

not a “guaranteed” Medicare benefit. So even though the amendment from the Senator from Massachusetts passed 96 to 0, will it have a real impact on protecting seniors from the loss of access to home health care? No. The better approach was offered by the Senator from Nebraska. Unfortunately, the better approaches are failing by party line votes. However, I compliment the Senator from Virginia, Mr. WEBB, for his support of the motion by the Senator from Nebraska. This motion would have recommitted this entire legislation to the appropriate Senate committee to remove the cuts to home health benefits. I think that is the best and most direct approach. I think that is the most honest approach. Simply remove the cuts. For the past several days we have been discussing the cuts to Medicare and especially the cuts to Medicare Advantage. In each case, the Republicans have offered motions and amendments to recommit this massive 2,000-page health bill back to committee to improve it, namely, to remove the cuts to programs seniors and the disabled use. I was disappointed to see this most recent attempt to send this massive bill back to committee to improve it fail 41 to 53.

I look forward to today’s debate. One scheduled for a vote is on medical malpractice reform. It will be very interesting to see just how serious the Democrats are about health care reform. Currently, the bill only has a “sense of the Senate” recognizing medical malpractice costs are a problem. We’ll see if they think it is important to really do anything about it.

#### MORNING BUSINESS

Mr. BEGICH. Mr. President, I ask unanimous consent that the Senate proceed to a period of morning business, with Senators permitted to speak therein for up to 10 minutes each.

The PRESIDING OFFICER. Without objection, it is so ordered.

#### ADDITIONAL COSPONSORS

S. 1389

At the request of Mr. NELSON of Nebraska, the name of the Senator from Arkansas (Mr. PRYOR) was added as a cosponsor of S. 1389, a bill to clarify the exemption for certain annuity contracts and insurance policies from Federal regulation under the Securities Act of 1933.

AMENDMENT NO. 2884

At the request of Ms. STABENOW, the name of the Senator from Minnesota (Mr. FRANKEN) was added as a cosponsor of amendment No. 2884 intended to be proposed to H.R. 3590, a bill to amend the Internal Revenue Code of 1986 to modify the first-time homebuyers credit in the case of members of the Armed Forces and certain other Federal employees, and for other purposes.

AMENDMENT NO. 2927

At the request of Mrs. HUTCHISON, her name was added as a cosponsor of amendment No. 2927 proposed to H.R. 3590, a bill to amend the Internal Revenue Code of 1986 to modify the first-time homebuyers credit in the case of members of the Armed Forces and certain other Federal employees, and for other purposes.

AMENDMENT NO. 2939

At the request of Mr. PRYOR, the names of the Senator from Iowa (Mr. HARKIN) and the Senator from Massachusetts (Mr. KERRY) were added as cosponsors of amendment No. 2939 proposed to H.R. 3590, a bill to amend the Internal Revenue Code of 1986 to modify the first-time homebuyers credit in the case of members of the Armed Forces and certain other Federal employees, and for other purposes.

#### AMENDMENTS SUBMITTED AND PROPOSED

SA 2940. Mr. SPECTER (for himself, Mr. MERKLEY, Mr. WYDEN, Mr. CASEY, Ms. STABENOW, Mr. LEVIN, and Mr. BROWN) submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, to amend the Internal Revenue Code of 1986 to modify the first-time homebuyers credit in the case of members of the Armed Forces and certain other Federal employees, and for other purposes; which was ordered to lie on the table.

SA 2941. Mr. SPECTER (for himself, Mr. WYDEN, and Mr. CASEY) submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, supra; which was ordered to lie on the table.

SA 2942. Mr. GREGG (for himself, Mr. CORKER, Mr. THUNE, Mr. COBURN, Mr. ENSIGN, Mr. ISAKSON, Mr. BURR, Mr. ENZI, Mr. ALEXANDER, Mr. BARRASSO, Mr. CORNYN, Mr. MCCAIN, and Mr. LEMIEUX) submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, supra.

SA 2943. Mr. CARPER (for himself and Mr. CONRAD) submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, supra; which was ordered to lie on the table.

SA 2944. Mrs. BOXER submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, supra; which was ordered to lie on the table.

SA 2945. Mrs. BOXER submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, supra; which was ordered to lie on the table.

SA 2946. Mr. CASEY submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, supra; which was ordered to lie on the table.

SA 2947. Ms. KLOBUCHAR submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, supra; which was ordered to lie on the table.

SA 2948. Ms. SNOWE submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, supra; which was ordered to lie on the table.

SA 2949. Mr. ROCKEFELLER (for himself and Mr. BROWN) submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, supra; which was ordered to lie on the table.

SA 2950. Mr. ROCKEFELLER submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, supra; which was ordered to lie on the table.

SA 2951. Mr. ROCKEFELLER submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, supra; which was ordered to lie on the table.

SA 2952. Mr. ROCKEFELLER submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, supra; which was ordered to lie on the table.

#### TEXT OF AMENDMENTS

**SA 2940.** Mr. SPECTER (for himself, Mr. MERKLEY, Mr. WYDEN, Mr. CASEY, Ms. STABENOW, Mr. LEVIN, and Mr. BROWN) submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, to amend the Internal Revenue Code of 1986 to modify the first-time homebuyers credit in the case of members of the Armed Forces and certain other Federal employees, and for other purposes; which was ordered to lie on the table; as follows:

On page 466, between lines 5 and 6, insert the following:

**SEC. 2305. EXTENSION OF DELAY IN APPLICATION OF MEDICAID PROVIDER TAX PROVISIONS TO CERTAIN MANAGED CARE ORGANIZATIONS.**

Effective as if included in the enactment of the Deficit Reduction Act of 2005 (Public Law 109-171), section 6051(b)(2)(A) of that Act of 2005 42 U.S.C. 1396b note) is amended by striking “2009” and inserting “2011”.

**SA 2941.** Mr. SPECTER (for himself, Mr. WYDEN, and Mr. CASEY) submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, to amend the Internal Revenue Code of 1986 to modify the first-time homebuyers credit in the case of members of the Armed Forces and certain other Federal employees, and for other purposes; which was ordered to lie on the table; as follows:

On page 857, strike lines 5 through 25 and insert the following:

(a) IN GENERAL.—Section 1834(a)(7)(A)(iii) of the Social Security Act (42 U.S.C. 1395m(a)(7)(A)(iii)) is amended—

(1) by inserting “complex rehabilitative power-driven wheelchair and any other” after “in the case of a” and

(2) by adding at the end the following: “In the case of a power-driven wheelchair that is

not a complex rehabilitative power-driven wheelchair, the following rules shall apply:

“(aa) The first sentence of this clause shall only apply if the length of need is at least 13 months, as certified by a physician.

“(bb) If the individual exercises the option under the first sentence of this clause and the individual discontinues use of the item prior to end of the 13-month period that begins on the date the individual exercises such option, the supplier shall be subject to recovery by the Secretary of an amount equal to the amount (if any) by which the lump-sum payment for the purchase for the wheelchair exceeds the total of the monthly payments for the wheelchair that would have been made on a rental basis for continuous use of less than 13 months.

“(cc) If the Secretary recovers any payments under item (bb), the title for the wheelchair shall revert to the supplier at the option of the supplier.”

**SA 2942.** Mr. GREGG (for himself, Mr. CORKER, Mr. THUNE, Mr. COBURN, Mr. ENSIGN, Mr. ISAKSON, Mr. BURR, Mr. ENZI, Mr. ALEXANDER, Mr. BARRASSO, Mr. CORNYN, Mr. MCCAIN, and Mr. LEMIEUX) submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, to amend the Internal Revenue Code of 1986 to modify the first-time homebuyers credit in the case of members of the Armed Forces and certain other Federal employees, and for other purposes; as follows:

At the appropriate place, insert the following:

**SEC. \_\_\_\_ . PREVENTING THE IMPLEMENTATION OF NEW ENTITLEMENTS THAT WOULD RAID MEDICARE.**

(a) **BAN ON NEW SPENDING TAKING EFFECT.**—

(1) **PURPOSE.**—The purpose of this section is to require that savings resulting from this Act must fully offset the increase in Federal spending and reductions in revenues resulting from this Act before any such Federal spending increases or revenue reductions can occur.

(2) **IN GENERAL.**—Notwithstanding any other provision of this Act, the Secretary of the Treasury and the Secretary of Health and Human Service are prohibited from implementing the provisions of, and amendments made by, sections 1401, 1402, 2001, and 2101, or any other spending increase or revenue reduction provision in this Act until both the Director of the Office of Management and Budget (referred to in this section as “OMB”) and the Chief Actuary of the Centers for Medicare and Medicaid Services Office of the Actuary (referred to in this section as “CMS OACT”) each certify that they project that all of the projected Federal spending increases and revenue reductions resulting from this Act will be offset by projected savings from this Act.

(3) **CALCULATIONS.**—For purposes of this section, projected savings shall exclude any projected savings or other offsets directly resulting from changes to Medicare and Social Security made by this Act.

(b) **LIMIT ON FUTURE SPENDING.**—On September 1 of each year (beginning with 2013), the CMS OACT and the OMB shall each issue an annual report that—

(1) certifies whether all of the projected Federal spending increases and revenue reductions resulting from this Act, starting with the next fiscal year and for the following 9 fiscal years, are fully offset by pro-

jected savings resulting from this Act (as calculated under subsection (a)); and

(2) provides detailed estimates of such spending increases, revenue reductions, and savings, year by year, program by program and provision by provision.

**SA 2943.** Mr. CARPER (for himself and Mr. CONRAD) submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, to amend the Internal Revenue Code of 1986 to modify the first-time homebuyers credit in the case of members of the Armed Forces and certain other Federal employees, and for other purposes; which was ordered to lie on the table; as follows:

On page 722, after line 20, insert the following:

**SEC. 3016. ADVANCING IMPLEMENTATION OF CERTAIN VALUE-BASED PURCHASING PROGRAMS.**

(a) **ADVANCING IMPLEMENTATION OF HOSPITAL VALUE-BASED PURCHASING PROGRAM.**—

(1) **IN GENERAL.**—Section 1886(o) of the Social Security Act, as added by section 3001, is amended—

(A) in paragraph (1)(B)—

(i) in the subparagraph heading, by striking “2013” and inserting “2012”; and

(ii) by striking “2012” and inserting “2011”;

(B) in paragraph (2)(B)—

(i) in clause (i), by striking “2013” each place it appears and inserting “2012”; and

(ii) in clause (ii), by striking “2014” and inserting “2013”; and

(C) in paragraph (7)—

(i) in subparagraph (B)(i), by striking “2013” and inserting “2012”; and

(ii) in subparagraph (C)—

(I) in clause (i), by striking “2013” and inserting “2012”; and

(II) in clause (ii), by striking “2014” and inserting “2013”; and

(III) in clause (iii), by striking “2015” and inserting “2014”; and

(IV) in clause (iv), by striking “2016” and inserting “2015”; and

(V) in clause (v), by striking “2017” and inserting “2016”; and

(iii) in subparagraph (D)(ii)(I), by striking “2012 and 2013” and inserting “2011, 2012, and 2013”.

(2) **CONFORMING AMENDMENT.**—Section 1886(b)(3)(B)(viii) of the Social Security Act, as amended by section 3001, is further amended—

(A) in subclause (V), by striking “2012” and inserting “2011”; and

(B) in each of subclauses (VIII) and (IX), by striking “2013” each place it appears and inserting “2012”.

(b) **ADVANCING IMPLEMENTATION OF NATIONAL PILOT PROGRAM ON PAYMENT BUNDLING.**—Section 1866D(a)(3) of the Social Security Act, as added by section 3023, is amended by striking “2013” and inserting “2012”.

**SEC. 3017. INTEGRATED HEALTH CARE SYSTEM COLLABORATION INITIATIVE.**

(a) **IN GENERAL.**—In order to improve health care quality and reduce costs, the Secretary of Health and Human Services (in this section referred to as the “Secretary”) shall develop, in consultation with major integrated health systems that have consistently demonstrated high quality and low cost (as determined by the Secretary and verified by a third party) a collaboration initiative (referred to in this section as “the Collaborative”). The Collaborative shall develop an exportable model of optimal health care delivery to apply value-based measure-

ment, integrated information technology infrastructure, standard care pathways, and population-based payment models, to measurably improve health care quality, outcomes, and patient satisfaction and achieve cost savings.

(b) **PARTICIPATION.**—Prior to January 1, 2010, the Secretary shall determine 5 initial participants who will form the Collaborative and at least 6 additional participants who will join the Collaborative beginning in the fourth year that the Collaborative is in effect.

(1) **INITIAL PARTICIPANTS.**—Initial participants selected by the Secretary shall meet the following criteria:

(A) Be integrated health systems organized for the purpose of providing health care services.

(B) Have demonstrated a record of providing high value health care for at least the 5 previous years, as determined by the Secretary in accordance with the Dartmouth Atlas of Health Care.

(C) Any additional criteria specified by the Secretary.

(2) **ADDITIONAL PARTICIPANTS.**—Beginning January 1, 2013, the Secretary shall select 6 or more additional participants who represent diverse geographic areas and are situated in areas of differing population densities who agree to comply with the guidelines, processes, and requirements set forth for the Collaborative. Such additional participants shall meet the following additional criteria:

(A) Be organized for the provision of patient medical care.

(B) Be capable of implementing infrastructure and health care delivery modifications necessary to enhance health care quality and efficiency, as determined by the Secretary in accordance with the Dartmouth Atlas of Health Care.

(C) The participant’s cost and intensity of care do not meet the definition of high value health care.

(3) **ADDITIONAL CRITERIA.**—In addition to the criteria described in paragraphs (1) and (2), the participants in the Collaborative shall meet the following criteria:

(A) Have a legal structure that would allow the participant to receive incentive payments under this section.

(B) Agree to report on quality, cost, and efficiency in such form, manner, and frequency as specified by the Secretary.

(C) Provide care to patients enrolled in the Medicare program.

(D) Agree to contribute to a best practices network and website, that is maintained by the Collaborative for sharing strategies on quality improvement, care coordination, efficiency, and effectiveness.

(E) Use patient-centered processes of care, including those that emphasize patient and caregiver involvement in shared decision-making for treatment decisions.

(F) Meet other criteria determined to be appropriate by the Secretary.

(c) **COLLABORATIVE INITIATIVE.**—

(1) **IN GENERAL.**—Beginning January 1, 2010, the Collaborative shall begin a 2 year development phase in which initial participants share the quantitative and qualitative methods through which they have developed high value health care followed by a dissemination of that learning model to additional participants of the Collaborative.

(2) **COORDINATING MEMBER.**—In consultation with the Secretary, the Collaborative shall select a coordinating member organization (hereafter identified as the Coordinating Organization) of the Collaborative.

(3) **QUALIFICATIONS.**—The Coordinating Organization will have in place a comprehensive Medicare database and possess experience using and analyzing Medicare data to

measure health care utilization, cost, and variation, such as The Dartmouth Institute for Health Policy and Clinical Practice. The Coordinating Organization shall be responsible for reporting to the Secretary as required and for any other requirements deemed necessary by the Secretary.

(4) RESPONSIBILITIES.—The Coordinating Member shall—

(A) lead efforts to develop each aspect of the learning model;

(B) organize efforts to disseminate the learning model for high value health care, including educating participant institutions; and

(C) provide administrative, technical, accounting, reporting, organizational and infrastructure support needed to carry out the goals of the Collaborative.

(5) DEVELOPMENT OF LEARNING MODEL.—

(A) IN GENERAL.—Initial participants in the Collaborative shall work together to develop a learning model based on their experience that includes a reliance on evidence based care that emphasizes quality and practice techniques that emphasize efficiency, joint development and implementation of health information technology, introduction of clinical microsystems of care, shared decision-making, outcomes and measurement, and the establishment of an e-learning distributive network, which have been put into practice at their respective institutions.

(B) RESPONSIBILITIES.—The Coordinating Member shall do the following:

(i) Partner with initial participants to comprehensively understand each institution's contribution to providing value-based health care.

(ii) Provide and measure value-based health care in a manner that ensures that measures are aligned with current measures approved by a consensus-based organization, such as the National Quality Forum, or other measures as determined appropriate by the Secretary, while also incorporating patient self-reported status and outcomes.

(iii) Create a replicable and scalable infrastructure for common measurement of value-based care that can be broadly disseminated across the Collaborative and other institutions.

(iv) Implement care pathways for common conditions using standard measures for assessment across institutions, targeting high variation and high cost conditions, including but not limited to—

(I) acute myocardial infarction (AMI) and angioplasty;

(II) coronary artery bypass graft surgery and percutaneous coronary intervention;

(III) hip or knee replacement;

(IV) spinal surgery; and

(V) care for chronic diseases including, but not limited to, diabetes, heart disease, and high blood pressure.

(v) Deploy and disseminate the comprehensive learning model across initial participant institutions, achieving improvements in care delivery and lowering costs, and demonstrating the portability and viability of the processes.

(6) ADDITIONAL BEST PRACTICES.—As additional methods of improving health care quality and efficiency are identified by members of the Collaborative or by other institutions, Initial Participants in the Collaborative shall incorporate those practices into the learning model.

(d) IMPLEMENTATION OF LEARNING MODEL.—

(1) IN GENERAL.—Beginning January 1, 2013, as additional participants are selected by the Secretary, Initial Participants in the Collaborative shall actively engage in the deployment of the learning model to educate each additional participant in the common conditions that have been identified.

(A) DISSEMINATION OF LEARNING MODEL.—Dissemination methods shall include but not be limited to the following methods:

(i) Specialized teams deployed by the Initial Participants to teach and facilitate implementation on site.

(ii) Distance-learning, taking advantage of latest interactive technologies.

(iii) On-line, fully accessible repositories of shared learning and information related to best practices.

(iv) Advanced population health information technology models.

(B) EVALUATION OF PARTICIPANTS.—Evaluation of initial participants shall be based on documented success in meeting quality and efficiency targets. Specific statistically valid measures of evaluation shall be determined by the Secretary.

(e) EFFICIENCY AND QUALITY TARGETS.—

(1) EFFICIENCY TARGET BASED ON GROWTH RATE.—Initial participants shall implement techniques under the comprehensive learning model to meet a growth rate target equal to, as selected by the Secretary with respect to the participant—

(A) the percentage increase in the consumer price index for all urban consumers (all items; United States city average) over the previous year, plus 2 percentage points; or

(B) the percentage increase in the projected per capita amount of National Health Expenditures from the calendar year in which the previous fiscal year ends to the calendar year in which the fiscal year involved ends, as most recently published by the Secretary before the beginning of the fiscal year, minus 1.5 percentage points.

(2) QUALITY TARGET.—The Secretary shall establish a quality target, based on measures endorsed by a consensus-based quality organization, for the initial participants in the first year and subsequently for the additional participants.

(f) PAYMENTS.—

(1) BASE PAYMENT.—With respect to each participant in the Collaborative, the Secretary shall determine a base amount on a per capita basis for the participant for purposes of measuring the growth rate in total payments for common conditions, based on the reimbursement amount paid to the participant under title XVIII of the Social Security Act for furnishing items and services with respect to such conditions.

(2) BONUS PAYMENT.—If the growth rate in total payments for services for common conditions does not exceed the growth rate target selected for the participant under subsection (e)(1), and the participant satisfies the quality target established by the Secretary under subsection (e)(2), the Secretary shall provide a bonus payment equal to 50 percent of any per capita payment reductions that are below the capita base amounts determined under paragraph (1).

(3) PENALTY PAYMENT.—If the growth rate in total per capita payments for furnishing items and services for common conditions exceeds the growth rate target, the Secretary shall pay only 25 percent of any additional expenses that exceed the base amounts determined under paragraph (1).

(4) BUDGET NEUTRALITY LIMITATION.—The Secretary shall limit incentive payments to each of the participating organizations under this section as necessary to ensure that the aggregate expenditures with respect to applicable beneficiaries under title XVIII of the Social Security Act (inclusive of incentive payments described in this subsection) do not exceed the amount that the Secretary estimates would be expended for such beneficiaries if the Collaborative under this section were not implemented.

(g) ADMINISTRATIVE PAYMENT.—Out of funds not otherwise obligated in the Treas-

ury, there are appropriated \$228,000,000, to remain available until expended, to be distributed in the following manner:

(1) The Coordinating Organization shall receive \$10,000,000 per year for program development related to the Collaborative, including for health information technology and other infrastructure, project evaluations, analysis, and measurement, compliance, audits and other reporting. Not less than \$5,000,000 of such funds shall be provided for education and training, including for support for the establishment of training teams for the Collaborative, to assist in the integration of new health information technology, best practices of care delivery, microsystems of care delivery, and a distributive e-learning network for the Collaborative.

(2) Each Initial Participant shall receive \$4,000,000 per year for internal program development for health information technology and other infrastructure, education and training, project evaluations, analysis, and measurement, and compliance, auditing, and other reporting.

(3) Beginning in 2013, the Secretary may provide funding to additional participants in the Collaborative in an amount not to exceed \$4,000,000 per participant per year under the same use guidelines as apply to the Initial Participants.

(h) CONTINUATION OR EXPANSION.—

(1) TERMINATION.—Subject to paragraph (2), the Collaborative shall terminate on the date that is 6 years after the date on which the Collaborative is established.

(2) EXPANSION.—The Secretary may continue or expand the Collaborative if—

(A) participants meet the established growth rate targets and consistently receive bonus payments during the first 4 years of the Collaborative and are consistently meeting quality standards; or

(B) the Collaborative is consistently exceeding quality standards and is not increasing spending under the program.

(i) TERMINATION.—The Secretary may terminate an agreement with the Collaborative or a participating organization under the Collaborative if such organization did not qualify for incentive payments or consistently failed to meet quality standards in any of the first 3 years of the Collaborative.

(j) REPORTS.—

(1) PERFORMANCE RESULTS REPORTS.—The Secretary shall provide such data as is necessary for the Collaborative to measure the efficacy of the Collaborative and facilitate regular reporting on spending and cost savings results relative to a value-based program initiative.

(2) REPORTS TO CONGRESS.—Not later than 2 years after the date the first agreement is entered into under this section, and annually thereafter, the Secretary shall submit to Congress and make publicly available a report on the authority granted to the Secretary to carry out the Collaborative under this section. Each report shall address the impact of the use of such authority on expenditures for, access to, and quality of, care under title XVIII of the Social Security Act.

(k) DEFINITIONS.—In this section:

(1) BENEFICIARY.—The term “beneficiary” means a Medicare beneficiary enrolled under part B and entitled to benefits under part A who is not enrolled in Medicare Advantage under part C or a PACE program under section 1894, and meets other criteria as the Secretary determines appropriate.

(2) HIGH VALUE HEALTH CARE.—The term “high value health care” means the care delivered by organizations shown by statistically valid methods to meet the highest quality measures established by the Secretary as of or after the date of enactment of this Act and to be delivering low-cost care

with high patient satisfaction and clinical outcomes.

(3) **LEARNING MODEL.**—The term “learning model” means a standardized model developed by the Initial Participants in the Collaborative and based on best practices, as jointly developed and put into practice at the Initial Participant’s respective institutions.

(4) **SECRETARY.**—The term “Secretary” means the Secretary of Health and Human Services.

(1) **ADDITIONAL MONITORING.**—The Secretary may monitor data on expenditures and quality of services under title XVIII of the Social Security Act with respect to a beneficiary after the beneficiary discontinues receiving services under the Collaborative.

(m) **OTHER PROVISIONS.**—

(1) **LIMITATIONS ON REVIEW.**—There shall be no administrative or judicial review under this section or otherwise of—

(A) the elements, parameters, scope, and duration of the Collaborative, including the selection of participants in the Collaborative;

(B) the establishment of targets, measurement of performance;

(C) determinations with respect to whether savings have been achieved and the amount of savings;

(D) determinations regarding whether, to whom, and in what amounts incentive payments are paid; and

(E) decisions about the extension or expansion of the Collaborative.

(2) **ADMINISTRATION.**—Chapter 35 of title 44, United States Code shall not apply to this section.

(3) **EVALUATION.**—The Secretary shall evaluate the payment incentive model for the Collaborative to assess impacts on beneficiaries and on the Medicare program under title XVIII of the Social Security Act. The Secretary shall make such evaluation publicly available within 60 days of the date of completion of such report.

(4) **MONITORING.**—The Inspector General of the Department of Health and Human Services shall provide for monitoring of the operation of the Collaborative with regard to violations of section 1877 of the Social Security Act (popularly known as the “Stark law”).

(5) **ANTI-DISCRIMINATION.**—The Secretary shall not enter into an agreement with an entity to provide health care items or services under the Collaborative, or with an entity to administer the Collaborative, unless such entity guarantees that it will not deny, limit, or condition the coverage or provision of benefits under the Collaborative for beneficiaries to participate in the Collaborative, based on any health status-related factor described in section 2702(a)(1) of the Public Health Service Act.

**SA 2944.** Mrs. BOXER submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, to amend the Internal Revenue Code of 1986 to modify the first-time homebuyers credit in the case of members of the Armed Forces and certain other Federal employees, and for other purposes; which was ordered to lie on the table; as follows:

At the end of subtitle D of title V, add the following:

**SEC. 5316. GERIATRIC HEALTH CARE WORKFORCE.**

(a) **INVESTMENT IN TOMORROW’S GERIATRIC HEALTH CARE WORKFORCE.**—Part E of title VII of the Public Health Service Act (42

U.S.C. 294n et seq.), as amended by section 5314, is further amended by adding at the end the following:

**“SEC. 779. INVESTMENT IN TOMORROW’S GERIATRIC HEALTH CARE WORKFORCE.**

“(a) **ESTABLISHMENT.**—The Secretary shall establish and carry out a Geriatric and Gerontology Loan Repayment Program under which the eligible individual agrees to be employed full-time for a specified period (which shall not be less than 2 years) as a physician, physician assistant, nurse practitioner, clinical nurse specialist, pharmacist, psychologist, physical therapist, or social worker in geriatric care practice.

“(b) **PROGRAM ADMINISTRATION.**—Under the program established under subsection (a), the Secretary shall enter into contracts with qualified health professionals described in subsection (c) under which—

“(1) such qualified health professionals agree to provide full-time clinical practice and service to older adults through work serving, or for a provider serving—

“(A) an area with shortage of the specified geriatric or gerontology specialty that has a sufficient population of older adults to support such geriatric or gerontology specialty, as determined by the Secretary; and

“(B) a medically underserved community (including a health professional shortage area), or a medically underserved population; and

“(2) the Secretary agrees to make payments on the principal and interest of the graduate medical education loans of professionals described in paragraph (1) that—

“(A) are not more than \$35,000 a year for each year of agreed upon service under such paragraph for a period of not more than 4 years; and

“(B) are not more than 1/4 of the total of such principal and interest, for each year of the service, for a period of not more than 4 years.

“(c) **QUALIFIED HEALTH PROFESSIONALS.**—

“(1) **IN GENERAL.**—A qualified health professional described in this subsection is an individual—

“(A) who—

“(i) is a physician, including an osteopathic physician, who—

“(I) is entering or enrolled in an accredited fellowship in geriatric medicine or geriatric psychiatry; or

“(II) has completed (but not prior to the calendar year in which this section is enacted) an accredited fellowship in geriatric medicine or geriatric psychiatry; or

“(i) is a nurse practitioner or clinical nurse specialist, pharmacist, social worker, physician assistant, physical therapist, or psychologist who has completed specialty training in geriatrics or gerontology;

“(B) who has obtained an educational loan for costs associated with graduate training in medicine, pharmacy, psychology, physical therapy, or social work, or costs associated with training to become a nurse practitioner, clinical nurse specialist, or physician assistant;

“(C) who is appropriately licensed or certified in the State in which the individual practices, or who meets other qualifications as determined by the Secretary;

“(D) who agrees to provide clinical services to older adults for a period of not less than 2 years in a setting determined appropriate by the Secretary; and

“(E) who has demonstrated the capability through education or training to work with frail older adults and older adults with disabilities, including individuals with dementia, urinary incontinence, and problems with balance or mobility, and medication regimes for older adults.

“(2) **ADDITIONAL ELIGIBILITY REQUIREMENTS.**—The Secretary may not enter into a

contract under this subsection with an individual unless—

“(A) the individual is a United States citizen or a permanent legal United States resident;

“(B) if the individual is enrolled in a graduate program, the program is accredited, and the individual has an acceptable level of academic standing (as determined by the Secretary); and

“(C) the individual is not participating in any other Federal undergraduate or graduate medical education loan repayment program.

“(d) **PRIORITY.**—In entering into contracts under this section, the Secretary shall give priority to qualified health professionals who demonstrate financial need.

“(e) **APPLICABILITY OF CERTAIN PROVISIONS.**—With respect to the National Health Service Corps Loan Repayment Program established in subpart III of part D of title III, the provisions of such subpart shall, except as inconsistent with this section, apply to the program established in this section in the same manner and to the same extent as such provisions apply to the National Health Service Corps Loan Repayment Program.

“(f) **DEFINITION.**—In this section:

“(1) **GERIATRICS.**—The term ‘geriatrics’ means the branch of medicine that deals with the problems and diseases of older adults and aging, including chronic conditions and geriatric syndromes such as dementia, delirium, urinary incontinence, osteoporosis, falls or gait disorders, or sleep disorders.

“(2) **GERONTOLOGY.**—The term ‘gerontology’ means the interdisciplinary study of the aging process and individuals as they grow from middle age through later life. Such term encompasses the social, cognitive, psychological, biological, and economic aspects of aging.

“(3) **GRADUATE MEDICAL EDUCATION.**—The term ‘graduate medical education’ means a graduate program in medicine, pharmacy, psychology, physical therapy, or social work, or a graduate program that trains individuals to become nurse practitioners, clinical nurse specialists, or physician assistants.

“(4) **SPECIALTY TRAINING.**—The term ‘specialty training’ means a concentration in coursework in geriatrics or gerontology or clinical training, including internships, residency programs, or fellowships, in a geriatric setting, or other requirements, as determined by the Secretary.

“(g) **AUTHORIZATION OF APPROPRIATIONS.**—There is authorized to be appropriated to carry out this section, \$4,000,000 for fiscal year 2010, \$9,500,000 for fiscal year 2011, \$16,000,000 for fiscal year 2012, \$24,000,000 for fiscal year 2013, and \$30,500,000 for fiscal year 2014.”

(b) **EXPANSION OF NURSING EDUCATION LOAN REPAYMENT PROGRAM.**—Section 846 of the Public Health Service Act (42 U.S.C. 297n) is amended—

(1) by redesignating subsection (i) as subsection (j); and

(2) by inserting after subsection (h), the following:

“(i) **GERIATRIC CARE PRACTICE IN LONG-TERM CARE SETTINGS.**—

“(1) **LOAN REPAYMENTS.**—In providing for loan repayments under this section, the Secretary shall ensure that eligible individuals include registered nurses who complete specialty training in geriatrics or gerontology and who elect to provide nursing services to older adults in home and community-based or facility-based long-term care settings, or any other program determined appropriate by the Secretary.

“(2) **DEFINITION.**—In this subsection, the term ‘specialty training’ means coursework in geriatrics or gerontology or clinical training, including internships or fellowships, in a geriatric setting.

“(3) AUTHORIZATION OF APPROPRIATIONS.—There is authorized to be appropriated to carry out this subsection, \$1,500,000 for fiscal year 2010, \$3,000,000 for fiscal year 2011, \$5,000,000 for fiscal year 2012, \$7,000,000 for fiscal year 2013, and \$8,500,000 for fiscal year 2014.”.

**SA 2945.** Mrs. BOXER submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, to amend the Internal Revenue Code of 1986 to modify the first-time homebuyers credit in the case of members of the Armed Forces and certain other Federal employees, and for other purposes; which was ordered to lie on the table; as follows:

At the appropriate place, insert the following:

**SEC. \_\_\_\_ . REPORT ON IMPACT OF NURSE STAFFING.**

Not later than 18 months after the date of the enactment of this Act, the Director of the Agency for Healthcare Research and Quality shall submit to Congress a report on the impact of the nurse-to-patient ratio on the quality of care and patient outcomes, including recommendations for further integration into quality measurement and quality improvement activities as determined appropriate.

**SA 2946.** Mr. CASEY submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, to amend the Internal Revenue Code of 1986 to modify the first-time homebuyers credit in the case of members of the Armed Forces and certain other Federal employees, and for other purposes; which was ordered to lie on the table; as follows:

On page 330, line 9, insert after “1402(g)(1)” the following: “, or an individual who would be eligible for an exemption under such section if the individual were self-employed.”.

**SA 2947.** Ms. KLOBUCHAR submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, to amend the Internal Revenue Code of 1986 to modify the first-time homebuyers credit in the case of members of the Armed Forces and certain other Federal employees, and for other purposes; which was ordered to lie on the table; as follows:

On page 1411, between lines 5 and 6, insert the following:

**SEC. 5316. GRANTS FOR EMERGENCY MEDICAL SERVICES PERSONNEL TRAINING FOR VETERANS.**

Section 330J of the Public Health Service Act (42 U.S.C. 254c-15) is amended—

(1) in subsection (b)(1)—  
(A) in subparagraph (E), by striking “or” at the end;

(B) by redesignating subparagraph (F) as subparagraph (G); and

(C) by inserting after subparagraph (E), the following:

“(F) an entity providing training for emergency medical services personnel, including institutions of higher education, technical colleges, community colleges, and other State-certified training entities; or”;

(2) in subsection (c)—

(A) in paragraph (7), by striking “and” at the end;

(B) in paragraph (8), by striking the period and inserting “; and”; and

(C) by adding at the end the following:

“(9) provide to military veterans required coursework and training that take into account, and are not duplicative of, previous medical coursework and training received when such veterans were active members of the Armed Forces, to enable such veterans to satisfy emergency medical services personnel certification requirements, as determined by the appropriate State regulatory entity.”.

**SA 2948.** Ms. SNOWE submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, to amend the Internal Revenue Code of 1986 to modify the first-time homebuyers credit in the case of members of the Armed Forces and certain other Federal employees, and for other purposes; which was ordered to lie on the table; as follows:

Strike subtitle I of title VI and insert the following:

**Subtitle I—State Medical Malpractice Programs**

**SEC. 6801. PRE-LITIGATION SCREENING AND MEDIATION PANELS.**

(a) IN GENERAL.—As a condition for receiving Federal funds under the Medicaid program under title XIX of the Social Security Act (42 U.S.C. 1396 et seq.), each State and territory shall, not later than 3 years after the date of enactment of this Act, create a pre-litigation screening and mediation panel which shall provide timely review of each medical malpractice claim before such claim is filed in a State or Federal court in such State.

(b) REQUIREMENTS.—

(1) IN GENERAL.—Each medical malpractice claim shall be heard by such panel before such claim may be filed in a State or Federal court and before litigation of such case may commence.

(2) REPORTS.—The panel shall issue a report containing the findings and recommendations of such panel, based on the evidence presented to the panel. The report described in this paragraph shall not affect a claimant's right to bring a medical malpractice claim in State or Federal court. Notwithstanding any other provision of State or Federal law, such report may be admissible in such court.

(c) DUTIES.—Each panel established under subsection (a) shall—

(1) review medical malpractice claims;

(2) assess the evidence offered by the parties; and

(3) render professional judgment on the validity of claims.

(d) MEMBERSHIP.—Each panel established under subsection (a) shall be comprised of lawyers, retired judges, doctors, and medical professionals. Members of the panel shall serve on a volunteer basis, unless a State chooses to arrange for compensation of, or reimbursement of expenses for, such members.

(e) EXEMPTED STATES.—A State that, on the day before the date of enactment of this Act, has enacted laws that require medical malpractice claims to be heard by a pre-litigation panel, in a manner similar to the requirements of this section, may, at the discretion of the Secretary, be exempt from the requirements of this section for as long as such State maintains such panel.

(f) RULE OF CONSTRUCTION.—Nothing in this section shall be construed to interfere with or restrict an individual's right to bring a lawsuit in civil courts.

**SEC. 6802. STANDARDS FOR MEDICAL LIABILITY EXPERT WITNESSES.**

As a condition for receiving Federal funds under the Medicaid program under title XIX of the Social Security Act (42 U.S.C. 1396 et seq.), each State and territory shall require that an individual wishing to present evidence through an expert witness in a medical malpractice case demonstrate that such expert witness—

(1) be credentialed or licensed in one or more States to deliver health care services;

(2) typically treat the diagnosis or condition at issue in the case, or provide the type of treatment under review; and

(3) is substantially familiar with applicable standards of care and practice as they relate to the act or omission that is the subject of the lawsuit.

**SEC. 6803. ENCOURAGING SETTLEMENT OF MEDICAL MALPRACTICE LAWSUITS.**

As a condition for receiving Federal funds under the Medicaid program under title XIX of the Social Security Act (42 U.S.C. 1396 et seq.), each State and territory shall require that a party in a medical malpractice lawsuit that refuses a settlement offer in an amount that is significantly greater than the amount awarded by a jury after trial reimburse the party that made such settlement offer for the costs of the trial, including attorney's fees associated with the trial.

**SA 2949.** Mr. ROCKEFELLER (for himself and Mr. BROWN) submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, to amend the Internal Revenue Code of 1986 to modify the first-time homebuyers credit in the case of members of the Armed Forces and certain other Federal employees, and for other purposes; which was ordered to lie on the table; as follows:

Beginning on page 182, strike line 8 and all that follows through page 200, line 5, and insert the following:

**SEC. 1323. CONSUMERS CHOICE HEALTH PLAN.**

(a) FINDINGS.—Congress makes the following findings:

(1) Americans need health care coverage that is always affordable.

(2) Americans need health care coverage that is always adequate.

(3) Americans need health care coverage that is always accountable.

(4) A public health insurance plan option that can compete with private insurance plans is the only way to guarantee that all consumers have affordable, adequate, and accountable options available in the insurance marketplace.

(b) OFFICE OF HEALTH PLAN MANAGEMENT.—

(1) ESTABLISHMENT.—Not later than July 1, 2010, there shall be established within the Department of Health and Human Services an Office of Health Plan Management (referred to in this section as the “Office”). The Office shall be headed by a Director (referred to in this section as the “Director”) who shall be appointed by the President, by and with the advice and consent of the Senate.

(2) COMPENSATION.—The Director shall be paid at the annual rate of pay for a position at level II of the Executive Schedule under section 5313 of title 5, United States Code.

(3) LIMITATION.—Neither the Director nor the Office shall participate in the administration of the Exchanges established under

this title or the promulgation or administration of any regulation regarding the health insurance industry.

(4) PERSONNEL AND OPERATIONS AUTHORITY.—The Director shall have the same general authorities with respect to personnel and operations of the Office as the heads of other agencies and departments of the Federal Government have with respect to such agencies and departments.

(c) CONSUMER CHOICE HEALTH PLAN.—

(1) IN GENERAL.—The Office shall establish and administer the Consumer Choice Health Plan (referred to in this section as the “Plan”) to provide for health insurance coverage that is made available to all eligible individuals (as described in paragraph (4)(A)) in the United States and its territories.

(2) REGULATORY COMPLIANCE.—The Plan shall comply with—

(A) all regulations and requirements that are applicable with respect to other qualified health plans that are offered through the Exchanges; and

(B) any additional regulations and requirements, as determined by the Director.

(3) BENEFITS.—

(A) IN GENERAL.—The Plan shall offer health insurance coverage at different benefit levels, provided that such benefits are commensurate with the required benefit levels to be provided by a qualified health plan through the Exchanges.

(B) MINIMUM BENEFITS FOR CHILDREN.—

(i) IN GENERAL.—The minimum benefit level available under the Plan for children shall include at least the services described in the most recently published version of the “Maternal and Child Health Plan Benefit Model” developed by the National Business Group on Health.

(ii) AMENDMENT OF BENEFIT LEVEL.—The Secretary of Health and Human Services, acting through the Director of the Agency for Healthcare Research and Quality, may amend the benefits described in clause (i) based on the most recent peer-reviewed and evidence-based data.

(4) ELIGIBILITY AND ENROLLMENT.—

(A) ELIGIBILITY.—An individual who is eligible to purchase coverage from a qualified health plan through an Exchange shall be eligible to enroll in the Plan.

(B) ENROLLMENT PROCESS.—An individual may enroll in the Plan only in such manner and form as may be prescribed by applicable regulations, and only during an enrollment period as prescribed by the Director.

(C) EMPLOYER ENROLLMENT.—An employer shall be eligible to purchase health insurance coverage for their employees and the employees’ dependents to the extent provided for all qualified health plans under the Exchanges.

(D) SATISFACTION OF INDIVIDUAL MANDATE REQUIREMENT.—An individual’s enrollment with the Plan shall be treated as satisfying any requirement under Federal law for such individual to demonstrate enrollment in health insurance or benefits coverage, including the requirement under section 5000A of the Internal Revenue Code of 1986.

(5) PROVIDERS.—

(A) NETWORK REQUIREMENT.—

(i) MEDICARE.—A participating provider who is voluntarily providing health care services under the Medicare program established under title XVIII of the Social Security Act (42 U.S.C. 1395 et seq.) shall be required to provide services to any individual enrolled in the Plan.

(ii) MEDICAID AND CHIP.—A provider of health care services under the Medicaid program established under title XIX of the Social Security Act (42 U.S.C. 1396 et seq.), or the CHIP program established under title XXI of such Act (42 U.S.C. 1397aa et seq.),

shall be required to provide services to any individual enrolled in the Plan.

(B) EXCEPTION.—Subparagraph (A) shall not be construed as requiring a provider to accept new patients due to bona fide capacity limitations of the provider.

(C) OPT-OUT PROVISION.—

(i) MEDICARE.—A participating provider as described under subparagraph (A)(i) shall be required to provide services to any individual enrolled in the Plan for the 3-year period following the establishment of the Plan. Upon the expiration of the 3-year period, a participating provider in the Plan may elect to become a non-participating provider without affecting their status as a participating provider under the Medicare program.

(ii) MEDICAID AND CHIP.—A provider as described under subparagraph (A)(ii) shall be required to provide services to any individual enrolled in the Plan for the 3-year period following the establishment of the Plan. Upon the expiration of the 3-year period, a provider in the Plan may elect to cease provision of services under the Plan without affecting their status as a provider under the Medicaid program or the CHIP program.

(D) PAYMENT RATES.—

(i) INITIAL PAYMENT RATES.—

(I) IN GENERAL.—During the 2-year period following the establishment of the Plan, providers shall be reimbursed at such payment rates as are applicable under the Medicare program.

(II) ADJUSTMENT.—The Director may reimburse providers at rates lower or higher than applicable under the Medicare program if the Director determines that the adjusted rates are appropriate and ensure that enrollees in the Plan are provided with adequate access to health care services.

(ii) SUBSEQUENT PAYMENT RATES.—Subject to clause (iii), upon the expiration of the 2-year period following the establishment of the Plan, the Director shall develop payment rates for reimbursement of providers in order to maintain an adequate provider network necessary to assure that enrollees in the Plan have adequate access to health care. In determining such payment rates, the Director shall consider—

(I) competitive provider payment rates in both the public and private sectors;

(II) best practices among providers;

(III) integrated models of care delivery (including medical home and chronic care coordination models);

(IV) geographic variation in health care costs;

(V) evidence-based practices;

(VI) quality improvement;

(VII) use of health information technology; and

(VIII) any additional measures, as determined by the Director.

(iii) PAYMENT RATE CONSULTATION.—The Director shall determine payment rates under clause (ii) in consultation with providers participating under the Plan, the Director of the Office of Personnel Management, the Medicare Payment Advisory Commission, and the Medicaid and CHIP Payment and Access Commission.

(E) ADOPTION OF MEDICARE REFORMS.—The Plan may adopt Medicare system delivery reforms that provide patients with a coordinated system of care and make changes to the provider payment structure.

(6) SUBSIDIES.—The Plan shall be eligible to accept subsidies, including subsidies for the enrollment of individuals under the Plan, in the same manner and to the same extent as other qualified health plans offered through an Exchange (including credits under section 36B of the Internal Revenue Code of 1986).

(7) FINANCING.—

(A) TRANSITIONAL FUNDING.—

(i) IN GENERAL.—In order to provide for adequate funding of the Plan in advance of receipt of payments as described in subparagraph (B), beginning July 1, 2010, there are transferred to the Plan from the general fund of the Treasury such amounts as may be necessary for operation of the Plan until the end of the 3-year period following the establishment of the Plan.

(ii) RETURN OF FUNDS.—Upon the expiration of the 3-year period following the establishment of the Plan, the Director shall enter into a repayment schedule with the Secretary of the Treasury to provide for repayment of funds provided under clause (i). Any expenditures made by the Plan pursuant to a repayment schedule established under this subparagraph shall not constitute administrative expenses as described in subparagraph (B)(ii).

(B) SELF-FINANCING.—

(i) IN GENERAL.—The Plan shall be financially self-sustaining insofar as funds used for operation of the Plan (including benefits, administration, and marketing) shall be derived from—

(I) insurance premium payments and subsidies for individuals enrolled in the Plan; and

(II) assessable payments made pursuant to section 4980H of the Internal Revenue Code of 1986 (as added by section 1513) by employers that fail to offer their full-time employees (and their dependents) the opportunity to enroll in minimum essential coverage under an eligible employer-sponsored plan.

(ii) LIMITATION ON ADMINISTRATIVE EXPENSES.—Not more than 5 percent of the amounts provided under clause (i) may be used for the annual administrative costs of the Plan.

(C) CONTINGENCY RESERVE.—

(i) IN GENERAL.—The Director shall establish and fund a contingency reserve for the Plan in a form similar to the contingency reserve provided for health benefits plans under the Federal Employees Health Benefits Program under chapter 89 of title 5, United States Code.

(ii) REVENUE.—Any revenue generated through the contingency reserve established in clause (i) shall be transferred to the Plan for the purpose of reducing enrollee premiums, reducing enrollee cost-sharing, increasing enrollee benefits, or any combination thereof.

(D) GAO FINANCIAL AUDIT AND REPORT.—Beginning not later than October 1, 2011, the Comptroller General shall conduct an annual audit of the financial statements and records of the Plan, in accordance with generally accepted government auditing standards, and submit an annual report on such audit to the Congress.

(E) SUPERMAJORITY REQUIREMENT FOR SUPPLEMENTAL FUNDING.—Upon certification by the Comptroller General that the financial audit described in subparagraph (D) indicates that the Plan is insolvent, supplemental funding may be appropriated for the Plan if such measure receives not less than a three-fifths vote of approval of the total number of Members of the House of Representatives and the Senate.

(8) TRANSPARENCY.—

(A) IN GENERAL.—Beginning with the first year of operation of the Plan through the Exchanges, the Director shall provide standards and undertake activities for promoting transparency in costs, benefits, and other factors for health insurance coverage provided under the Plan.

(B) STANDARD DEFINITIONS OF INSURANCE AND MEDICAL TERMS.—

(i) IN GENERAL.—The Director shall provide for the development of standards for the definitions of terms used in health insurance

coverage under the Plan, including insurance-related terms (including the insurance-related terms described in clause (ii)) and medical terms (including the medical terms described in clause (iii)).

(ii) **INSURANCE-RELATED TERMS.**—The insurance-related terms described in this clause are premium, deductible, co-insurance, copayment, out-of-pocket limit, preferred provider, non-preferred provider, out-of-network co-payments, UCR (usual, customary and reasonable) fees, excluded services, grievance and appeals, and such other terms as the Director determines are important to define so that consumers may compare health insurance coverage and understand the terms of their coverage.

(iii) **MEDICAL TERMS.**—The medical terms described in this clause are hospitalization, hospital outpatient care, emergency room care, physician services, prescription drug coverage, durable medical equipment, home health care, skilled nursing care, rehabilitation services, hospice services, emergency medical transportation, and such other terms as the Director determines are important to define so that consumers may compare the medical benefits offered by health insurance plans and understand the extent of those medical benefits (or exceptions to those benefits).

(C) **DISCLOSURE.**—

(i) **IN GENERAL.**—In carrying out this paragraph, the Director shall disclose to Plan enrollees, potential enrollees, in-network health care providers, and others (through a publically available Internet website and other appropriate means) relevant information regarding each policy of health insurance coverage marketed or in force (in such standardized manner as determined by the Director), including—

(I) full policy contract language; and

(II) a summary of the information described in subparagraph (D).

(ii) **PERSONALIZED STATEMENT.**—The Director shall disclose to enrollees (in such standardized manner as determined by the Director) an annual personalized statement that summarizes use of health care services and payment of claims with respect to an enrollee (and covered dependents) under health insurance coverage provided through the Plan in the preceding year.

(D) **REQUIRED INFORMATION.**—The information described in this subparagraph includes, but is not limited to, the following:

(i) Data on the price of each new policy of health insurance coverage and renewal rating practices.

(ii) Claims payment policies and practices, including how many and how quickly claims were paid.

(iii) Provider fee schedules and usual, customary, and reasonable fees (for both in-network and out-of-network providers).

(iv) Provider participation and provider directories.

(v) Loss ratios, including detailed information about amount and type of non-claims expenses.

(vi) Covered benefits, cost-sharing, and amount of payment provided toward each type of service identified as a covered benefit, including preventive care services recommended by the United States Preventive Services Task Force.

(vii) Civil or criminal actions successfully concluded against the Plan by any governmental entity.

(viii) Benefit exclusions and limits.

(E) **DEVELOPMENT OF PATIENT CLAIMS SCENARIOS.**—

(i) **IN GENERAL.**—In order to improve the ability of individuals and employers to compare the coverage and relative value provided under the Plan, the Director shall develop and make publically available a series

of patient claims scenarios under which benefits (including out-of-pocket costs) under the Plan are simulated for certain common or expensive conditions or courses of treatment (including maternity care, breast cancer, heart disease, diabetes management, and well-child visits).

(ii) **CONSULTATION.**—The Director shall develop the patient claims scenarios described in clause (i)—

(I) in consultation with the Secretary of Health and Human Services, the National Institutes of Health, the Centers for Disease Control and Prevention, the Agency for Healthcare Research and Quality, health professional societies, patient advocates, and other entities as deemed necessary by the Director; and

(II) based upon recognized clinical practice guidelines.

(F) **MANNER OF DISCLOSURE.**—The Director shall disclose the information under this paragraph—

(i) with all marketing materials;

(ii) on the website for the Plan; and

(iii) at other times upon request.

(d) **CONFORMING AMENDMENTS.**—

(1) **COMMUNITY HEALTH INSURANCE OPTION.**—

(A) **IN GENERAL.**—Title I of this Act is amended by striking “community health insurance option” each place it appears and inserting “Consumer Choice Health Plan”.

(B) **ANNUAL FEE ON HEALTH INSURANCE PROVIDERS.**—Section 9010(c)(2)(B) is amended by striking “community health insurance option” and inserting “Consumer Choice Health Plan”.

(2) **SPECIAL RULES.**—Section 1303(a)(1)(C) is amended by—

(A) in clause (i)(III), striking “section 1323(e)(1)(C) or”; and

(B) in clause (ii), striking “section 1323(b)(3)(A)” and inserting “section 1323(c)(3)(A)”.

**SEC. 1323A. ESTABLISHMENT OF AMERICA'S HEALTH INSURANCE TRUST.**

(a) **ESTABLISHMENT.**—As of the date of enactment of this Act, there is authorized to be established a non-profit corporation that shall be known as the “America’s Health Insurance Trust” (referred to in this section and section 1323B as the “Trust”), which is neither an agency nor establishment of the United States Government.

(b) **LOCATION; SERVICE OF PROCESS.**—The Trust shall maintain its principal office within the District of Columbia and have a designated agent in the District of Columbia to receive service of process for the Trust. Notice to or service on the agent shall be deemed as notice to or service on the corporation.

(c) **APPLICATION OF PROVISIONS.**—The Trust shall be subject to the provisions of this section and, to the extent consistent with this section, to the District of Columbia Non-profit Corporation Act.

(d) **TAX EXEMPT STATUS.**—The Trust shall be treated as a nonprofit organization described under section 170(c)(2)(B) and section 501(c)(3) of the Internal Revenue Code of 1986 that is exempt from taxation under section 501(a) of the Internal Revenue Code of 1986.

(e) **BOARD OF DIRECTORS.**—

(1) **IN GENERAL.**—The Board of Directors of the Trust (referred to in this section as the “Board”) shall consist of 19 voting members appointed by the Comptroller General.

(2) **TERMS.**—

(A) **IN GENERAL.**—Subject to subparagraph (C), each member of the Board shall serve for a term of 6 years.

(B) **LIMITATION.**—No individual shall be appointed to the Board for more than 2 consecutive terms.

(C) **INITIAL MEMBERS.**—The initial members of the Board shall be appointed by the Comptroller General not later than October 1, 2010, and shall serve terms as follows:

(i) 8 members shall be appointed for a term of 5 years.

(ii) 8 members shall be appointed for a term of 3 years.

(iii) 3 members shall be appointed for a term of 1 year.

(D) **EXPIRATION OF TERM.**—Any member of the Board whose term has expired may serve until such member’s successor has taken office, or until the end of the calendar year in which such member’s term has expired, whichever is earlier.

(E) **VACANCIES.**—

(i) **IN GENERAL.**—Any member appointed to fill a vacancy prior to the expiration of the term for which such member’s predecessor was appointed shall be appointed for the remainder of such term.

(ii) **VACANCIES NOT TO AFFECT POWER OF BOARD.**—A vacancy on the Board shall not affect its powers, but shall be filled in the same manner as the original appointment was made.

(3) **CHAIRPERSON AND VICE-CHAIRPERSON.**—

(A) **IN GENERAL.**—The Comptroller General shall designate a Chairperson and Vice-Chairperson of the Board from among the members of the Board.

(B) **TERM.**—The members designated as Chairperson and Vice-Chairperson shall serve for a period of 3 years.

(4) **CONFLICTS OF INTEREST.**—An individual may not serve on the Board if such individual (or an immediate family member of such individual) is employed by or has a financial interest in—

(A) an organization that provides a health insurance plan;

(B) a pharmaceutical manufacturer; or

(C) any subsidiary entities of an organization described in subparagraphs (A) or (B).

(5) **COMPOSITION OF THE BOARD.**—

(A) **POLITICAL PARTIES.**—Not more than 10 members of the Board may be affiliated with the same political party.

(B) **DIVERSITY.**—In appointing members under this paragraph, the Comptroller General shall ensure that such members provide appropriately diverse representation with respect to race, ethnicity, age, gender, and geography.

(C) **CONSUMER REPRESENTATION.**—10 members of the Board shall be independent and non-conflicted individuals representing the interests of health care consumers. Each member selected under this subparagraph shall represent 1 of the 10 Department of Health and Human Services regions in the United States.

(D) **REMAINING REPRESENTATION.**—

(i) **IN GENERAL.**—9 members of the Board shall be selected based on relevant experience, including expertise in—

(I) community affairs;

(II) Federal, State, and local government;

(III) health professions and administration;

(IV) business, finance, and accounting;

(V) legal affairs;

(VI) insurance;

(VII) trade unions;

(VIII) social services; and

(IX) any additional areas as determined by the Comptroller General.

(ii) **INCOME FROM HEALTH CARE INDUSTRY.**—Not more than 4 of the members selected under this subparagraph shall earn more than 10 percent of their income from the health care industry.

(6) **MEETINGS AND HEARINGS.**—The Board shall meet and hold hearings at the call of the Chairperson or a majority of its members. Meetings of the Board on matters not related to personnel shall be open to the public and advertised through public notice at least 7 days prior to the meeting.

(7) **QUORUM.**—A majority of the members of the Board shall constitute a quorum for purposes of conducting the duties of the Trust,

but a lesser number of members may meet and hold hearings.

(8) EXECUTIVE DIRECTOR AND STAFF; PERFORMANCE OF DUTIES.—The Board may—

(A) employ and fix the compensation of an Executive Director and such other personnel as may be necessary to carry out the duties of the Trust;

(B) seek such assistance and support as may be required in the performance of the duties of the Trust from appropriate departments and agencies of the Federal Government;

(C) enter into contracts or other arrangements and make such payments as may be necessary for performance of the duties of the Trust;

(D) provide travel, subsistence, and per diem compensation for individuals performing the duties of the Trust, including members of the Advisory Council (as described in subsection (f)); and

(E) prescribe such rules, regulations, and bylaws as the Board determines necessary with respect to the internal organization and operation of the Trust.

(9) LOBBYING COOLING-OFF PERIOD FOR MEMBERS OF THE BOARD.—Section 207(c) of title 18, United States Code, as amended by section 3403(a)(2), is amended by inserting at the end the following:

“(4) MEMBERS OF THE BOARD OF DIRECTORS OF THE AMERICA’S HEALTH INSURANCE TRUST.—Paragraph (1) shall apply to a member of the Board of Directors of the America’s Health Insurance Trust who was appointed to the Board as of the day before the date of enactment of the Patient Protection and Affordable Care Act.”

(f) ADVISORY COUNCIL.—

(1) ESTABLISHMENT.—The Board shall establish an advisory council that shall be comprised of the insurance commissioners of each State (including the District of Columbia) to advise the Board on the development and impact of measures to improve the transparency and accountability of qualified health plans provided through the Exchanges established under this title.

(2) MEETINGS.—The advisory council shall meet not less than twice a year and at the request of the Board.

(g) FINANCIAL OVERSIGHT.—

(1) CONTRACT FOR AUDITS.—The Trust shall provide for financial audits of the Trust on an annual basis by a private entity with expertise in conducting financial audits.

(2) REVIEW AND REPORT ON AUDITS.—The Comptroller General shall—

(A) review and evaluate the results of the audits conducted pursuant to paragraph (1); and

(B) submit a report to Congress containing the results and review of such audits, including an analysis of the adequacy and use of the funding for the Trust and its activities.

(h) RULES ON GIFTS AND OUTSIDE CONTRIBUTIONS.—

(1) GIFTS.—The Trust (including the Board and any staff acting on behalf of the Trust) shall not accept gifts, bequests, or donations of services or property.

(2) PROHIBITION ON OUTSIDE FUNDING OR CONTRIBUTIONS.—The Trust shall not—

(A) establish a corporation other than as provided under this section; or

(B) accept any funds or contributions other than as provided under this section.

(i) AMERICA’S HEALTH INSURANCE TRUST FUND.—

(1) IN GENERAL.—There is established in the Treasury a trust fund to be known as the “America’s Health Insurance Trust Fund” (referred to in this section as the “Trust Fund”), consisting of such amounts as may be credited to the Trust Fund as provided under this subsection.

(2) TRANSFER.—The Secretary of the Treasury shall transfer to the Trust Fund out of the general fund of the Treasury amounts determined by the Secretary to be equivalent to the amounts received into such general fund that are attributable to the fees collected under sections 4385 and 4386 of the Internal Revenue Code of 1986 (relating to fees on health insurance policies and self-insured health plans).

(3) FINANCING FOR FUND FROM FEES ON INSURED AND SELF-INSURED HEALTH PLANS.—

(A) GENERAL RULE.—Chapter 34 of the Internal Revenue Code of 1986 is amended by adding at the end the following new subchapter:

**“Subchapter C—Additional Fees on Insured and Self-Insured Health Plans**

“Sec. 4385. Health insurance.

“Sec. 4386. Self-insured health plans.

“Sec. 4387. Definitions and special rules.

**“SEC. 4385. HEALTH INSURANCE.**

“(a) IMPOSITION OF FEE.—In the case of any specified health insurance policy issued after October 1, 2009, there is hereby imposed a fee equal to—

“(1) for policies issued during fiscal years 2010 through 2013, 50 cents multiplied by the average number of lives covered under the policy; and

“(2) for policies issued after September 30, 2013, \$1 multiplied by the average number of lives covered under the policy.

“(b) LIABILITY FOR FEE.—The fee imposed by subsection (a) shall be paid by the issuer of the policy.

“(c) SPECIFIED HEALTH INSURANCE POLICY.—For purposes of this section:

“(1) IN GENERAL.—Except as otherwise provided in this section, the term ‘specified health insurance policy’ means any accident or health insurance policy (including a policy under a group health plan) issued with respect to individuals residing in the United States.

“(2) EXEMPTION FOR CERTAIN POLICIES.—The term ‘specified health insurance policy’ does not include any insurance if substantially all of its coverage is of excepted benefits described in section 9832(c).

“(3) TREATMENT OF PREPAID HEALTH COVERAGE ARRANGEMENTS.—

“(A) IN GENERAL.—In the case of any arrangement described in subparagraph (B)—

“(i) such arrangement shall be treated as a specified health insurance policy, and

“(ii) the person referred to in such subparagraph shall be treated as the issuer.

“(B) DESCRIPTION OF ARRANGEMENTS.—An arrangement is described in this subparagraph if under such arrangement fixed payments or premiums are received as consideration for any person’s agreement to provide or arrange for the provision of accident or health coverage to residents of the United States, regardless of how such coverage is provided or arranged to be provided.

“(d) ADJUSTMENTS FOR INCREASES IN HEALTH CARE SPENDING.—In the case of any policy issued in any fiscal year beginning after September 30, 2014, the dollar amount in effect under subsection (a) for such policy shall be equal to the sum of such dollar amount for policies issued in the previous fiscal year (determined after the application of this subsection), plus an amount equal to the product of—

“(1) such dollar amount for policies issued in the previous fiscal year, multiplied by

“(2) the percentage increase in the projected per capita amount of National Health Expenditures from the calendar year in which the previous fiscal year ends to the calendar year in which the fiscal year involved ends, as most recently published by the Secretary of Health and Human Services before the beginning of the fiscal year.

“(e) TERMINATION.—This section shall not apply to policy years ending after September 30, 2019.

**“SEC. 4386. SELF-INSURED HEALTH PLANS.**

“(a) IMPOSITION OF FEE.—In the case of any applicable self-insured health plan issued after October 1, 2009, there is hereby imposed a fee equal to—

“(1) for plans issued during fiscal years 2010 through 2013, 50 cents multiplied by the average number of lives covered under the plan; and

“(2) for plans issued after September 30, 2013, \$1 multiplied by the average number of lives covered under the plans.

“(b) LIABILITY FOR FEE.—

“(1) IN GENERAL.—The fee imposed by subsection (a) shall be paid by the plan sponsor.

“(2) PLAN SPONSOR.—For purposes of paragraph (1) the term ‘plan sponsor’ means—

“(A) the employer in the case of a plan established or maintained by a single employer,

“(B) the employee organization in the case of a plan established or maintained by an employee organization,

“(C) in the case of—

“(i) a plan established or maintained by 2 or more employers or jointly by 1 or more employers and 1 or more employee organizations,

“(ii) a multiple employer welfare arrangement, or

“(iii) a voluntary employees’ beneficiary association described in section 501(c)(9), the association, committee, joint board of trustees, or other similar group of representatives of the parties who establish or maintain the plan, or

“(D) the cooperative or association described in subsection (c)(2)(F) in the case of a plan established or maintained by such a cooperative or association.

“(c) APPLICABLE SELF-INSURED HEALTH PLAN.—For purposes of this section, the term ‘applicable self-insured health plan’ means any plan for providing accident or health coverage if—

“(1) any portion of such coverage is provided other than through an insurance policy, and

“(2) such plan is established or maintained—

“(A) by one or more employers for the benefit of their employees or former employees,

“(B) by one or more employee organizations for the benefit of their members or former members,

“(C) jointly by 1 or more employers and 1 or more employee organizations for the benefit of employees or former employees,

“(D) by a voluntary employees’ beneficiary association described in section 501(c)(9),

“(E) by any organization described in section 501(c)(6), or

“(F) in the case of a plan not described in the preceding subparagraphs, by a multiple employer welfare arrangement (as defined in section 3(40) of Employee Retirement Income Security Act of 1974), a rural electric cooperative (as defined in section 3(40)(B)(iv) of such Act), or a rural telephone cooperative association (as defined in section 3(40)(B)(v) of such Act).

“(d) ADJUSTMENTS FOR INCREASES IN HEALTH CARE SPENDING.—In the case of any plan issued in any fiscal year beginning after September 30, 2014, the dollar amount in effect under subsection (a) for such plan shall be equal to the sum of such dollar amount for plans issued in the previous fiscal year (determined after the application of this subsection), plus an amount equal to the product of—

“(1) such dollar amount for plans issued in the previous fiscal year, multiplied by

“(2) the percentage increase in the projected per capita amount of National Health

Expenditures from the calendar year in which the previous fiscal year ends to the calendar year in which the fiscal year involved ends, as most recently published by the Secretary of Health and Human Services before the beginning of the fiscal year.

“(e) TERMINATION.—This section shall not apply to plans issued after September 30, 2019.

**“SEC. 4387. DEFINITIONS AND SPECIAL RULES.**

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

“(1) ACCIDENT AND HEALTH COVERAGE.—The term ‘accident and health coverage’ means any coverage which, if provided by an insurance policy, would cause such policy to be a specified health insurance policy (as defined in section 4385(c)).

“(2) INSURANCE POLICY.—The term ‘insurance policy’ means any policy or other instrument whereby a contract of insurance is issued, renewed, or extended.

“(3) UNITED STATES.—The term ‘United States’ includes any possession of the United States.

“(b) TREATMENT OF GOVERNMENTAL ENTITIES.—

“(1) IN GENERAL.—For purposes of this subchapter—

“(A) the term ‘person’ includes any governmental entity, and

“(B) notwithstanding any other law or rule of law, governmental entities shall not be exempt from the fees imposed by this subchapter except as provided in paragraph (2).

“(2) TREATMENT OF EXEMPT GOVERNMENTAL PROGRAMS.—In the case of an exempt governmental program, no fee shall be imposed under section 4385 or section 4386 on any covered policy or plan under such program.

“(3) EXEMPT GOVERNMENTAL PROGRAM DEFINED.—For purposes of this subchapter, the term ‘exempt governmental program’ means—

“(A) any insurance program established under title XVIII of the Social Security Act,

“(B) the medical assistance program established by title XIX or XXI of the Social Security Act,

“(C) the Federal Employees Health Benefits Program under chapter 89 of title 5, United States Code,

“(D) the Consumer Choice Health Plan established under section 1323 of the Patient Protection and Affordable Care Act,

“(E) any program established by Federal law for providing medical care (other than through insurance policies) to individuals (or the spouses and dependents thereof) by reason of such individuals being—

“(i) members of the Armed Forces of the United States, or

“(ii) veterans, and

“(F) any program established by Federal law for providing medical care (other than through insurance policies) to members of Indian tribes (as defined in section 4(d) of the Indian Health Care Improvement Act).

“(c) TREATMENT AS TAX.—For purposes of subtitle F, the fees imposed by this subchapter shall be treated as if they were taxes.

“(d) NO COVER OVER TO POSSESSIONS.—Notwithstanding any other provision of law, no amount collected under this subchapter shall be covered over to any possession of the United States.”.

(B) CLERICAL AMENDMENTS.—

(i) Chapter 34 of such Code is amended by striking the chapter heading and inserting the following:

**“CHAPTER 34—TAXES ON CERTAIN INSURANCE POLICIES**

“SUBCHAPTER A. POLICIES ISSUED BY FOREIGN INSURERS

“SUBCHAPTER B. INSURED AND SELF-INSURED HEALTH PLANS

“SUBCHAPTER C. ADDITIONAL FEES ON INSURED AND SELF-INSURED HEALTH PLANS

**“Subchapter A—Policies Issued By Foreign Insurers”.**

(ii) The table of chapters for subtitle D of such Code is amended by striking the item relating to chapter 34 and inserting the following new item:

“CHAPTER 34—TAXES ON CERTAIN INSURANCE POLICIES”.

**SEC. 1323B. DUTIES OF AMERICA'S HEALTH INSURANCE TRUST.**

(a) INSURANCE PLAN RANKINGS AND WEBSITE.—

(1) WEB-BASED MATERIALS.—The Trust shall establish and maintain a website that provides informational materials regarding the qualified health plans provided through the Exchanges established under this title, including appropriate links for all available State insurance commissioner websites.

(2) PLAN RANKINGS.—The Trust shall develop and publish annual rankings of the qualified health plans provided through the Exchanges, based on the assignment of a letter grade between “grade A” (highest) and “grade F” (lowest). The Trust shall provide for a comparative evaluation of each plan based upon—

(A) administrative expenditures;

(B) affordability of coverage;

(C) adequacy of coverage;

(D) timeliness and adequacy of consumer claims processing;

(E) available consumer complaint systems;

(F) grievance and appeals processes;

(G) transparency;

(H) consumer satisfaction; and

(I) any additional measures as determined by the Board.

(3) INFORMATION AVAILABLE ON WEBSITE BY ZIP CODE.—The annual rankings of the qualified health plans (as described in paragraph (2)) shall be available on the website for the Trust (as described in paragraph (1)), and websites for the Exchanges, in a manner that is searchable and sortable by zip code.

(4) CONSUMER FEEDBACK.—

(A) CONSUMER COMPLAINTS.—The Trust shall develop written and web-based methods for individuals to provide recommendations and complaints regarding the qualified health plans provided through the Exchanges.

(B) CONSUMER SURVEYS.—The Trust shall obtain meaningful consumer input, including consumer surveys, that measure the extent to which an individual receives the services and supports described in the individual's health insurance plan and the individual's satisfaction with such services and supports.

(b) DATA SHARING.—

(1) IN GENERAL.—An organization that provides a qualified health plan through an Exchange shall provide the Trust with all information and data that is necessary for improving transparency, monitoring, and oversight of such plans.

(2) ANNUAL DISCLOSURE.—Beginning with the first full year for which Exchanges are required to be operational under this title, an organization that provides a qualified health plan through an Exchange shall annually provide the Trust with appropriate information regarding the following:

(A) Name of the plan.

(B) Levels of available plan benefits.

(C) Description of plan benefits.

(D) Number of enrollees under the plan.

(E) Demographic profile of enrollees under the plan.

(F) Number of claims paid to enrollees.

(G) Number of enrollees that terminated their coverage under the plan.

(H) Total operating cost for the plan (including administrative costs).

(I) Patterns of utilization of the plan's services.

(J) Availability, accessibility, and acceptability of the plan's services.

(K) Such information as the Trust may require demonstrating that the organization has a fiscally sound operation.

(L) Any additional information as determined by the Trust.

(3) FORM AND MANNER OF INFORMATION.—Information to be provided to the Trust under paragraphs (1) and (2) shall be provided—

(A) in such form and manner as specified by the Trust; and

(B) within 30 days of the date of receipt of the request for such information, or within such extended period as the Trust deems appropriate.

(4) INFORMATION FROM THE DEPARTMENT OF HEALTH AND HUMAN SERVICES.—

(A) IN GENERAL.—Any information regarding the qualified health plans that are offered through the Exchanges that has been provided to the Secretary of Health and Human Services shall also be made available (as deemed appropriate by the Secretary) to the Trust for the purpose of improving transparency, monitoring, and oversight of such plans. Such information may include, but is not limited to, the following:

(i) Underwriting guidelines to ensure compliance with applicable Federal health insurance requirements.

(ii) Rating practices to ensure compliance with applicable Federal health insurance requirements.

(iii) Enrollment and disenrollment data, including information the Secretary may need to detect patterns of discrimination against individuals based on health status or other characteristics, to ensure compliance with applicable Federal health insurance requirements (including non-discrimination in group coverage, guaranteed issue, and guaranteed renewability requirements applicable in all markets).

(iv) Post-claims underwriting and rescission practices to ensure compliance with applicable Federal health insurance requirements relating to guaranteed renewability.

(v) Marketing materials and agent guidelines to ensure compliance with applicable Federal health insurance requirements.

(vi) Data on the imposition of pre-existing condition exclusion periods and claims subjected to such exclusion periods.

(vii) Information on issuance of certificates of creditable coverage.

(viii) Information on cost-sharing and payments with respect to any out-of-network coverage.

(ix) The application to issuers of penalties for violation of applicable Federal health insurance requirements (including failure to produce requested information).

(x) Such other information as the Trust may determine to be necessary to verify compliance with the requirements of this section.

(B) REQUIRED DISCLOSURE.—The Secretary of Health and Human Services shall provide the Trust with all consumer claims data or information that has been provided to the Secretary by any qualified health plan that is offered through an Exchange.

(C) PERIOD FOR PROVIDING INFORMATION.—Information to be provided to the Trust under this paragraph shall be provided by the Secretary within 30 days of the date of receipt of the request for such information, or within such extended period as the Secretary and the Trust mutually deem appropriate.

(5) NON-DISCLOSURE OF HEALTH INSURANCE DATA.—The Trust shall prevent disclosure of any data or information provided under this paragraph that the Trust determines is proprietary or qualifies as a trade secret subject to withholding from public dissemination. Any data or information provided under this paragraph shall not be subject to disclosure under section 552 of title 5, United States Code (commonly referred to as the Freedom of Information Act).

**SA 2950.** Mr. ROCKEFELLER submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, to amend the Internal Revenue Code of 1986 to modify the first-time homebuyers credit in the case of members of the Armed Forces and certain other Federal employees, and for other purposes; which was ordered to lie on the table; as follows:

On page 34, between lines 4 and 5, insert the following:

**“SEC. 2720. LIMITATION ON ANNUAL GROWTH IN HEALTH INSURANCE PREMIUMS.**

“(a) IN GENERAL.—A group health plan and a health insurance issuer offering group or individual health insurance coverage may not increase the health insurance premium rates for such plan or coverage in any year by a percentage that is greater than the percentage increase in the Medical Care Component of the Consumer Price Index for all urban consumers for year involved.

“(b) EFFECT.—If a plan or an issuer increases the health insurance premium rate by a percentage greater than the percentage described in subsection (a), that plan or issuer shall refund the excess premium dollars back to the enrollee or to the Federal treasury, in amounts equal to the respective premium contributions of the enrollee and the Federal Government, taking into account premium subsidies provided to individuals or families for coverage purchased in an Exchange.”.

**SA 2951.** Mr. ROCKEFELLER submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, to amend the Internal Revenue Code of 1986 to modify the first-time homebuyers credit in the case of members of the Armed Forces and certain other Federal employees, and for other purposes; which was ordered to lie on the table; as follows:

On page 112, between lines 8 and 9, insert the following:

(5) MAXIMUM TOTAL OUT-OF-POCKET EXPENSES.—

(A) IN GENERAL.—Notwithstanding any other provision of this Act (or any amend-

ments made by this Act), in no case may out-of-pocket expenses incurred under a health plan with respect to self-only coverage or coverage other than self-only exceed the following limits for any plan year beginning in or after 2014:

(i) 7.5 percent of annual household income for an individual with household income under 200 percent of the poverty line for the size of the family involved.

(ii) 10 percent of annual household income for an individual with household income between 200 and 400 percent of the poverty line for the size of the family involved.

(iii) 12 percent of annual household income for an individual with household income above 400 percent of the poverty line for the size of the family involved.

(B) OUT-OF-POCKET EXPENSES.—In this paragraph, the term “out-of-pocket expenses” includes deductibles, coinsurance, copayments, premiums, balance billing amounts for non-network providers, and similar charges.

**SA 2952.** Mr. ROCKEFELLER submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, to amend the Internal Revenue Code of 1986 to modify the first-time homebuyers credit in the case of members of the Armed Forces and certain other Federal employees, and for other purposes; which was ordered to lie on the table; as follows:

On page 125, between lines 14 and 15, insert the following:

**Subtitle C—Provisions Relating to Authorized Generic Drugs**

**SEC. 7201. PROHIBITION OF AUTHORIZED GENERICS.**

(a) IN GENERAL.—Section 505 of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 355) is amended by adding at the end the following:

“(w) PROHIBITION OF AUTHORIZED GENERIC DRUGS.—

“(1) IN GENERAL.—Notwithstanding any other provision of this Act, no holder of a new drug application approved under subsection (c) shall manufacture, market, sell, or distribute an authorized generic drug, direct or indirectly, or authorize any other person to manufacture, market, sell, or distribute an authorized generic drug.

“(2) AUTHORIZED GENERIC DRUG.—For purposes of this subsection, the term ‘authorized generic drug’—

“(A) means any version of a listed drug (as such term is used in subsection (j)) that the holder of the new drug application approved under subsection (c) for that listed drug seeks to commence marketing, selling, or distributing, directly or indirectly, after receipt of a notice sent pursuant to subsection (j)(2)(B) with respect to that listed drug; and

“(B) does not include any drug to be marketed, sold, or distributed—

“(i) by an entity eligible for exclusivity with respect to such drug under subsection (j)(5)(B)(iv); or

“(ii) after expiration or forfeiture of any exclusivity with respect to such drug under such subsection (j)(5)(B)(iv).”.

(b) CONFORMING AMENDMENT.—Section 505(t)(3) of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 355(t)(3)) is amended by striking “In this section” and inserting “In this subsection”.

**ORDERS FOR MONDAY, DECEMBER 7, 2009**

Mr. BEGICH. Mr. President, I ask unanimous consent that when the Senate completes its business today, it adjourn until 10 a.m., Monday, December 7; that following the prayer and the pledge, the Journal of proceedings be approved to date, the morning hour be deemed to have expired, the time for the two leaders be reserved for their use later in the day, and the Senate resume consideration of H.R. 3590, the health care reform legislation; that following leader remarks, the first 2 hours be equally divided and controlled between the two leaders or their designees, with Senators permitted to speak therein for up to 10 minutes each, with the Republicans controlling the first 30 minutes, and the majority controlling the next 30 minutes, and with no amendments or motions in order during the controlled time.

The PRESIDING OFFICER. Without objection, it is so ordered.

**PROGRAM**

Mr. BEGICH. Mr. President, rollcall votes in relation to the amendments to the health care reform bill are expected to occur after 3:15 p.m. tomorrow.

**ADJOURNMENT UNTIL 10 A.M. TOMORROW**

Mr. BEGICH. Mr. President, if there is no further business to come before the Senate, I ask unanimous consent that it adjourn under the previous order.

There being no objection, the Senate, at 5:24 p.m., adjourned until Monday, December 7, 2009, at 10 a.m.