other direct spending.
“(g) DEFINITIONS.—For purposes of the development of the Spending Review Report referred to in subsection (b):

“(1) SOLVENCY OF THE OASDI.—The term ‘solvency’ as used in this section means the solvency of the Old-Age Security and Disability Insurance Trust Funds over a 75-year period beginning in the year the Spending Review Report is reported.

“(2) SUSTAINABILITY.—The term ‘sustainability’ means the following:

“(A) MEDICARE.—The Medicare program is sustainable if it is projected to grow, beginning in the tenth year following the date of the enactment of this Act from the fixed percentage of Gross Domestic Product in the year prior to the date of enactment of this subsection, adjusted by the adjustment formula as set forth in section 252A(e) of the Balanced Budget and Emergency Deficit Control Act of 1985.

“(B) MEDICAID.—The Medicaid program is sustainable if its outlays, excluding those designated as emergencies, are projected to grow from the fixed percentage of Gross Domestic Product in the year prior to the date of the enactment of this Act, adjusted by a rate no high-
er than a blend of the Consumer Price Index
and the Medical Economic Index, as adjusted
after fiscal year 2018 using the same calcula-
tion, excluding benefits provided from the
OASDI Trust funds, as that set forth in section
252A(e) of the Balanced Budget and Emer-
gency Deficit Control Act of 1985 to reflect the
increase in the the number of Medicare eligible
retirees receiving benefits in the program rel-
ative to fiscal year 2018.

“(C) Other direct spending.—Other
direct spending is direct spending other than
OASDI, the Medicare and Medicaid program
and is sustainable if it grows from a fixed per-
centage of gross domestic product in fiscal year
2008.”.

(b) Office of Management and Budget.—Sec-
tion 1105(a) of title 31, United States Code, (as amended
by section 142(e)) is further amended by adding at the
end the following:

“(38) long-term projections of total spending
over 75 years as a percentage of gross domestic
product annually and the impact of proposed policies
over that period.”.
SEC. 822. GAO AND OMB STATEMENTS OF THE FEDERAL GOVERNMENT'S FINANCIAL CONDITION.

(a) Government Accountability Office.—On or before April 15 of each fiscal year, the Government Accountability Office shall submit a report on the federal government’s financial condition, including the long-term unfunded obligations.

(b) Definition of Long-Term Unfunded Obligations.—Section 3 of the Congressional Budget Act of 1974 is further amended by adding at the end the following new paragraph, and redesignate the paragraph accordingly:

“(11) Unfunded Obligations.—The term ‘Unfunded Obligations’ means the dollar sum of the Total Net Position as displayed in the United States Government Balance Sheets contained within the most recently published Financial Report of the United States Government; plus the 75-year actuarial balances, using the intermediate open-group assumption, of Medicare’s Hospital Insurance, Supplementary Medical Insurance, and Prescription Drug programs contained within the most recently published Annual Report of the Boards of Trustees of the Federal Hospital Insurance and Federal Supplementary Medical Insurance Trust Funds; plus the 75-year actuarial balance, using the intermediate
open group assumption, of the Old-Age Survivors and Disability Insurance program contained within the most recently published Annual Report of the Board of Trustees of the Federal Old-Age and Survivors Insurance and Federal Disability Insurance Trust Funds.”.

(c) Office of Management and Budget.—Section 1105(a) of title 31, United States Code, (as amended by section 301(b)) is further amended by adding at the end the following:

“(39) a report on the Federal Government’s financial condition, the including the long-term unfunded obligations.”.

SEC. 823. FIVE-YEAR FISCAL SUSTAINABILITY REVIEW.

Title III of the Congressional Budget Act of 1974 (as amended by section 126(a)) is further amended by adding at the end the following new section:

“FIVE-YEAR FISCAL SUSTAINABILITY REVIEW

“Sec. 318. (a) Congressional Spending Review Report.—Not later than 15 calendar days after the date of the transmittal of the report referred to in subsection 308(e), the Committees on the Budget of the House of Representatives and the Senate shall issue, and have printed in the Congressional Record, an assessment of such report.
“(b) Committee Recommendations.—Not later than 15 calendar days after the date of the report of the review referred to in subsection (c), the committees of the House of Representatives and the Senate shall consider and vote to submit to the Committees on the Budget of the House of Representatives and Senate, as applicable, recommendations, if any, such committees deem appropriate in response to the Spending Review Report issued pursuant to subsection (e).

“(c) Expedited Consideration of Spending Review Legislation.—

“(1) Consideration in the House of Representatives.—

“(A) Introduction of Spending Review Legislation.—

“(i) If the report referred to in section 308 indicates that the OASDI Trust Funds are not solvent, or that Medicare, Medicaid or other direct spending programs are not sustainable, or total spending exceeds the limits set forth in section 252A for any year within the 75-year period referred to in such report, then not later than 30 calendar days after the transmittal of the report referred to in
subsection (a), if any, the majority leader and minority leader of the House of Representatives shall each introduce legislation implementing to the extent practicable the recommendations referred to in subsection (d), or if necessary additional spending reduction sufficient to achieve the spending levels referred to in subsection (b).

“(ii) If Spending Review Legislation is not introduced pursuant to this subparagraph by the majority leader or minority leader, then not later than 45 calendar days after the transmittal of the report referred to in subsection (a), the chairman or ranking member of the Committee on the Budget shall introduce Spending Review Legislation sufficient to achieve the same spending levels.

“(iii) Spending review legislation shall be referred solely to the Committee on the Budget of the House of Representatives which shall have sole jurisdiction of such legislation.

“(iv) Spending review legislation introduced pursuant to this section shall
cause total spending to be reduced by an amount equal or greater than the amount of the breach of the limits set forth in section 252A, and shall cause the OASDI Trust Funds to achieve solvency, and shall cause Medicare, Medicaid, and other direct spending programs to achieve sustainability.

“(B) Referral and Reporting.—The Committee on the Budget of the House of Representatives shall report Spending Review Legislation to the House of Representatives not later than the seventh legislative day after the date of introduction of the legislation referred to in subparagraph (A). If such committee fails to report the Spending Review Legislation within that period or the House of Representatives has adopted a concurrent resolution providing for adjournment sine die at the end of a Congress, such committee shall be automatically discharged from further consideration of the Spending Review Legislation and it shall be placed on the appropriate calendar.

“(C) Proceeding to Consideration.—

After Spending Review Legislation is reported
by or discharged from the Committee on the
Budget or the House of Representatives has
adopted a concurrent resolution providing for
adjournment sine die at the end of a Congress,
it shall be in order to move to proceed to con-
sider the Spending Review Legislation in the
House of Representatives. Such a motion shall
be in order in the legislative schedule within
two legislative days after the day on which the
proponent announces his intention to offer the
motion. Such a motion shall not be in order
after the House of Representatives has disposed
of a motion to proceed with respect to that spe-
cial message. The previous question shall be
considered as ordered on the motion to its
adoption without intervening motion. A motion
to reconsider the vote by which the motion is
disposed of shall not be in order.

“(D) CONSIDERATION.—The Spending Re-
view Legislation shall be considered as read. All
points of order against Spending Review Legis-
lation and against its consideration are waived.
The previous question shall be considered as or-
dered on an Spending Review Legislation to its
passage without intervening motion except five
hours of debate equally divided and controlled
by the proponent and an opponent and one mo-
tion to limit debate on the Spending Review
Legislation. A motion to reconsider the vote on
passage of the Spending Review Legislation
shall not be in order.

“(E) Senate Spending Review Legislation.—Spending Review Legislation received
from the Senate shall not be referred to com-
mittee.

“(2) Consideration in the Senate.—

“(A) Motion to Proceed to Consider-
atation.—A motion to proceed to the consider-
ation of Spending Review Legislation under this
subsection in the Senate shall not be debatable.
It shall not be in order to move to reconsider
the vote by which the motion to proceed is
agreed to or disagreed to.

“(B) Limits on Debate.—Debate in the
Senate on Spending Review Legislation under
this subsection, and all debatable motions and
appeals in connection therewith (including de-
bate pursuant to subparagraph (D)), shall not
exceed 10 hours, equally divided and controlled
in the usual form.
“(C) APPEALS.—Debate in the Senate on any debatable motion or appeal in connection with Spending Review Legislation under this subsection shall be limited to not more than 1 hour, to be equally divided and controlled in the usual form.

“(D) MOTION TO LIMIT DEBATE.—A motion in the Senate to further limit debate on Spending Review Legislation under this subsection is not debatable.

“(E) MOTION TO RECOMMIT.—A motion to recommit Spending Review Legislation under this subsection is not in order.

“(F) CONSIDERATION OF THE HOUSE OF REPRESENTATIVES SPENDING REVIEW LEGISLATION.—

“(i) IN GENERAL.—If the Senate has received the House of Representatives companion resolution to the Spending Review Legislation introduced in the Senate prior to the vote required under paragraph (1)(C), then the Senate may consider, and the vote under paragraph (1)(C) may occur on, the House of Representatives companion resolution.
“(ii) Procedure after vote on Senate spending review legislation.—If the Senate votes, pursuant to paragraph (1)(C), on the Spending Review Legislation introduced in the Senate, then immediately following that vote, or upon receipt of the House of Representatives companion resolution, the House of Representatives Spending Review Legislation shall be deemed to be considered, read the third time, and the vote on passage of the Senate resolution shall be considered to be the vote on the Spending Review Legislation received from the House of Representatives.

“(3) Jurisdiction.—The Committees on the Budget of the House of Representatives and Senate shall have exclusive jurisdiction over any Spending Review Legislation and all the provisions therein for all purposes of the rules of either House.”.

SEC. 824. LONG-TERM RECONCILIATION.

(a) Long-Term Reconciliation.—Section 310 of the Congressional Budget Act of 1974 is amended as follows:

“(h) Long-Term Reconciliation Directives.—
“(1) Long-term reconciliation directives.—In addition to a reconciliation measure as
set forth in subsection (a), a concurrent resolution
on the budget for any fiscal year, to the extent nec-
essary to effectuate the spending levels as set forth
for such categories in section 301(a) (providing for
long-term spending levels as a percentage of gross
domestic product) of such resolution, shall—

“(A) specify the total amount by which
Medicare, Medicaid, the OASDI Trust Funds,
and other direct spending outlays are to be re-
duced within the jurisdiction of a committee as
a percentage of gross domestic product of such
fiscal year; and

“(B) direct that committee to determine
and recommend changes to accomplish a reduc-
tion of such total amount for such categories as
a percentage of gross domestic product.

“(2) Limitation on amendments to long-
term reconciliation legislation.—

“(A) It shall not be in order in the House
of Representatives to consider any amendment
to a reconciliation bill or reconciliation resolu-
tion if such amendment decreases outlay reduc-
tions below the level of such outlay reductions
provided (for the fiscal years covered) in the
reconciliation instructions which relate to such
long-term reconciliation bill.

“(B) It shall not be in order in the Senate
to consider any amendment to a reconciliation
bill or reconciliation resolution if such amend-
ment decreases outlay reductions below the level
of such outlay reductions provided (for the fis-
cal years covered) in the reconciliation instruc-
tions which relate to such long-term reconcili-
ation bill.

“(C) Subparagraphs (A) and (B) shall not
apply if a declaration of war by the Congress is
in effect.

“(D) For purposes of this section, the lev-
els of outlays as a percentage of a gross domes-
tic product for a fiscal year shall be determined
on the basis of estimates made by the Com-
mittee on the Budget of the House of Rep-
resentatives or of the Senate.

“(E) The Committee on Rules of the
House of Representatives may make in order
amendments to achieve outlay reductions speci-
fied by reconciliation directives contained in a
concurrent resolution on the budget if a com-
mittee or committees of the House of Representatives fail to submit recommended reductions in outlays as a percentage or gross domestic product to its Committee on the Budget pursuant to its instruction.

“(F) In the Senate, a motion to strike a provision shall always be in order.

“(3) SUBJECT MATTER.—Subject matter included in a long-term reconciliation bill may be any of the following:

“(A) Any part of the Medicare program.

“(B) Medicaid.

“(C) The Old-Age, Survivors, and Disability Insurance Trust Fund.

“(D) Other direct spending.

“(4) APPLICATION.—Subsections (c), (d), and (g) shall not apply to long-term reconciliation measures reported under this subsection.”.

(b) CONFORMING AMENDMENT.—In section 310(b) of the Congressional Budget Act of 1974, strike “subsection (a)” and insert “subsections (a) and (h)”.

SEC. 825. LONG-TERM SPENDING INCREASE POINT OF ORDER.

(a) IN GENERAL.—Title III of the Congressional Budget Act of 1974 (as amended by section 303) is fur-
ther amended by adding at the end the following new sec-

“LONG-TERM SPENDING INCREASE POINT OF ORDER

“SEC. 317. (a) CONGRESSIONAL BUDGET OFFICE
ANALYSIS OF PROPOSALS.—The Director of the Congres-
sional Budget Office shall, to the extent practicable, pre-
pare for each bill and joint resolution reported from com-
mittee (except measures within the jurisdiction of the
Committee on Appropriations), and amendments thereto
and conference reports thereon, an estimate of whether
the measure causes, relative to current law, a net increase
in direct spending in excess of $5,000,000,000 in any of
the four 10-year periods beginning in fiscal year 2019
through fiscal year 2058.

“(b) IN THE SENATE.—

“(1) POINT OF ORDER.—It shall not be in
order in the Senate to consider any bill, joint resolu-
tion, amendment, motion, or conference report that
causes a net increase in deficits in excess of
$5,000,000,000 in any of the four 10-year periods
beginning in 2019 through 2058.

“(2) SUPERMAJORITY WAIVER AND APPEAL.—

“(A) This section may be waived or sus-
pended only by the affirmative vote of three-
fifths of the Members, duly chosen and sworn.
“(B) An affirmative vote of three-fifths of the Members, duly chosen and sworn, shall be required to sustain an appeal of the ruling of the Chair on a point of order raised under this section.

“(c) In the House of Representatives.—

“(1) Point of Order.—It shall not be in order in the House of Representatives to consider any bill, joint resolution, amendment, motion, or conference report that causes a net increase in deficits in excess of $5,000,000,000 in any of the four 10-year periods beginning in 2019 through 2058.

“(2) Supermajority Waiver and Appeal.—

“(A) This section may be waived or suspended only by the affirmative vote of three-fifths of the Members, duly chosen and sworn.

“(B) An affirmative vote of two-thirds of the Members, duly chosen and sworn, shall be required to sustain an appeal of the ruling of the Chair on a point of order raised under this section.

“(d) Determinations of Budget Levels.—For purposes of this section, the levels of net deficit increases shall be determined on the basis of estimates provided by
the chairmen of the Senate and House Committees on the Budget, as applicable.”.

(b) CONFORMING AMENDMENT.—The table of contents set forth in section 1(b) of the Congressional Budget and Impoundment Control Act of 1974 is amended by inserting after the item relating to section 316 the following new item:

“Sec. 317. Long-term spending increase point of order.”.