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111TH CONGRESS
1ST SESSION

H. R. 3970

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

IN THE HOUSE OF REPRESENTATIVES

OCTOBER 29, 2009

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

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A BILL

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

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,

SECTION 1. SHORT TITLE.

This Act may be cited as the ''Medical Rights and Reform Act of 2009''.

SEC. 2. TABLE OF CONTENTS.

TITLE I—PROTECTING THE DOCTOR-PATIENT RELATIONSHIP

SEC. 101. PROHIBITION ON RESTRICTIONS ON THE PRACTICE OF MEDICINE AND OTHER HEALTH CARE PROFESSIONS.

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

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

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

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

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

(4) the administration or operation of any such institution, business, non-Federal agency, or individual, with respect to the provision of health care services to a patient.

(b) PRESERVING CERTAIN CURRENT PROGRAMS.—Subsection (a) shall not prohibit the Federal Government from operating, managing, supervising employees of, or defining the scope of services provided by Federal entities when directly providing health care services and products, only with respect to the following:

(1) The Veterans Health Administration—

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

(B) in the case of coordinating health care services not described in subparagraph (A) and paid for with Federal funds under programs operated by the Veterans Health Administration.

(2) The Department of Defense—

(A) in the case of directly providing health care services through military treatment facilities;

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

(C) in the case of directly providing health care services to the public in the event of emergency or under other lawful circumstances; or

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

(3) The United States Public Health Service—

(A) in the case of providing health care services through its own facilities or by its officers or civilian Federal employees;

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

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

(4) The Indian Health Service—

(A) in the case of directly providing health care services through its own facilities or Federal employees; or

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

(5) The National Institutes of Health—

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

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

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

(6) The Health Resources and Services Administration—

(A) in the case of certifying federally qualified health centers, as defined by section 1905(l)(2)(B) of the Social Security Act (42 U.S.C. 1396d(l)(2)(B)), certifying FQHC look-alike status, as defined in section 413.65(n) of title 45 of the Code of Federal Regulations, or providing grants under section 330 of the Public Health Service Act (42 U.S.C. 254b), but only to the extent necessary to determine eligibility for such certification and grant funding and the appropriate amounts of such funding; or

(B) in the case of operating the nation's human organ, bone marrow, and umbilical cord blood donation and transplantation systems, as and to the extent authorized by law and necessary for the operation of those programs.

SEC. 102. RIGHT TO CONTRACT FOR HEALTH CARE SERVICES AND HEALTH INSURANCE.

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

to prohibit any individual from receiving health care services from any provider of health care services—

(1) under terms and conditions mutually acceptable to the patient and the provider; or

(2) under terms and conditions mutually acceptable to the patient, the provider, and any group health plan or health insurance issuer that is obligated to provide health insurance coverage to the patient or any other entity indemnifying the patient's consumption of health care services;

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

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

(c) ELIGIBILITY FOR FEDERAL BENEFITS.—No person's eligibility for benefits under any program operated by or funded wholly or partly by the Federal Government

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

(d) FEDERAL PROGRAM PARTICIPATION.—No provider of health care services—

(1) shall be denied participation in a Federal program for which it would otherwise be eligible as a result of having provided services in a manner described in subsection (a); or

(2) shall be denied payment for services otherwise eligible for payment under a Federal program as a result of having provided services in a manner described in subsection (a), except to the extent required by subsection (a)(1).

SEC. 103. PROHIBITION ON MANDATING STATE RESTRICTIONS.

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

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

eral Government shall be conditioned on that State enacting any restriction or prohibition prohibited to the Federal Government by this title, nor adversely affected by that State's failure to enact any restriction or prohibition prohibited to the Federal Government by this title.

SEC. 104. CLARIFICATION.

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

SEC. 105. CONFORMING AMENDMENT.

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

SEC. 106. DEFINITIONS.

For purposes of this title:

(1) HEALTH CARE SERVICES.—The term ''health care services'' means any lawful service intended to diagnose, cure, prevent, or mitigate the adverse effects of any disease, injury, infirmity, or physical or mental disability, including the provision of any lawful product the use of which is so intended.

(2) PHYSICIAN.—The term ''physician'' means—

(A) a doctor of medicine or osteopathy legally authorized to practice medicine and sur-

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

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

(C) a doctor of podiatric medicine but only with respect to functions which he is legally authorized to perform as such by the State in which he performs them;

(D) a doctor of optometry with respect to the provision of items or services which he is legally authorized to perform as a doctor of optometry by the State in which he performs them; or

(E) a chiropractor who is licensed as such by the State (or in a State which does not license chiropractors as such, is legally authorized to perform the services of a chiropractor in the jurisdiction in which he performs such services), but only with respect to treatment which he is legally authorized to perform by the State

or jurisdiction in which such treatment is provided.

(3) PRACTICE OF MEDICINE.—The term ''practice of medicine'' means—

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

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

(4) HEALTH CARE PRACTITIONER.—The term ''health care practitioner'' means a physician assistant, registered nurse, nurse practitioner, psychologist, clinical social worker, midwife, or other individual (other than a physician) licensed or legally authorized to perform health care services in the State in which the individual performs such services.

(5) PRACTICE OF OTHER HEALTH CARE PROFESSIONS.—The term ''practice of other health care professions'' means—

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

(B) services and supplies furnished as an incident to a health care practitioner's professional service.

(6) GROUP HEALTH PLAN.—The term ''group health plan'' has the meaning given such term in

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

(7) HEALTH INSURANCE ISSUER.—The term ''health insurance issuer'' has the meaning given such term in section 733(b)(2) of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1191b(b)(2)).

(8) BUSINESS.—The term ''business'' means any sole proprietorship, partnership, for-profit corporation, or not-for-profit corporation.

(9) STATE.—The term ''State'' means any of the United States, the Commonwealth of Puerto Rico, the Commonwealth of the Northern Mariana Islands, the United States Virgin Islands, Guam, American Samoa, or the District of Columbia.

SEC. 107. EFFECTIVE DATE.

The provisions of this title shall apply to Federal entities, including employees and officials of such entities, beginning on January 1, 2009.

TITLE II—IMPROVING QUALITY AND LOWERING THE COST OF HEALTH CARE

Subtitle A—Equity for Our Nation's Self-Employed

SEC. 201. SECA TAX DEDUCTION FOR HEALTH INSURANCE COSTS.

(a) IN GENERAL.—Subsection (l) of section 162 of the Internal Revenue Code of 1986 (relating to special rules for health insurance costs of self-employed individuals) is amended by striking paragraph (4) and by redesignating paragraph (5) as paragraph (4).

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

Subtitle B—Help Efficient, Accessible, Low-cost, Timely Healthcare

SEC. 211. FINDINGS AND PURPOSE.

(a) FINDINGS.—

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

is a costly and ineffective mechanism for resolving claims of health care liability and compensating injured patients, and is a deterrent to the sharing of information among health care professionals which impedes efforts to improve patient safety and quality of care.

(2) EFFECT ON INTERSTATE COMMERCE.—Congress finds that the health care and insurance industries are industries affecting interstate commerce and the health care liability litigation systems existing throughout the United States are activities that affect interstate commerce by contributing to the high costs of health care and premiums for health care liability insurance purchased by health care system providers.

(3) EFFECT ON FEDERAL SPENDING.—Congress finds that the health care liability litigation systems existing throughout the United States have a significant effect on the amount, distribution, and use of Federal funds because of—

(A) the large number of individuals who receive health care benefits under programs operated or financed by the Federal Government;

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

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

(C) the large number of health care providers who provide items or services for which the Federal Government makes payments.

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

(1) improve the availability of health care services in cases in which health care liability actions have been shown to be a factor in the decreased availability of services;

(2) reduce the incidence of ''defensive medicine'' and lower the cost of health care liability insurance, all of which contribute to the escalation of health care costs;

(3) ensure that persons with meritorious health care injury claims receive fair and adequate compensation, including reasonable noneconomic damages;

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

(5) provide an increased sharing of information in the health care system which will reduce unintended injury and improve patient care.

SEC. 212. ENCOURAGING SPEEDY RESOLUTION OF CLAIMS.

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

(1) upon proof of fraud;

(2) intentional concealment; or

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

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

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

SEC. 213. COMPENSATING PATIENT INJURY.

(a) UNLIMITED AMOUNT OF DAMAGES FOR ACTUAL ECONOMIC LOSSES IN HEALTH CARE LAWSUITS.—In any health care lawsuit, nothing in this subtitle shall limit a claimant's recovery of the full amount of the available economic damages, notwithstanding the limitation in subsection (b).

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

(c) NO DISCOUNT OF AWARD FOR NONECONOMIC DAMAGES.—For purposes of applying the limitation in subsection (b), future noneconomic damages shall not be discounted to present value. The jury shall not be informed about the maximum award for noneconomic damages. An award for noneconomic damages in excess of $250,000 shall be reduced either before the entry of judgment, or by amendment of the judgment after entry of judgment, and such reduction shall be made before accounting for any other reduction in damages required by

law. If separate awards are rendered for past and future noneconomic damages and the combined awards exceed $250,000, the future noneconomic damages shall be reduced first.

(d) FAIR SHARE RULE.—In any health care lawsuit, each party shall be liable for that party's several share of any damages only and not for the share of any other person. Each party shall be liable only for the amount of damages allocated to such party in direct proportion to such party's percentage of responsibility. Whenever a judgment of liability is rendered as to any party, a separate judgment shall be rendered against each such party for the amount allocated to such party. For purposes of this section, the trier of fact shall determine the proportion of responsibility of each party for the claimant's harm.

SEC. 214. MAXIMIZING PATIENT RECOVERY.

(a) COURT SUPERVISION OF SHARE OF DAMAGES ACTUALLY PAID TO CLAIMANTS.—In any health care lawsuit, the court shall supervise the arrangements for payment of damages to protect against conflicts of interest that may have the effect of reducing the amount of damages awarded that are actually paid to claimants. In particular, in any health care lawsuit in which the attorney for a party claims a financial stake in the outcome by vir-

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

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

(2) 33⅓ percent of the next $50,000 recovered by the claimant(s).

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

(4) 15 percent of any amount by which the recovery by the claimant(s) is in excess of $600,000.

(b) APPLICABILITY.—The limitations in this section shall apply whether the recovery is by judgment, settlement, mediation, arbitration, or any other form of alternative dispute resolution. In a health care lawsuit involving a minor or incompetent person, a court retains the authority to authorize or approve a fee that is less than the maximum permitted under this section. The requirement for court supervision in the first two sentences of subsection (a) applies only in civil actions.

SEC. 215. ADDITIONAL HEALTH BENEFITS.

In any health care lawsuit involving injury or wrongful death, any party may introduce evidence of collateral source benefits. If a party elects to introduce such evidence, any opposing party may introduce evidence of any amount paid or contributed or reasonably likely to be paid or contributed in the future by or on behalf of the opposing party to secure the right to such collateral source benefits. No provider of collateral source benefits shall recover any amount against the claimant or receive any lien or credit against the claimant's recovery or be equitably or legally subrogated to the right of the claimant in a health care lawsuit involving injury or wrongful death. This section shall apply to any health care lawsuit that is settled as well as a health care lawsuit that is resolved by a fact finder. This section shall not apply to section 1862(b) (42 U.S.C. 1395y(b)) or section 1902(a)(25) (42 U.S.C. 1396a(a)(25)) of the Social Security Act.

SEC. 216. PUNITIVE DAMAGES.

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

stantially certain to suffer. In any health care lawsuit where no judgment for compensatory damages is rendered against such person, no punitive damages may be awarded with respect to the claim in such lawsuit. No demand for punitive damages shall be included in a health care lawsuit as initially filed. A court may allow a claimant to file an amended pleading for punitive damages only upon a motion by the claimant and after a finding by the court, upon review of supporting and opposing affidavits or after a hearing, after weighing the evidence, that the claimant has established by a substantial probability that the claimant will prevail on the claim for punitive damages. At the request of any party in a health care lawsuit, the trier of fact shall consider in a separate proceeding—

(1) whether punitive damages are to be awarded and the amount of such award; and

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

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

(b) DETERMINING AMOUNT OF PUNITIVE DAMAGES.—

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

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

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

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

(D) the number of products sold or medical procedures rendered for compensation, as the case may be, by such party, of the kind causing the harm complained of by the claimant;

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

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

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

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

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

(1) IN GENERAL.—

(A) No punitive damages may be awarded against the manufacturer or distributor of a medical product, or a supplier of any component or raw material of such medical product, based on a claim that such product caused the claimant's harm where—

(i)(I) such medical product was subject to premarket approval, clearance, or licensure by the Food and Drug Administration with respect to the safety of the formulation or performance of the aspect of such medical product which caused the claimant's harm or the adequacy of the packaging or labeling of such medical product; and

(II) such medical product was so approved, cleared, or licensed; or

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

lished by the Food and Drug Administration and applicable Food and Drug Administration regulations, including without limitation those related to packaging and labeling, unless the Food and Drug Administration has determined that such medical product was not manufactured or distributed in substantial compliance with applicable Food and Drug Administration statutes and regulations.

(B) RULE OF CONSTRUCTION.—Subparagraph (A) may not be construed as establishing the obligation of the Food and Drug Administration to demonstrate affirmatively that a manufacturer, distributor, or supplier referred to in such subparagraph meets any of the conditions described in such subparagraph.

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

seller of such product. Nothing in this paragraph prevents a court from consolidating cases involving health care providers and cases involving products liability claims against the manufacturer, distributor, or product seller of such medical product.

(3) PACKAGING.—In a health care lawsuit for harm which is alleged to relate to the adequacy of the packaging or labeling of a drug which is required to have tamper-resistant packaging under regulations of the Secretary of Health and Human Services (including labeling regulations related to such packaging), the manufacturer or product seller of the drug shall not be held liable for punitive damages unless such packaging or labeling is found by the trier of fact by clear and convincing evidence to be substantially out of compliance with such regulations.

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

(A) a person, before or after premarket approval, clearance, or licensure of such medical product, knowingly misrepresented to or withheld from the Food and Drug Administration information that is required to be submitted under the Federal Food, Drug, and Cosmetic

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

(B) a person made an illegal payment to an official of the Food and Drug Administration for the purpose of either securing or maintaining approval, clearance, or licensure of such medical product.

SEC. 217. AUTHORIZATION OF PAYMENT OF FUTURE DAMAGES TO CLAIMANTS IN HEALTH CARE LAWSUITS.

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

(b) APPLICABILITY.—This section applies to all actions which have not been first set for trial or retrial before the effective date of this subtitle.

SEC. 218. DEFINITIONS.

In this subtitle:

(1) ALTERNATIVE DISPUTE RESOLUTION SYSTEM; ADR.—The term ''alternative dispute resolution system'' or ''ADR'' means a system that provides for the resolution of health care lawsuits in a manner other than through a civil action brought in a State or Federal court.

(2) CLAIMANT.—The term ''claimant'' means any person who brings a health care lawsuit, including a person who asserts or claims a right to legal or equitable contribution, indemnity, or subrogation, arising out of a health care liability claim or action, and any person on whose behalf such a claim is asserted or such an action is brought, whether deceased, incompetent, or a minor.

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

ant, as a result of the injury or wrongful death, pursuant to—

(A) any State or Federal health, sickness, income-disability, accident, or workers' compensation law;

(B) any health, sickness, income-disability, or accident insurance that provides health benefits or income-disability coverage;

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

(D) any other publicly or privately funded program.

(4) COMPENSATORY DAMAGES.—The term ''compensatory damages'' means objectively verifiable monetary losses incurred as a result of the provision of, use of, or payment for (or failure to provide, use, or pay for) health care services or medical products, such as past and future medical expenses, loss of past and future earnings, cost of obtaining domestic services, loss of employment, and loss of business or employment opportunities, damages for physical and emotional pain, suffering, in-

convenience, physical impairment, mental anguish, disfigurement, loss of enjoyment of life, loss of society and companionship, loss of consortium (other than loss of domestic service), hedonic damages, injury to reputation, and all other nonpecuniary losses of any kind or nature. The term ''compensatory damages'' includes economic damages and noneconomic damages, as such terms are defined in this section.

(5) CONTINGENT FEE.—The term ''contingent fee'' includes all compensation to any person or persons which is payable only if a recovery is effected on behalf of one or more claimants.

(6) ECONOMIC DAMAGES.—The term ''economic damages'' means objectively verifiable monetary losses incurred as a result of the provision of, use of, or payment for (or failure to provide, use, or pay for) health care services or medical products, such as past and future medical expenses, loss of past and future earnings, cost of obtaining domestic services, loss of employment, and loss of business or employment opportunities.

(7) HEALTH CARE LAWSUIT.—The term ''health care lawsuit'' means any health care liability claim concerning the provision of health care goods

or services or any medical product affecting interstate commerce, or any health care liability action concerning the provision of health care goods or services or any medical product affecting interstate commerce, brought in a State or Federal court or pursuant to an alternative dispute resolution system, against a health care provider, a health care organization, or the manufacturer, distributor, supplier, marketer, promoter, or seller of a medical product, regardless of the theory of liability on which the claim is based, or the number of claimants, plaintiffs, defendants, or other parties, or the number of claims or causes of action, in which the claimant alleges a health care liability claim. Such term does not include a claim or action which is based on criminal liability; which seeks civil fines or penalties paid to Federal, State, or local government; or which is grounded in antitrust.

(8) HEALTH CARE LIABILITY ACTION.—The term ''health care liability action'' means a civil action brought in a State or Federal court or pursuant to an alternative dispute resolution system, against a health care provider, a health care organization, or the manufacturer, distributor, supplier, marketer, promoter, or seller of a medical product, regardless

of the theory of liability on which the claim is based, or the number of plaintiffs, defendants, or other parties, or the number of causes of action, in which the claimant alleges a health care liability claim.

(9) HEALTH CARE LIABILITY CLAIM.—The term ''health care liability claim'' means a demand by any person, whether or not pursuant to ADR, against a health care provider, health care organization, or the manufacturer, distributor, supplier, marketer, promoter, or seller of a medical product, including, but not limited to, third-party claims, cross-claims, counter-claims, or contribution claims, which are based upon the provision of, use of, or payment for (or the failure to provide, use, or pay for) health care services or medical products, regardless of the theory of liability on which the claim is based, or the number of plaintiffs, defendants, or other parties, or the number of causes of action.

(10) HEALTH CARE ORGANIZATION.—The term ''health care organization'' means any person or entity which is obligated to provide or pay for health benefits under any health plan, including any person or entity acting under a contract or arrangement with a health care organization to provide or administer any health benefit.

(11) HEALTH CARE PROVIDER.—The term ''health care provider'' means any person or entity required by State or Federal laws or regulations to be licensed, registered, or certified to provide health care services, and being either so licensed, registered, or certified, or exempted from such requirement by other statute or regulation.

(12) HEALTH CARE GOODS OR SERVICES.—The term ''health care goods or services'' means any goods or services provided by a health care organization, provider, or by any individual working under the supervision of a health care provider, that relates to the diagnosis, prevention, or treatment of any human disease or impairment, or the assessment or care of the health of human beings.

(13) MALICIOUS INTENT TO INJURE.—The term ''malicious intent to injure'' means intentionally causing or attempting to cause physical injury other than providing health care goods or services.

(14) MEDICAL PRODUCT.—The term ''medical product'' means a drug, device, or biological product intended for humans, and the terms ''drug'', ''device'', and ''biological product'' have the meanings given such terms in sections 201(g)(1) and 201(h)

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

(15) NONECONOMIC DAMAGES.—The term ''noneconomic damages'' means damages for physical and emotional pain, suffering, inconvenience, physical impairment, mental anguish, disfigurement, loss of enjoyment of life, loss of society and companionship, loss of consortium (other than loss of domestic service), hedonic damages, injury to reputation, and all other nonpecuniary losses of any kind or nature.

(16) PUNITIVE DAMAGES.—The term ''punitive damages'' means damages awarded, for the purpose of punishment or deterrence, and not solely for compensatory purposes, against a health care provider, health care organization, or a manufacturer, distributor, or supplier of a medical product. Punitive damages are neither economic nor noneconomic damages.

(17) RECOVERY.—The term ''recovery'' means the net sum recovered after deducting any disbursements or costs incurred in connection with prosecu-

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

(18) STATE.—The term ''State'' means each of the several States, the District of Columbia, the Commonwealth of Puerto Rico, the Virgin Islands, Guam, American Samoa, the Northern Mariana Islands, the Trust Territory of the Pacific Islands, and any other territory or possession of the United States, or any political subdivision thereof.

SEC. 219. EFFECT ON OTHER LAWS.

(a) VACCINE INJURY.—

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

(A) this subtitle does not affect the application of the rule of law to such an action; and

(B) any rule of law prescribed by this subtitle in conflict with a rule of law of such title XXI shall not apply to such action.

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

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

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

SEC. 220. STATE FLEXIBILITY AND PROTECTION OF STATES' RIGHTS.

(a) HEALTH CARE LAWSUITS.—The provisions governing health care lawsuits set forth in this subtitle preempt, subject to subsections (b) and (c), State law to the extent that State law prevents the application of any provisions of law established by or under this subtitle. The provisions governing health care lawsuits set forth in this subtitle supersede chapter 171 of title 28, United States Code, to the extent that such chapter—

(1) provides for a greater amount of damages or contingent fees, a longer period in which a health care lawsuit may be commenced, or a reduced applicability or scope of periodic payment of future damages, than provided in this subtitle; or

(2) prohibits the introduction of evidence regarding collateral source benefits, or mandates or permits subrogation or a lien on collateral source benefits.

(b) PROTECTION OF STATES' RIGHTS AND OTHER LAWS.—(1) Any issue that is not governed by any provision of law established by or under this subtitle (including State standards of negligence) shall be governed by otherwise applicable State or Federal law.

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

(c) STATE FLEXIBILITY.—No provision of this subtitle shall be construed to preempt—

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

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

SEC. 221. APPLICABILITY; EFFECTIVE DATE.

This subtitle shall apply to any health care lawsuit brought in a Federal or State court, or subject to an alternative dispute resolution system, that is initiated on or after the date of the enactment of this subtitle, except that any health care lawsuit arising from an injury occurring prior to the date of the enactment of this subtitle shall be governed by the applicable statute of limitations provisions in effect at the time the injury occurred.

SEC. 222. SENSE OF CONGRESS.

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

Subtitle C—Accelerating the Deployment of Health Information Technology

PART 1—ENHANCED COORDINATION AND ADOPTION OF HEALTH INFORMATION TECHNOLOGY

SEC. 231. STRATEGIC PLAN FOR COORDINATING IMPLEMENTATION OF MEDICARE AND MEDICAID HEALTH INFORMATION TECHNOLOGY INCENTIVE PAYMENTS.

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

"(9) STRATEGIC PLAN FOR MEDICARE AND MEDICAID EHR PAYMENT INCENTIVES AND ADJUSTMENTS.—Not later than 90 days after the date of the enactment of the Medical Rights and Reform Act of 2009, the National Coordinator shall publish a strategic plan including—

"(A) timelines for applying the incentive payments and incentive adjustments applicable to eligible providers, eligible hospitals, and eligible professionals under sections 1848(a), 1848(o), 1853(l), 1853(m), 1886(n), 1814(l)(3), 1886(b)(3)(B)(ix), and

1903(a)(3)(F) during the 18-month period following such date of enactment, including specifying specific steps by date that providers and hospitals must take to be eligible for such incentive payments; and

''(B) a specific plan to educate health care providers, consumers, and vendors of health information technology about how eligible providers, eligible hospitals, and eligible professionals may become compliant with requirements under such sections for purposes of eligibility for incentive payments under such sections.''.

SEC. 232. PROCEDURES TO ENSURE TIMELY UPDATING OF STANDARDS THAT ENABLE ELECTRONIC EXCHANGES.

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

(1) in paragraph (1)—

(A) in the first sentence, by inserting ''and in accordance with paragraph (3)'' before the period; and

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

section 1173(c)(2), the term 'modification' includes a new version or a version upgrade''; and

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

''(3) EXPEDITED PROCEDURES FOR ADOPTION OF ADDITIONS AND MODIFICATIONS TO STANDARDS.—

''(A) IN GENERAL.—For purposes of paragraph (1), the Secretary shall provide for an expedited upgrade program (in this paragraph referred to as the 'upgrade program'), in accordance with this paragraph, to develop and approve additions and modifications to the standards adopted under section 1173(a) to improve the quality of such standards or to extend the functionality of such standards to meet evolving requirements in health care.

''(B) PUBLICATION OF NOTICES.—Under the upgrade program:

''(i) VOLUNTARY NOTICE OF INITIATION OF PROCESS.—Not later than 30 days after the date the Secretary receives a notice from a standard setting organization that the organization is initiating a process to develop an addition or modifica-

tion to a standard adopted under section 1173(a), the Secretary shall publish a notice in the Federal Register that—

"(I) identifies the subject matter of the addition or modification;

"(II) provides a description of how persons may participate in the development process; and

"(III) invites public participation in such process.

"(ii) VOLUNTARY NOTICE OF PRELIMINARY DRAFT OF ADDITIONS OR MODIFICATIONS TO STANDARDS.—Not later than 30 days after the date the Secretary receives a notice from a standard setting organization that the organization has prepared a preliminary draft of an addition or modification to a standard adopted by section 1173(a), the Secretary shall publish a notice in the Federal Register that—

"(I) identifies the subject matter of (and summarizes) the addition or modification;

"(II) specifies the procedure for obtaining the draft;

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

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

"(iii) NOTICE OF PROPOSED ADDITION OR MODIFICATION TO STANDARDS.—Not later than 30 days after the date the Secretary receives a notice from a standard setting organization that the organization has a proposed addition or modification to a standard adopted under section 1173(a) that the organization intends to submit under subparagraph (D)(iii), the Secretary shall publish a notice in the Federal Register that contains, with respect to the proposed addition or modification, the information required in the notice under clause (ii) with respect to the addition or modification.

"(iv) CONSTRUCTION.—Nothing in this paragraph shall be construed as requiring a standard setting organization to request the notices described in clauses (i) and (ii) with respect to an addition or modification to a standard in order to qualify for an expedited determination under subparagraph (C) with respect to a proposal submitted to the Secretary for adoption of such addition or modification.

"(C) PROVISION OF EXPEDITED DETERMINATION.—Under the upgrade program and with respect to a proposal by a standard setting organization for an addition or modification to a standard adopted under section 1173(a), if the Secretary determines that the standard setting organization developed such addition or modification in accordance with the requirements of subparagraph (D) and the National Committee on Vital and Health Statistics recommends approval of such addition or modification under subparagraph (E), the Secretary shall provide for expedited treatment of such proposal in accordance with subparagraph (F).

"(D) REQUIREMENTS.—The requirements under this subparagraph with respect to a proposed addition or modification to a standard by a standard setting organization are the following:

"(i) REQUEST FOR PUBLICATION OF NOTICE.—The standard setting organization submits to the Secretary a request for publication in the Federal Register of a notice described in subparagraph (B)(iii) for the proposed addition or modification.

"(ii) PROCESS FOR RECEIPT AND CONSIDERATION OF PUBLIC COMMENT.—The standard setting organization provides for a process through which, after the publication of the notice referred to under clause (i), the organization—

"(I) receives and responds to public comments submitted on a timely basis on the proposed addition or modification before submitting such proposed addition or modification to the National Committee on Vital and Health Statistics under clause (iii);

"(II) makes publicly available a written explanation for its response in the proposed addition or modification to comments submitted on a timely basis; and

"(III) makes public comments received under clause (I) available, or provides access to such comments, to the Secretary.

"(iii) SUBMITTAL OF FINAL PROPOSED ADDITION OR MODIFICATION TO NCVHS.—After completion of the process under clause (ii), the standard setting organization submits the proposed addition or modification to the National Committee on Vital and Health Statistics for review and consideration under subparagraph (E). Such submission shall include information on the organization's compliance with the notice and comment requirements (and responses to those comments) under clause (ii).

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

gram, upon receipt of a proposal submitted by a standard setting organization under subparagraph (D)(iii) for the adoption of an addition or modification to a standard, the National Committee on Vital and Health Statistics shall provide notice to the public and a reasonable opportunity for public testimony at a hearing on such addition or modification. The Secretary may participate in such hearing in such capacity (including presiding ex officio) as the Secretary shall determine appropriate. Not later than 90 days after the date of receipt of the proposal, the Committee shall submit to the Secretary its recommendation to adopt (or not adopt) the proposed addition or modification.

''(F) DETERMINATION BY SECRETARY TO ACCEPT OR REJECT NATIONAL COMMITTEE ON VITAL AND HEALTH STATISTICS RECOMMENDATION.—

''(i) TIMELY DETERMINATION.—Under the upgrade program, if the National Committee on Vital and Health Statistics submits to the Secretary a recommendation under subparagraph (E) to adopt a proposed addition or modification,

not later than 90 days after the date of receipt of such recommendation the Secretary shall make a determination to accept or reject the recommendation and shall publish notice of such determination in the Federal Register not later than 30 days after the date of the determination.

''(ii) CONTENTS OF NOTICE.—If the determination is to reject the recommendation, such notice shall include the reasons for the rejection. If the determination is to accept the recommendation, as part of such notice the Secretary shall promulgate the modified standard (including the accepted proposed addition or modification accepted).

''(iii) LIMITATION ON CONSIDERATION.—The Secretary shall not consider a proposal under this subparagraph unless the Secretary determines that the requirements of subparagraph (D) (including publication of notice and opportunity for public comment) have been met with respect to the proposal.

''(G) EXEMPTION FROM PAPERWORK REDUCTION ACT.—Chapter 35 of title 44, United States Code, shall not apply to a final rule promulgated under subparagraph (F).''.

SEC. 233. STUDY TO IMPROVE PRESERVATION AND PROTECTION OF SECURITY AND CONFIDENTIALITY OF HEALTH INFORMATION.

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

(1) Current Federal security and confidentiality standards to determine the strengths and weaknesses of such standards for purposes of protecting the security and confidentiality of individually identifiable health information while taking into account the need for timely and efficient exchanges of health information to improve quality of care and ensure the availability of health information necessary to make medical decisions at the location in which the medical care involved is provided.

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

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

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

(c) PRESERVATION OF CURRENT SECURITY AND CONFIDENTIALITY STANDARDS BEFORE SUBMITTAL OF REPORT.—None of the provisions of this subtitle or amendments made by this subtitle may limit, or require issuance of a regulation that would limit, the effect of a current Federal security and confidentiality standard before the date of the submittal of the report under subsection (b).

(d) CURRENT FEDERAL SECURITY AND CONFIDENTIALITY STANDARDS DEFINED.—For purposes of this section, the term ''current Federal security and confiden-

tiality standards'' means the Federal privacy standards established pursuant to section 264(c) of the Health Insurance Portability and Accountability Act of 1996 (42 U.S.C. 1320d–2 note) and security standards established under section 1173(d) of the Social Security Act.

SEC. 234. ASSISTING DOCTORS TO OBTAIN PROFICIENT AND TRANSMISSIBLE HEALTH INFORMATION TECHNOLOGY.

(a) IN GENERAL.—Section 179 of the Internal Revenue Code of 1986 (relating to election to expense certain depreciable assets) is amended by adding at the end the following new subsection:

''(f) HEALTH CARE INFORMATION TECHNOLOGY.—

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

''(A) subsection (b)(1) shall be applied by substituting '$250,000' for '$125,000';

''(B) subsection (b)(2) shall be applied by substituting '$600,000' for '$500,000'; and

''(C) subsection (b)(5)(A) shall be applied by substituting '$250,000 and $600,000' for '$125,000 and $500,000'.

''(2) DEFINITIONS.—For purposes of this subsection—

''(A) QUALIFIED HEALTH CARE INFORMATION TECHNOLOGY.—The term 'qualified health care information technology' means section 179 property which—

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

''(ii) is used primarily for the electronic creation, maintenance, and exchange of medical care information to provide or improve the quality or efficiency of medical care.

''(B) MEDICAL CARE PROVIDER.—The term 'medical care provider' means any person engaged in the trade or business of providing medical care.

''(C) MEDICAL CARE.—The term 'medical care' has the meaning given such term by section 213(d).''.

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

SEC. 235. EXPANSION OF STARK AND ANTI-KICKBACK EXCEPTIONS FOR ELECTRONIC HEALTH RECORDS ARRANGEMENTS.

(a) STARK EXCEPTION.—In applying section 1877(e) of the Social Security Act (42 U.S.C. 1395(e)), with respect to a regulation implementing such section by providing an exception to the prohibition against making certain physician referrals in the case of the offering or payment of nonmonetary remuneration (consisting of items and services in the form of software or information technology and training services) necessary and used predominantly to create, maintain, transmit, or receive electronic health records, the Secretary of Health and Human Services shall—

(1) not limit the period in which such an exception under such a regulation applies;

(2) not require the physician to pay any percentage of the cost of such nonmonetary remuneration; and

(3) apply the exception to such items and services in the form of hardware and maintenance services, in addition to such items and services in the form of software or information technology and training services.

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

1320a–7b(b)(3)(E)), with respect to a regulation implementing such section by providing an exception to the prohibition against offering, paying, soliciting, or receiving remuneration in order to induce or reward referrals making certain physician referrals in the case of the offering, payment, solicitation, or receipt of remuneration (consisting of certain arrangements involving interoperable electronic health records software or information technology and training services) necessary and used predominantly to create, maintain, transmit, or receive electronic health records, the Secretary of Health and Human Services shall—

(1) not limit the period in which such an exception under such a regulation applies;

(2) not require the recipient of such remuneration to pay any percentage of the cost of such remuneration; and

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

SEC. 236. APPLICATION OF MEDICARE EHR INCENTIVES AND ADJUSTMENTS TO ADDITIONAL PROVIDERS.

(a) APPLICATION OF EHR MEDICARE INCENTIVE PAYMENTS AND ADJUSTMENTS TO NURSE PRACTITIONER, PHYSICIAN ASSISTANTS, AND CLINICAL NURSE SPECIALISTS.—

(1) INCENTIVE PAYMENT.—Section 1848(o)(5)(C) of the Social Security Act is amended by inserting ", and a practitioner described in section 1842(b)(18)(C)(i)" after "1861(r)".

(2) INCENTIVE ADJUSTMENT.—Section 1848(a)(7)(E)(iii) of such Act is amended by inserting ", and a practitioner described in section 1842(b)(18)(C)(i)" after "1861(r)".

(b) APPLICATION OF EHR MEDICARE INCENTIVE PAYMENTS AND ADJUSTMENTS TO SNFS, HOME HEALTH AGENCIES, IRFS, LTCHS, ASCS, AND LONG-TERM CARE PHARMACIES.—

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

(A) determine eligible entities described in paragraph (2) that are to be considered meaningful EHR users in a manner similar to how eligible hospitals are determined to be meaningful EHR users for purposes of sections 1886(n)

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

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

(2) ELIGIBLE ENTITIES DESCRIBED.—Eligible entities described in this paragraph are the following:

(A) Skilled nursing facilities.

(B) Home health agencies.

(C) Inpatient rehabilitation facilities .

(D) Ambulatory surgical centers.

(E) Long-term care pharmacies.

(F) Long-term care hospitals.

PART 2—TELEHEALTH ENHANCEMENT

Subpart A—Medicare Program

SEC. 241. EXPANSION AND IMPROVEMENT OF TELEHEALTH SERVICES.

(a) EXPANDING ACCESS TO TELEHEALTH SERVICES TO ALL AREAS.—Section 1834(m)(4)(C)(i) of the Social Security Act (42 U.S.C. 1395m(m)(4)(C)(i)) is amended in paragraph (4)(C)(i) by striking ''and only if such site is located'' and all that follows and inserting ''without regard to the geographic area within the United States where the site is located.''.

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

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

SEC. 242. INCREASE IN NUMBER OF TYPES OF ORIGINATING SITES; CLARIFICATION.

(a) INCREASE.—Paragraph (4)(C)(ii) of section 1834(m) of the Social Security Act (42 U.S.C. 1395m(m)) is amended by adding at the end the following new subclause:

''(IX) A renal dialysis facility.''.

(b) CLARIFICATION OF INTENT OF THE TERM ORIGINATING SITE.—Such section is further amended by adding at the end the following new paragraph:

''(5) CONSTRUCTION.—In applying the term 'originating site' under this subsection, the Secretary shall apply the term only for the purpose of determining whether a site is eligible to receive a facility

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

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

SEC. 243. EXPANSION OF ELIGIBLE TELEHEALTH PROVIDERS AND CREDENTIALING OF TELEMEDICINE PRACTITIONERS.

(a) EXPANSION OF ELIGIBLE TELEHEALTH PROVIDERS.—Section 1834(m)(1) of the Social Security Act (42 U.S.C. 1395m(m)(1)) is amended—

(1) in paragraph (1)—

(A) by striking ''or a practitioner'' and inserting '', a practitioner'';

(B) by inserting '', or other telehealth provider'' after ''1842(b)(18)(C))''; and

(C) by striking ''or practitioner'' and inserting '', practitioner, or provider'';

(2) in paragraphs (2), (3)(A), and (4), by striking ''or practitioner'' and inserting '', practitioner, or other telehealth provider'' each place it appears; and

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

''(G) TELEHEALTH PROVIDER.—The term 'telehealth provider' means any supplier or provider of services (other than a physician or practitioner) that is eligible to provide other health services under this title.''.

(b) CREDENTIALING TELEMEDICINE PRACTITIONERS.—Section 1834(m) of such Act is amended by adding at the end the following new paragraph:

''(5) HOSPITAL CREDENTIALING OF TELEMEDICINE PRACTITIONERS.—A telemedicine practitioner that is credentialed by a hospital in compliance with the Joint Commission Standards for Telemedicine shall be considered in compliance with Medicare condition of participation and reimbursement credentialing requirements for telemedicine services.''.

SEC. 244. ACCESS TO TELEHEALTH SERVICES IN THE HOME.

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

''(f) COVERAGE OF TELEHEALTH SERVICES.—

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

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

''(B) do not substitute for in-person home health services ordered as part of a plan of care certified by a physician pursuant to such respective section; and

''(C) are considered the equivalent of a visit under criteria developed by the Secretary under paragraph (3).

''(2) PHYSICIAN CERTIFICATION.—Nothing in this section shall be construed as waiving the requirement for a physician certification under section 1814(a)(2)(C) or 1835(a)(2)(A) for the payment for home health services, whether or not furnished via a telecommunication system.

''(3) CRITERIA FOR VISIT EQUIVALENCY.—

''(A) STANDARDS.—The Secretary shall establish standards and qualifications for categorizing and coding under HCPCS codes telehealth services under this subsection as equivalent to an in-person visit for purposes of eligibility and payment for home health services under this title. In establishing the standards and qualifications, the Secretary may distinguish between varying modes and modalities of telehealth services and shall consider—

''(i) the nature and amount of service time involved; and

''(ii) the functions of the telecommunications.

''(B) LIMITATION.—A telecommunication that consists solely of a telephone audio conversation, facsimile, electronic text mail, or consultation between two health care practitioners is not considered a visit under this subsection.

''(4) TELEHEALTH SERVICE.—

''(A) DEFINITION.—For purposes of this subsection, the term 'telehealth service' means technology-based professional consultations, patient monitoring, patient training services, clinical observation, assessment, or treatment, and

any additional services that utilize technologies specified by the Secretary as HCPCS codes developed under paragraph (3).

''(B) UPDATE OF HCPCS CODES.—The Secretary shall establish a process for the updating, not less frequently than annually, of HCPCS codes for telehealth services.

''(5) CONDITIONS FOR PAYMENT AND COVERAGE.—Nothing in this subsection shall be construed as waiving any condition of payment under sections 1814(a)(2)(C) or 1835(a)(2)(A) or exclusion of coverage under section 1862(a)(1).

''(6) COST REPORTING.—Notwithstanding any provision to the contrary, the Secretary shall provide that the costs of telehealth services under this subsection shall be reported as a reimbursable cost center on any cost report submitted by a home health agency to the Secretary.''.

(b) EFFECTIVE DATE.—

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

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

(2) In the event that the Secretary has not complied with these deadlines, beginning October 1, 2010, a home health visit for purpose of eligibility and payment under title XVIII of the Social Security Act shall include telehealth services under section 1895(f) of such Act with the aggregate of telecommunication encounters in a 24-hour period considered the equivalent of one in-person visit.

SEC. 245. COVERAGE OF HOME HEALTH REMOTE PATIENT MANAGEMENT SERVICES FOR CHRONIC HEALTH CONDITIONS.

(a) MEDICARE COVERAGE.—

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

(A) in subparagraph (DD), by striking ''and'' at the end;

(B) in subparagraph (EE), by adding ''and'' at the end; and

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

''(FF) home health remote patient management services (as defined in subsection (hhh));''.

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

''(hhh) HOME HEALTH REMOTE PATIENT MANAGEMENT SERVICES FOR CHRONIC HEALTH CONDITIONS.—(1) The term 'remote patient management services' means the remote monitoring, evaluation, and management of an individual with a covered chronic health condition (as defined in paragraph (2)) through the utilization of a system of technology that allows a remote interface to collect and transmit clinical data between the individual and a home health agency, in accordance with a plan of care established by a physician, for the purposes of clinical review or response by the home health agency. Such term, with respect to an individual, does not include any remote monitoring, evaluation, or management of the individual if such remote monitoring, evaluation, or management, respectively, is included as a home health visit under section 1895(f) for purposes of payment under this title.

''(2) For purposes of paragraph (1), the term 'covered chronic health condition' means any chronic health condition specified by the Secretary.''.

(b) PAYMENT.—

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

''(n) HOME HEALTH REMOTE PATIENT MANAGEMENT SERVICES.—

''(1) IN GENERAL.—The Secretary shall establish a fee schedule for home health remote patient management services (as defined in section 1861(hhh)) for which payment is made under this part. The fee schedule shall be designed in a manner so that, on an annual basis, the aggregate payment amounts under this title for such services approximates 50 percent of the savings amount described in paragraph (2) for such year.

''(2) SAVINGS DESCRIBED.—

''(A) IN GENERAL.—For purposes of paragraph (1), the savings amount described in this paragraph for a year is the amount (if any), as estimated by the Secretary before the beginning of the year, by which—

''(i) the product described in subparagraph (B) for the year, exceeds

''(ii) the total payments under this part and part A for items and services furnished to individuals receiving home health

remote patient management services at any time during the year.

''(B) PRODUCT DESCRIBED.—The product described in this subparagraph for a year is the product of—

''(i) the average per capita total payments under this part and part A for items and services furnished during the year to individuals not described in subparagraph (A)(ii), adjusted to remove case mix differences between such individuals not described in such subparagraph and the individuals described in such subparagraph; and

''(ii) the number of individuals under subparagraph (A)(ii) for the year.

''(3) LIMITATION.—In no case may payments under this subsection result in the aggregate expenditures under this title (including payments under this subsection) exceeding the amount that the Secretary estimates would have been expended if coverage under this title for home health patient management services was not provided.

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

individual, shall be in addition to any other payments that a home health agency would otherwise receive under this title for items and services furnished to such individual and shall have no effect on the amount of such other payments.

''(5) PAYMENT TRANSFER.—There shall be transferred from the Federal Hospital Insurance Trust Fund under section 1817 to the Federal Supplementary Medical Insurance Trust Fund under section 1841 each year an amount equivalent to the product of—

''(A) expenditures under this subsection for the year, and

''(B) the ratio of the portion of the savings described in paragraph (2) for the year that are attributable to part A, to the total savings described in such paragraph for the year.''.

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

(A) by striking ''and (W)'' and inserting ''(W)''; and

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

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

(c) EXPANSION OF HOME HEALTH REMOTE PATIENT MANAGEMENT SERVICES COVERAGE TO ADDITIONAL CHRONIC HEALTH CONDITIONS.—The Secretary of Health and Human Services is authorized to carry out pilot projects for purposes of determining the extent to which the coverage under title XVIII of the Social Security Act of home health remote patient management services (as defined in paragraph (1) of section 1861(hhh) of such Act, as added by subsection (a)) should be extended to individuals with chronic health conditions other than those initially specified by the Secretary under paragraph (2) of such section.

(d) EFFECTIVE DATE.—The amendments made by subsections (a), (b), and (c) shall apply to services furnished on or after January 1, 2010.

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

(a) FINDINGS.—Congress finds as follows:

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

and efficient for patients and for the health care system.

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

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

(4) Management the medical condition or disease of a patient from the patient's home reduces the need for face to face provider interactions. Use of remote patient management services minimizes unnecessary travel and missed work and provides particular value to patients residing in rural or underserved communities who would otherwise face potentially significant access barriers to receiving needed care.

(5) Among the areas in which remote patient management services are emerging in health care are the treatment of congestive heart failure, diabetes, cardiac arrhythmia, epilepsy, and sleep apnea.

Prompt transmission of clinical data on each of these conditions, to the health care provider or the patient as appropriate, is essential to providing timely and appropriate therapeutic interventions which can then reduce expensive hospitalizations.

(6) Despite these benefits, remote patient management services have failed to diffuse rapidly. A significant barrier to wider adoption is the relative lack of payment mechanisms in fee for service Medicare to reimburse for remote, non face to face patient management.

(7) Elimination of this barrier to new remote patient management services should be encouraged by requiring reimbursement under the Medicare program for providers' time spent analyzing and responding to patient data transmitted by remote technologies.

(8) Reimbursement under the Medicare program for health care providers' time spent analyzing and responding to data transmitted to providers by remote technologies should be made on a separate basis and should not be combined with payments for others services (also referred to as ''bundled payments'').

(9) Payment codes used for reporting and billing for payment for providers' remote patient management services should be revised or adjusted, as appropriate, to encourage the application of such services for other medical conditions.

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

(1) remote patient management services are integral to improvement in the delivery, care, and efficiency of health care services furnished in the United States; and

(2) the Administrator of the Centers for Medicare & Medicaid Services should be encouraged to—

(A) expand the types of medical conditions for which the use of remote patient management services are reimbursed under the Medicare program;

(B) provide for separate, non-bundled payment under the Medicare program for remote patient management services; and

(C) create, revise and adjust, as appropriate, codes for the accurate reporting and billing for payment for remote patient management services.

SEC. 247. TELEHEALTH ADVISORY COMMITTEE.

(a) IN GENERAL.—Section 1834(m)(4)(F)(ii) of the Social Security Act (42 U.S.C. 1395m(m)(4)(F)(ii)) is amended by adding at the end the following sentences: ''Such process shall require the Secretary to take into account the recommendations of the Telehealth Advisory Committee (as established under section 247(b) of the Medical Rights and Reform Act of 2009) when adding or deleting services (and HCPCS codes) and in establishing policies of the Centers for Medicare & Medicaid Services regarding the delivery of telehealth services. If the Secretary does not implement a recommendation of the Telehealth Advisory Committee, the Secretary shall publish in the Federal Register a statement regarding the reason such recommendation was not implemented.''.

(b) TELEHEALTH ADVISORY COMMITTEE.—

(1) ESTABLISHMENT.—On and after the date that is 6 months after the date of enactment of this subtitle, the Secretary of Health and Human Services (in this subsection referred to as the ''Secretary'') shall have in place a Telehealth Advisory Committee (in this subsection referred to as the ''Advisory Committee'') to make recommendations to the Secretary on—

(A) policies of the Centers for Medicare & Medicaid Services regarding the delivery of telehealth services; and

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

(2) MEMBERSHIP; TERMS.—

(A) MEMBERSHIP.—

(i) IN GENERAL.—The Advisory Committee shall be composed of 9 members, to be appointed by the Secretary, of whom—

(I) five shall be practicing physicians;

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

(III) two shall be administrators of telehealth programs.

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

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

(II) give preference to individuals who are currently providing telemedicine or telehealth services or who are involved in telemedicine or telehealth programs;

(III) ensure that the membership of the Advisory Committee represents a balance of specialties and geographic regions; and

(IV) take into account the recommendations of stakeholders.

(B) TERMS.—The members of the Advisory Committee shall serve for such term as the Secretary may specify.

(C) CONFLICTS OF INTEREST.—An advisory committee member may not participate with respect to a particular matter considered in an advisory committee meeting if such member (or an immediate family member of such member) has a financial interest that could be affected by the advice given to the Secretary with respect to such matter.

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

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

(5) WAIVER OF ADMINISTRATIVE LIMITATION.—The Secretary shall establish the Advisory Committee notwithstanding any limitation that may apply to the number of advisory committees that may be established (within the Department of Health and Human Services or otherwise).

Subpart B—HRSA Grant Program

SEC. 250. GRANT PROGRAM FOR THE DEVELOPMENT OF TELEHEALTH NETWORKS.

(a) IN GENERAL.—The Secretary of Health and Human Services (in this section referred to as the ''Secretary''), acting through the Director of the Office for the Advancement of Telehealth (of the Health Resources and Services Administration), shall make grants to eligible entities (as described in subsection (b)(2)) for the purpose of expanding access to health care services for individuals in rural areas, frontier areas, and urban medically underserved areas through the use of telehealth.

(b) ELIGIBLE ENTITIES.—

(1) APPLICATION.—To be eligible to receive a grant under this section, an eligible entity described in paragraph (2) shall, in consultation with the State office of rural health or other appropriate State entity, prepare and submit to the Secretary an application, at such time, in such manner, and containing such information as the Secretary may require, including the following:

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

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

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

(D) A description of the manner in which the activities funded under the grant will meet health care needs of underserved rural populations within the State.

(E) A description of how the local community or region to be served by the network or proposed network will be involved in the development and ongoing operations of the network.

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

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

The application should demonstrate the manner in which the project will promote the integration of telehealth in the community so as to avoid redundancy of technology and achieve economies of scale.

(2) ELIGIBLE ENTITIES.—

(A) IN GENERAL.—An eligible entity described in this paragraph is a hospital or other health care provider in a health care network of community-based health care providers that includes at least—

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

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

if the institution or entity is able to demonstrate use of the network for purposes of education or economic development (as required by the Secretary).

(B) ORGANIZATIONS DESCRIBED.—The organizations described in this subparagraph are the following:

(i) Community or migrant health centers.

(ii) Local health departments.

(iii) Nonprofit hospitals.

(iv) Private practice health professionals, including community and rural health clinics.

(v) Other publicly funded health or social services agencies.

(vi) Skilled nursing facilities.

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

(viii) Providers of home health services.

(ix) Renal dialysis facilities.

(C) INSTITUTIONS AND ENTITIES DESCRIBED.—The institutions and entities described in this subparagraph are the following:

(i) A public school.

(ii) A public library.

(iii) A university or college.

(iv) A local government entity.

(v) A local health entity.

(vi) A health-related nonprofit foundation.

(vii) An academic health center.

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

(c) PREFERENCE.—The Secretary shall establish procedures to prioritize financial assistance under this section based upon the following considerations:

(1) The applicant is a health care provider in a health care network or a health care provider that proposes to form such a network that furnishes or proposes to furnish services in a medically underserved area, health professional shortage area, or mental health professional shortage area.

(2) The applicant is able to demonstrate broad geographic coverage in the rural or medically underserved areas of the State, or States in which the applicant is located.

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

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

mote greater efficiency in the use of health care resources.

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

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

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

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

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

modifications or improvements of telecommunications facilities including the following:

(1) The development and acquisition through lease or purchase of computer hardware and software, audio and video equipment, computer network equipment, interactive equipment, data terminal equipment, and other facilities and equipment that would further the purposes of this section.

(2) The provision of technical assistance and instruction for the development and use of such programming equipment or facilities.

(3) The development and acquisition of instructional programming.

(4) Demonstration projects for teaching or training medical students, residents, and other health profession students in rural or medically underserved training sites about the application of telehealth.

(5) The provision of telenursing services designed to enhance care coordination and promote patient self-management skills.

(6) The provision of services designed to promote patient understanding and adherence to national guidelines for common chronic diseases, such as congestive heart failure or diabetes.

(7) Transmission costs, maintenance of equipment, and compensation of specialists and referring health care providers, when no other form of reimbursement is available.

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

(9) Electronic archival of patient records.

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

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

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

(1) To acquire real property.

(2) Expenditures to purchase or lease equipment to the extent the expenditures would exceed more than 40 percent of the total grant funds.

(3) To purchase or install transmission equipment off the premises of the telehealth site and any transmission costs not directly related to the grant.

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

(5) Expenditures for indirect costs (as determined by the Secretary) to the extent the expenditures would exceed more than 15 percent of the total grant.

(g) ADMINISTRATION.—

(1) NONDUPLICATION.—The Secretary shall ensure that facilities constructed using grants provided under this section do not duplicate adequately established telehealth networks.

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

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

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

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

SEC. 251. REAUTHORIZATION OF TELEHEALTH NETWORK AND TELEHEALTH RESOURCE CENTERS GRANT PROGRAMS.

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

(1) in paragraph (1)—

(A) by striking ''and'' before ''such sums''; and

(B) by inserting ''$10,000,000 for fiscal year 2010, and such sums as may be necessary for each of fiscal years 2011 through 2014'' before the semicolon; and

(2) in paragraph (2)—

(A) by striking ''and'' before ''such sums''; and

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

for each of fiscal years 2011 through 2014'' before the semicolon.

Subtitle D—Eliminating Waste, Fraud, and Abuse

SEC. 261. SITE INSPECTIONS; BACKGROUND CHECKS; DENIAL AND SUSPENSION OF BILLING PRIVILEGES.

(a) SITE INSPECTIONS FOR DME SUPPLIERS, COMMUNITY MENTAL HEALTH CENTERS, AND OTHER PROVIDER GROUPS.—Title XVIII of the Social Security Act (42 U.S.C. 1395 et seq.) is amended by adding at the end the following:

''SITE INSPECTIONS FOR DME SUPPLIERS, COMMUNITY MENTAL HEALTH CENTERS, AND OTHER PROVIDER GROUPS

''SEC. 1898. (a) SITE INSPECTIONS.—

''(1) IN GENERAL.—The Secretary shall conduct a site inspection for each applicable provider (as defined in paragraph (2)) that applies to enroll under this title in order to provide items or services under this title. Such site inspection shall be in addition to any other site inspection that the Secretary would otherwise conduct with regard to an applicable provider.

''(2) APPLICABLE PROVIDER DEFINED.—

"(A) IN GENERAL.—Except as provided in subparagraph (B), in this section the term 'applicable provider' means—

"(i) a supplier of durable medical equipment (including items described in section 1834(a)(13));

"(ii) a supplier of prosthetics, orthotics, or supplies (including items described in paragraphs (8) and (9) of section 1861(s));

"(iii) a community mental health center; or

"(iv) any other provider group, as determined by the Secretary (including suppliers, both participating suppliers and non-participating suppliers, as such terms are defined for purposes of section 1842).

"(B) EXCEPTION.—In this section, the term 'applicable provider' does not include—

"(i) a physician that provides durable medical equipment (as described in subparagraph (A)(i)) or prosthetics, orthotics, or supplies (as described in subparagraph (A)(ii)) to an individual as incident to an office visit by such individual; or

''(ii) a hospital that provides durable medical equipment (as described in subparagraph (A)(i)) or prosthetics, orthotics, or supplies (as described in subparagraph (A)(ii)) to an individual as incident to an emergency room visit by such individual.

''(b) STANDARDS AND REQUIREMENTS.—In conducting the site inspection pursuant to subsection (a), the Secretary shall ensure that the site being inspected is in full compliance with all the conditions and standards of participation and requirements for obtaining billing privileges under this title.

''(c) TIME.—The Secretary shall conduct the site inspection for an applicable provider prior to the issuance of billing privileges under this title to such provider.

''(d) TIMELY REVIEW.—The Secretary shall provide for procedures to ensure that the site inspection required under this section does not unreasonably delay the issuance of billing privileges under this title to an applicable provider.''.

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

''BACKGROUND CHECKS; DENIAL AND SUSPENSION OF BILLING PRIVILEGES

''SEC. 1899. (a) BACKGROUND CHECK REQUIRED.—Except as provided in subsection (b), the Secretary shall conduct a background check on any individual or entity that enrolls under this title for the purpose of furnishing any item or service under this title, including any individual or entity that is a supplier, a person with an ownership or control interest, a managing employee (as defined in section 1126(b)), or an authorized or delegated official of the individual or entity. In performing the background check, the Secretary shall—

''(1) conduct the background check before authorizing billing privileges under this title to the individual or entity, respectively;

''(2) include a search of criminal records in the background check;

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

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

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

''(b) USE OF STATE LICENSING PROCEDURE.—The Secretary may use the results of a State licensing procedure as a background check under subsection (a) if the State licensing procedure meets the requirements of such subsection.

''(c) ATTORNEY GENERAL REQUIRED TO PROVIDE INFORMATION.—

''(1) IN GENERAL.—Upon request of the Secretary, the Attorney General shall provide the criminal background check information referred to in subsection (a)(2) to the Secretary.

''(2) RESTRICTION ON USE OF DISCLOSED INFORMATION.—The Secretary may only use the information disclosed under subsection (a) for the purpose of carrying out the Secretary's responsibilities under this title.

''(d) REFUSAL TO AUTHORIZE BILLING PRIVILEGES.—

''(1) AUTHORITY.—In addition to any other remedy available to the Secretary, the Secretary may refuse to authorize billing privileges under this title to an individual or entity if the Secretary determines, after a background check conducted under

this section, that such individual or entity, respectively, has a history of acts that indicate authorization of billing privileges under this title to such individual or entity, respectively, would be detrimental to the best interests of the program or program beneficiaries. Such acts may include—

''(A) any bankruptcy;

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

''(C) any felony conviction under Federal or State law.

''(2) REPORTING OF REFUSAL TO AUTHORIZE BILLING PRIVILEGES TO THE HEALTHCARE INTEGRITY AND PROTECTION DATA BANK (HIPDB).—

''(A) IN GENERAL.—Subject to subparagraph (B), a determination under paragraph (1) to refuse to authorize billing privileges under this title to an individual or entity as a result of a background check conducted under this section shall be reported to the healthcare integrity and protection data bank established under section 1128E in accordance with the procedures for reporting final adverse actions taken against a health care provider, supplier, or practitioner under that section.

''(B) EXCEPTION.—Any determination described in subparagraph (A) that the Secretary specifies is not appropriate for inclusion in the healthcare integrity and protection data bank established under section 1128E shall not be reported to such data bank.''.

(c) DENIAL AND SUSPENSION OF BILLING PRIVILEGES.—Section 1899 of the Social Security Act, as added by subsection (b), is amended by adding at the end the following new subsection:

''(e) AUTHORITY TO SUSPEND BILLING PRIVILEGES OR REFUSE TO AUTHORIZE ADDITIONAL BILLING PRIVILEGES.—

''(1) IN GENERAL.—The Secretary may suspend any billing privilege under this title authorized for an individual or entity or refuse to authorize any additional billing privilege under this title to such individual or entity if—

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

''(B) payments under this title to such individual or entity, respectively, have been suspended; or

''(C) 100 percent of the payment claims under this title for such individual or entity, respectively, are reviewed on a pre-payment basis.

''(2) APPLICATION TO RESTRUCTURED ENTITIES.—In the case that an individual or entity is subject to a suspension or refusal of billing privileges under this section, if the Secretary determines that the ownership or management of a new entity is under the control or management of such an individual or entity subject to such a suspension or refusal, the new entity shall be subject to any such applicable suspension or refusal in the same manner and to the same extent as the initial individual or entity involved had been subject to such applicable suspension or refusal.

''(3) DURATION OF SUSPENSION.—A suspension of billing privileges under this subsection, with respect to an individual or entity, shall be in effect beginning on the date of the Secretary's determination that the offense was committed and ending not earlier than such date on which all applicable overpayments and other applicable outstanding debts have been paid and all applicable payment suspensions have been lifted.''.

(d) REGULATIONS; EFFECTIVE DATE.—

(1) REGULATIONS.—Not later than one year after the date of the enactment of this Act, the Secretary of Health and Human Services shall promulgate such regulations as are necessary to implement the amendments made by subsections (a), (b), and (c).

(2) EFFECTIVE DATES.—

(A) SITE INSPECTIONS AND BACKGROUND CHECKS.—The amendments made by subsections (a) and (b) shall apply to applications to enroll under title XVIII of the Social Security Act received by the Secretary of Health and Human Services on or after the first day of the first year beginning after the date of the enactment of this Act.

(B) DENIALS AND SUSPENSIONS OF BILLING PRIVILEGES.—The amendment made by subsection (c) shall apply to overpayments or debts in existence on or after the date of the enactment of this Act, regardless of whether the final determination, with respect to such overpayment or debt, was made before, on, or after such date.

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

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

SEC. 262. REGISTRATION AND BACKGROUND CHECKS OF BILLING AGENCIES AND INDIVIDUALS.

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

''REGISTRATION AND BACKGROUND CHECKS OF BILLING AGENCIES AND INDIVIDUALS; IDENTIFICATION NUMBERS REQUIRED FOR PROVIDERS AND SUPPLIERS

''SEC. 1899A. (a) REGISTRATION.—

''(1) IN GENERAL.—The Secretary shall establish procedures, including modifying the Provider Enrollment and Chain Ownership System (PECOS) administered by the Centers for Medicare & Medicaid Services, to provide for the registration of all applicable persons in accordance with this section.

''(2) REQUIRED APPLICATION.—Each applicable person shall submit a registration application to the Secretary at such time, in such manner, and accompanied by such information as the Secretary may require.

"(3) IDENTIFICATION NUMBER.—If the Secretary approves an application submitted under subsection (b), the Secretary shall assign a unique identification number to the applicable person.

"(4) REQUIREMENT.—Every claim for reimbursement under this title that is compiled or submitted by an applicable person shall contain the identification number that is assigned to the applicable person pursuant to subsection (c).

"(5) TIMELY REVIEW.—The Secretary shall provide for procedures that ensure the timely consideration and determination regarding approval of applications under this subsection.

"(6) DEFINITION OF APPLICABLE PERSON.—In this section, the term 'applicable person' means any individual or entity that compiles or submits claims for reimbursement under this title to the Secretary on behalf of any individual or entity.

"(b) BACKGROUND CHECKS.—

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

''(A) conduct the background check before issuing a unique identification number to the applicable person;

''(B) include a search of criminal records in the background check;

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

''(D) establish criteria for periodic targeted reviews with respect to the background check of the applicable person.

''(2) USE OF STATE LICENSING PROCEDURE.—The Secretary may use the results of a State licensing procedure as a background check under paragraph (1) if the State licensing procedure meets the requirements of such paragraph.

''(3) ATTORNEY GENERAL REQUIRED TO PROVIDE INFORMATION.—

''(A) IN GENERAL.—Upon request of the Secretary, the Attorney General shall provide the criminal background check information referred to in paragraph (1)(B) to the Secretary.

''(B) RESTRICTION ON USE OF DISCLOSED INFORMATION.—The Secretary may only use the infor-

mation disclosed under paragraph (1) for the purpose of carrying out the Secretary's responsibilities under this title.

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

''(A) any bankruptcy;

''(B) any act resulting in a civil judgment against such person; or

''(C) any felony conviction under Federal or State law.

''(c) IDENTIFICATION NUMBERS FOR PROVIDERS AND SUPPLIERS.—The Secretary shall establish procedures to ensure that each provider of services and each supplier that submits claims for reimbursement under this title to the Secretary is assigned a unique identification number.''.

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

''(16) FRAUD BY APPLICABLE PERSON.—An applicable person (as defined in section 1899A(a)(6)) that the Secretary determines knowingly submitted or caused to be submitted a claim for reimbursement under title XVIII that the applicable person knows or should know is false or fraudulent.''.

(c) REGULATIONS; EFFECTIVE DATE.—

(1) REGULATIONS.—Not later than one year after the date of the enactment of this Act, the Secretary of Health and Human Services shall promulgate such regulations as are necessary to implement the amendments made by subsections (a) and (b).

(2) EFFECTIVE DATE.—The amendments made by subsections (a) and (b) shall apply to applicable persons and other entities on and after the first day of the first year beginning after the date of the enactment of this Act.

SEC. 263. EXPANDED ACCESS TO THE HEALTHCARE INTEGRITY AND PROTECTION DATA BANK (HIPDB).

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

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

''(A) Federal and State government agencies and health plans, and any health care provider, supplier, or practitioner entering an employment or contractual relationship with an individual or entity who could potentially be the subject of a final adverse action, where the contract involves the furnishing of items or services reimbursed by one or more Federal health care programs (regardless of whether the individual or entity is paid by the programs directly, or whether the items or services are reimbursed directly or indirectly through the claims of a direct provider); and

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

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

''Federal agencies or other entities, such as fiscal intermediaries and carriers, acting under contract on behalf of such agencies''.

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

''(4) Whoever knowingly uses information maintained in the healthcare integrity and protection data bank maintained in accordance with section 1128E for a purpose other than a purpose authorized under that section shall be imprisoned for not more than three years or fined under title 18, United States Code, or both.''.

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

SEC. 264. LIABILITY OF MEDICARE ADMINISTRATIVE CONTRACTORS FOR CLAIMS SUBMITTED BY EXCLUDED PROVIDERS.

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

''(6) REIMBURSEMENTS TO SECRETARY FOR AMOUNTS PAID TO EXCLUDED PROVIDERS.—The Secretary shall not enter into a contract with a Medicare administrative contractor under this section unless the contractor agrees to reimburse the Secretary for any amounts paid by the contractor for a service under this title which is furnished by an individual or entity during any period for which the individual or entity is excluded, pursuant to section 1128, 1128A, or 1156, from participation in the health care program under this title if the amounts are paid after the 60-day period beginning on the date the Secretary provides notice of the exclusion to the contractor, unless the payment was made as a result of incorrect information provided by the Secretary or the individual or entity excluded from participation has concealed or altered their identity.''.

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

(1) in paragraph (1)(B), by striking ''and when the person'' and all that follows through ''person)''; and

(2) by amending paragraph (2) to read as follows:

''(2) No individual or entity may bill (or collect any amount from) any individual for any item or service for which payment is denied under paragraph (1). No individual is liable for payment of any amounts billed for such an item or service in violation of the preceding sentence.''.

(c) EFFECTIVE DATE.—

(1) IN GENERAL.—The amendments made by this section shall apply to claims for payment submitted on or after the date of the enactment of this Act.

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

SEC. 265. COMMUNITY MENTAL HEALTH CENTERS.

(a) IN GENERAL.—Section 1861(ff)(3)(B) of the Social Security Act (42 U.S.C. 1395x(ff)(3)(B)) is amended by striking ''entity that—'' and all that follows and inserting the following: ''entity that—

''(i) provides the community mental health services specified in paragraph (1) of section 1913(c) of the Public Health Service Act;

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

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

''(iv) meets such additional standards or requirements for obtaining billing privileges under this title as the Secretary may specify to ensure—

''(I) the health and safety of beneficiaries receiving such services; or

''(II) the furnishing of such services in an effective and efficient manner.''.

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

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

SEC. 266. LIMITING THE DISCHARGE OF DEBTS IN BANKRUPTCY PROCEEDINGS IN CASES WHERE A HEALTH CARE PROVIDER OR A SUPPLIER ENGAGES IN FRAUDULENT ACTIVITY.

(a) IN GENERAL.—

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

(2) RECOVERY OF OVERPAYMENT TO PROVIDERS OF SERVICES UNDER PART A OF MEDICARE.—Section 1815(d) of the Social Security Act (42 U.S.C. 1395g(d)) is amended—

(A) by inserting ''(1)'' after ''(d)''; and

(B) by adding at the end the following:

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

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

(A) by inserting ''(1)'' after ''(j)''; and

(B) by adding at the end the following:

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

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

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

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

SEC. 267. ILLEGAL DISTRIBUTION OF A MEDICARE OR MEDICAID BENEFICIARY IDENTIFICATION OR BILLING PRIVILEGES.

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

''(5) Whoever knowingly, intentionally, and with the intent to defraud purchases, sells or distributes, or arranges for the purchase, sale, or distribution of two or more Medicare or Medicaid beneficiary identification numbers or billing privileges under title XVIII or title XIX shall be imprisoned for not more than three years or fined under title 18, United States Code (or, if greater, an amount equal to the monetary loss to the Federal and any State government as a result of such acts), or both.''.

SEC. 268. TREATMENT OF CERTAIN SOCIAL SECURITY ACT CRIMES AS FEDERAL HEALTH CARE OFFENSES.

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

(1) by striking the period at the end of paragraph (2) and inserting ''; or''; and

(2) by adding at the end the following:

''(3) section 1128B of the Social Security Act (42 U.S.C. 1320a–7b).''.

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

SEC. 269. AUTHORITY OF OFFICE OF INSPECTOR GENERAL OF THE DEPARTMENT OF HEALTH AND HUMAN SERVICES.

(a) AUTHORITY.—Notwithstanding any other provision of law, upon designation by the Inspector General of the Department of Health and Human Services, any criminal investigator of the Office of Inspector General of such department may, in accordance with guidelines issued by the Secretary of Health and Human Services and approved by the Attorney General, while engaged in activities within the lawful jurisdiction of such Inspector General—

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

(2) make an arrest without a warrant for—

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

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

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

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

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

SEC. 270. UNIVERSAL PRODUCT NUMBERS ON CLAIMS FORMS FOR REIMBURSEMENT UNDER THE MEDICARE PROGRAM.

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

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

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

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

''USE OF UNIVERSAL PRODUCT NUMBERS

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

''(b) DEFINITIONS.—In this section:

''(1) UPN COVERED ITEM.—

''(A) IN GENERAL.—Except as provided in subparagraph (B), the term 'UPN covered item' means—

''(i) a covered item as that term is defined in section 1834(a)(13);

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

''(iii) an item described in paragraph (5) of section 1861(s); and

"(iv) any other item for which payment is made under this title that the Secretary determines to be appropriate.

"(B) EXCLUSION.—The term 'UPN covered item' does not include a customized item for which payment is made under this title.

"(2) UNIVERSAL PRODUCT NUMBER.—The term 'universal product number' means a number that is—

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

"(B) based on commercially acceptable identification standards such as, but not limited to, standards established by the Uniform Code Council-International Article Numbering System or the Health Industry Business Communication Council.".

(3) DEVELOPMENT AND IMPLEMENTATION OF PROCEDURES.—

(A) INFORMATION INCLUDED IN UPN.—The Secretary of Health and Human Services, in consultation with manufacturers and entities with appropriate expertise, shall determine the relevant descriptive information appropriate for

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

(B) REVIEW OF PROCEDURE.—From the information obtained by the use of universal product numbers on claims for reimbursement under the Medicare program, the Secretary of Health and Human Services, in consultation with interested parties, shall periodically review the UPN covered items billed under the Health Care Financing Administration Common Procedure Coding System and adjust such coding system to ensure that functionally equivalent UPN covered items are billed and reimbursed under the same codes.

(4) EFFECTIVE DATE.—The amendment made by paragraph (2) shall apply to claims for reimbursement submitted on and after February 1, 2011.

(b) STUDY AND REPORTS TO CONGRESS.—

(1) STUDY.—The Secretary of Health and Human Services shall conduct a study on the results of the implementation of the provisions in paragraphs (1) and (3) of subsection (a) and the amendment to the Social Security Act in paragraph (2) of such subsection.

(2) REPORTS.—

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

(B) IMPLEMENTATION.—Not later than 18 months after the date of the enactment of this Act, and annually thereafter for three years, the Secretary of Health and Human Services shall submit to Congress a report that contains a detailed description of the results of the study conducted pursuant to paragraph (1), together with the Secretary's recommendations regarding the use of universal product numbers and the use of data obtained from the use of such numbers.

(c) DEFINITIONS.—In this section:

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

(2) UNIVERSAL PRODUCT NUMBER.—The term ''universal product number'' has the meaning given such term in section 1899B(b)(2) of the Social Security Act (as added by subsection (a)(2)).

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

Subtitle E—Promoting Health and Preventing Chronic Disease Through Prevention and Wellness Programs

SEC. 281. FINDINGS.

Congress finds the following:

(1) Keeping people healthy and preventing disease must be an important part of improving our Federal health system.

(2) More than 133 million Americans, which accounts for 45 percent of the U.S. population, have at least one chronic condition.

(3) With the growth in obesity, especially among younger Americans, the diagnosis of childhood chronic diseases has almost quadrupled over

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

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

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

(6) Seventy-five percent of the nation's aggregate health care spending is on treating patients with chronic disease, and the vast majority of these diseases are preventable. Unfortunately, less than one percent of total health care spending goes toward prevention.

(7) According to a recent study, treatment of the seven most common chronic diseases, coupled with productivity losses, cost the U.S. economy more than $1 trillion dollars annually. It has been estimated that modest reductions in unhealthy behaviors could prevent or delay 40 million cases of chronic illness per year.

(8) Chronic diseases are burdensome to American businesses. Not only does a sicker American

workforce have higher health care costs, but it is also less productive. Chronic illnesses lead to absenteeism and decreased effectiveness while at work due to illness.

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

SEC. 282. TAX CREDIT TO EMPLOYERS FOR COSTS OF IMPLEMENTING PREVENTION AND WELLNESS PROGRAMS.

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

"SEC. 45R. PREVENTION AND WELLNESS PROGRAM CREDIT.

"(a) ALLOWANCE OF CREDIT.—

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

period with respect to an employer is an amount equal to 50 percent of the costs paid or incurred by the employer in connection with a qualified prevention and wellness during the taxable year. For purposes of the preceding sentence, in the case of any qualified prevention and wellness offered as part of an employer-provided group health plan, including health insurance offered in connection with such plan, only costs attributable to the qualified prevention and wellness and not to the group health plan or health insurance coverage may be taken into account.

''(2) LIMITATION.—The amount of credit allowed under paragraph (1) for any taxable year shall not exceed the sum of—

''(A) the product of $200 and the number of employees of the employer not in excess of 200 employees, plus

''(B) the product of $100 and the number of employees of the employer in excess of 200 employees.

''(b) QUALIFIED PREVENTION AND WELLNESS.—For purposes of this section—

''(1) QUALIFIED PREVENTION AND WELLNESS.—The term 'qualified prevention and wellness' means a program which—

''(A) consists of any 3 of the prevention and wellness components described in subsection (c), and

''(B) which is certified by the Secretary of Health and Human Services, in coordination with the Director of the Center for Disease Control and Prevention, as a qualified prevention and wellness under this section.

''(2) PROGRAMS MUST BE CONSISTENT WITH RESEARCH AND BEST PRACTICES.—

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

''(i) is consistent with evidence-based research and best practices, as identified by persons with expertise in employer health promotion and prevention and wellness,

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

entific reviews, including the Guide to Community Preventive Services, the Guide to Clinical Preventive Services, and the National Registry for Effective Programs, and

''(iii) includes strategies which focus on employee populations with a disproportionate burden of health problems.

''(B) PERIODIC UPDATING AND REVIEW.—The Secretary of Health and Human Services shall establish procedures for periodic review of programs under this subsection. Such procedures shall require revisions of programs if necessary to ensure compliance with the requirements of this section and require updating of the programs to the extent the Secretary, in coordination with the Director of the Centers for Disease Control and Prevention, determines necessary to reflect new scientific findings.

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

''(c) PREVENTION AND WELLNESS PROGRAM COMPONENTS.—For purposes of this section, the prevention and wellness components described in this subsection are the following:

''(1) HEALTH AWARENESS COMPONENT.—A health awareness component which provides for the following:

''(A) HEALTH EDUCATION.—The dissemination of health information which addresses the specific needs and health risks of employees.

''(B) HEALTH SCREENINGS.—The opportunity for periodic screenings for health problems and referrals for appropriate follow up measures.

''(2) EMPLOYEE ENGAGEMENT COMPONENT.—An employee engagement component which provides for—

''(A) the establishment of a committee to actively engage employees in worksite prevention and wellness through worksite assessments and program planning, delivery, evaluation, and improvement efforts, and

''(B) the tracking of employee participation.

''(3) BEHAVIORAL CHANGE COMPONENT.—A behavioral change component which provides for altering employee lifestyles to encourage healthy living through counseling, seminars, on-line programs, or self-help materials which provide technical assistance and problem solving skills. Such component may include programs relating to—

''(A) tobacco use,

''(B) obesity,

''(C) stress management,

''(D) physical fitness,

''(E) nutrition,

''(F) substance abuse,

''(G) depression, and

''(H) mental health promotion (including anxiety).

''(4) SUPPORTIVE ENVIRONMENT COMPONENT.—A supportive environment component which includes the following:

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

''(i) tobacco use at the worksite,

''(ii) the nutrition of food available at the worksite through cafeterias and vending options,

''(iii) minimizing stress and promoting positive mental health in the workplace,

''(iv) where applicable, accessible and attractive stairs, and

''(v) the encouragement of physical activity before, during, and after work hours.

''(B) PARTICIPATION INCENTIVES.—

''(i) IN GENERAL.—Qualified incentive benefits for each employee who participates in the health screenings described in paragraph (1)(B) or the behavioral change programs described in paragraph (3).

''(ii) QUALIFIED INCENTIVE BENEFIT.—For purposes of clause (i), the term 'qualified incentive benefit' means any benefit which is approved by the Secretary of Health and Human Services, in coordination with the Director of the Centers for Disease Control and Prevention.

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

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

''(d) PARTICIPATION REQUIREMENT.—

''(1) IN GENERAL.—No credit shall be allowed under subsection (a) unless the Secretary of Health and Human Services, in coordination with the Director of the Centers for Disease Control and Prevention, certifies, as a part of any certification described in subsection (b), that each prevention and wellness component of the qualified prevention and wellness applies to all qualified employees of the employer. The Secretary of Health and Human Services shall prescribe rules under which an employer shall not be treated as failing to meet the requirements of this subsection merely because the employer provides specialized programs for employees with specific health needs or unusual employment requirements or provides a pilot program to test new wellness strategies.

''(2) QUALIFIED EMPLOYEE.—For purposes of paragraph (1), the term 'qualified employee' means—

''(A) for employers offering health insurance coverage, an employee who is eligible for such coverage, or

"(B) for employers not offering health insurance coverage, an employee who works an average of not less than 25 hours per week during the taxable year.

"(e) OTHER DEFINITIONS AND SPECIAL RULES.—For purposes of this section—

"(1) EMPLOYEE AND EMPLOYER.—

"(A) PARTNERS AND PARTNERSHIPS.—The term 'employee' includes a partner and the term 'employer' includes a partnership.

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

"(2) CERTAIN COSTS NOT INCLUDED.—Costs paid or incurred by an employer for food or health insurance shall not be taken into account under subsection (a).

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

spect to any grant which does not constitute a significant portion of the funding for the qualified prevention and wellness.

''(4) CREDIT PERIOD.—

''(A) IN GENERAL.—The term 'credit period' means the period of 10 consecutive taxable years beginning with the taxable year in which the qualified prevention and wellness is first certified under this section.

''(B) SPECIAL RULE FOR EXISTING PROGRAMS.—In the case of an employer (or predecessor) which operates a prevention and wellness for its employees on the date of the enactment of this section, subparagraph (A) shall be applied by substituting '3 consecutive taxable years' for '10 consecutive taxable years'. The Secretary shall prescribe rules under which this subsection shall not apply if an employer is required to make substantial modifications in the existing prevention and wellness in order to qualify such program for certification as a qualified prevention and wellness.

''(C) CONTROLLED GROUPS.—For purposes of this paragraph, all persons treated as a single employer under subsection (b), (c),

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

''(f) PORTION OF CREDIT MADE REFUNDABLE.—

''(1) IN GENERAL.—In the case of an eligible employer of an employee, the aggregate credits allowed to a taxpayer under subpart C shall be increased by the lesser of—

''(A) the credit which would be allowed under this section without regard to this subsection and the limitation under section 38(c), or

''(B) the amount by which the aggregate amount of credits allowed by this subpart (determined without regard to this subsection) would increase if the limitation imposed by section 38(c) for any taxable year were increased by the amount of employer payroll taxes imposed on the taxpayer during the calendar year in which the taxable year begins.

The amount of the credit allowed under this subsection shall not be treated as a credit allowed under this subpart and shall reduce the amount of the credit otherwise allowable under subsection (a) without regard to section 38(c).

''(2) ELIGIBLE EMPLOYER.—For purposes of this subsection, the term 'eligible employer' means an employer which is—

''(A) a State or political subdivision thereof, the District of Columbia, a possession of the United States, or an agency or instrumentality of any of the foregoing, or

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

''(3) EMPLOYER PAYROLL TAXES.—For purposes of this subsection—

''(A) IN GENERAL.—The term 'employer payroll taxes' means the taxes imposed by—

''(i) section 3111(b), and

''(ii) sections 3211(a) and 3221(a) (determined at a rate equal to the rate under section 3111(b)).

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

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

(b) TREATMENT AS GENERAL BUSINESS CREDIT.—Subsection (b) of section 38 of the Internal Revenue Code of 1986 (relating to general business credit) is amended by striking ''plus'' at the end of paragraph (34), by striking the period at the end of paragraph (35) and inserting '', plus'', and by adding at the end the following:

''(36) the prevention and wellness credit determined under section 45R.''.

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

''(g) PREVENTION AND WELLNESS PROGRAM CREDIT.—

''(1) IN GENERAL.—No deduction shall be allowed for that portion of the costs paid or incurred for a qualified prevention and wellness (within the meaning of section 45R) allowable as a deduction for the taxable year which is equal to the amount of the credit allowable for the taxable year under section 45R.

''(2) SIMILAR RULE WHERE TAXPAYER CAPITALIZES RATHER THAN DEDUCTS EXPENSES.—If—

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

''(B) the amount allowable as a deduction for such taxable year for a qualified prevention and wellness,

the amount chargeable to capital account for the taxable year for such expenses shall be reduced by the amount of such excess.

''(3) CONTROLLED GROUPS.—In the case of a corporation which is a member of a controlled group of corporations (within the meaning of section 41(f)(5)) or a trade or business which is treated as being under common control with other trades or business (within the meaning of section 41(f)(1)(B)), this subsection shall be applied under rules prescribed by the Secretary similar to the rules applicable under subparagraphs (A) and (B) of section 41(f)(1).''.

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

''Sec. 45R. Prevention and wellness program credit.''.

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

(f) OUTREACH.—

(1) IN GENERAL.—The Secretary of the Treasury, in conjunction with the Director of the Centers for Disease Control and members of the business community, shall institute an outreach program to inform businesses about the availability of the prevention and wellness credit under section 45R of the Internal Revenue Code of 1986 as well as to educate businesses on how to develop programs according to recognized and promising practices and on how to measure the success of implemented programs.

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

SEC. 283. GRANTS TO INCREASE PHYSICAL ACTIVITY AND EMOTIONAL WELLNESS, IMPROVE NUTRITION, AND PROMOTE HEALTHY EATING BEHAVIORS.

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

"SEC. 399W. GRANTS TO INCREASE PHYSICAL ACTIVITY AND EMOTIONAL WELLNESS, IMPROVE NUTRITION, AND PROMOTE HEALTHY EATING BEHAVIORS AND HEALTHY LIVING.

''(a) ESTABLISHMENT.—

''(1) IN GENERAL.—The Secretary, acting through the Director of the Centers for Disease Control and Prevention and in coordination with the Administrator of the Health Resources and Services Administration, the Director of the Indian Health Service, the Secretary of Education, the Secretary of Agriculture, the Secretary of the Interior, the Director of the National Institutes of Health, the Director of the Office of Women's Health, and the heads of other appropriate agencies, shall award competitive grants to eligible entities to plan and implement prevention and wellness programs that promote health and wellness and prevent chronic disease. Such grants may be awarded to target at-risk populations including youth, health disparity populations (as defined in section 485E(d)), and the underserved.

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

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

the Secretary at such time, in such manner, and containing such information as the Secretary may require, including—

''(1) a plan describing a comprehensive program of approaches to encourage healthy living, emotional wellness, healthy eating behaviors, and healthy levels of physical activity;

''(2) the manner in which the eligible entity will coordinate with appropriate State and local authorities and community-based organizations, including but not limited to—

''(A) State and local educational agencies;

''(B) departments of health;

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

''(D) community-based organizations serving youth; and

''(3) the manner in which the applicant will evaluate the effectiveness of the program carried out under this section.

''(c) COORDINATION.—In awarding grants under this section, the Secretary shall ensure that the proposed programs show a history of addressing these issues, have program evaluations that show success, and are coordinated

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

''(d) ELIGIBLE ENTITY.—In this section, the term 'eligible entity' means—

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

''(2) a State educational agency;

''(3) a tribal educational agency;

''(4) a local educational agency;

''(5) a federally qualified health center (as defined in section 1861(aa)(4) of the Social Security Act);

''(6) a rural health clinic;

''(7) a health department;

''(8) an Indian Health Service hospital or clinic;

''(9) an Indian tribal health facility;

''(10) an urban Indian facility;

''(11) any health provider;

''(12) an accredited university or college;

''(13) a youth serving organization;

''(14) a community-based organization; or

''(15) any other entity determined appropriate by the Secretary.

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

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

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

''(g) TECHNICAL ASSISTANCE.—The Secretary may set aside an amount not to exceed 10 percent of the total amount appropriated for a fiscal year under subsection (j) to permit the Director of the Centers for Disease Control and Prevention to provide grantees with technical support in the development, implementation, and evaluation of prevention and wellness programs under this section and to disseminate information about effective strategies and interventions in promoting health and wellness and preventing chronic disease.

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

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

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

''(j) DEFINITION.—In this section, the term 'prevention and wellness program' means a program that consists of a combination of activities that are designed to increase awareness, assess risks, educate, and promote voluntary behavior change to improve the health of an individual, modify his or her consumer health behavior, enhance his or her personal well-being and productivity, and prevent illness and injury.

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

SEC. 284. PREVENTION AND WELLNESS PROGRAMS FOR INDIVIDUALS AND FAMILIES.

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

(b) DEFINITION.—In this section, the term ''prevention and wellness program'' means a program that consists of a combination of activities that are designed to increase awareness, assess risks, educate, and promote voluntary behavior change to improve the health of an individual, modify his or her consumer health behavior, enhance his or her personal well-being and productivity, and prevent illness and injury.

TITLE III—EXPANDING ACCESS TO HEALTH CARE

Subtitle A—State Innovation Program

SEC. 301. ENSURING AFFORDABILITY AND ACCESS THROUGH UNIVERSAL ACCESS PROGRAMS.

(a) STATE REQUIREMENT.—

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

under section 412(a), each State shall implement at least one of the following programs for the purposes of mitigating the cost to insurers of providing insurance to high risk individuals in the State:

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

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

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

(A) make available non-Federal contributions, as specified by the Secretary, to ensure the continuing stability of any program implemented by the State under paragraph (1); and

(B) at the time of application, submit to the Secretary of Health and Human Services a budget plan, including assurances that the State has in place a method to satisfy the requirement under subparagraph (A).

(b) QUALIFIED STATE REINSURANCE PROGRAM.—

(1) QUALIFIED STATE REINSURANCE PROGRAM DEFINED.—For purposes of this section, the term ''qualified State reinsurance program'' means a program that is operated by a State or a program au-

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

(2) FORM OF PROGRAM.—A qualified State reinsurance program may provide reinsurance—

(A) on a prospective or retrospective basis;

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

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

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

''(B) TREATMENT OF CERTAIN REINSURANCE PROGRAMS.—For purposes of subparagraph (A), the term 'qualified high risk pool' includes a qualified State reinsurance program under the Medical Rights and Reform Act of 2009.''.

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

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

pool program'' means a program that operates a high risk pool that—

(A) is a qualified high risk pool under section 2745(g)(1)(A) of the Public Health Service Act; and

(B) meets all of the following requirements:

(i) The high risk pool provides a variety of types of coverage, including at least one high deductible health plan that may be coupled with a health savings account.

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

(iii) The high risk pool has no waiting list and no pre-existing condition exclusionary periods so that all eligible residents who are seeking coverage through the pool can receive coverage through the pool.

(iv) The high risk pool allows for coverage of individuals who, but for the 24-month disability waiting period under section 226(b) of the Social Security Act,

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

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

(vi) The high risk pool conducts education and outreach initiatives so that residents and insurance brokers understand that the pool is available to eligible residents.

(2) RELATION TO SECTION 2745.—Section 2745(g)(1) of the Public Health Service Act is further amended—

(A) in subparagraph (A), by striking ''The term'' and inserting ''Subject to subparagraph (C), the term''; and

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

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

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

(3) RELATION TO CURRENT QUALIFIED HIGH RISK POOL PROGRAM OPERATING A QUALIFIED HIGH RISK POOL.—In the case of a State that is operating a qualified high risk pool under section 2745 of the Public Health Service Act as of the date of the enactment of this Act, the State may use current funding sources to transition from the operation of such a pool to—

(A) the operation of a qualified State reinsurance program described in subsection (b); or

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

(d) WAIVERS.—In order to accommodate new and innovative programs, the Secretary may waive such requirements of this section for qualified State reinsurance programs and for subsection (c) qualifying State high risk pools as the Secretary deems appropriate.

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

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

(1) INCREASED FLEXIBILITY FOR STATES.—In the case of a State that conducts an universal access program described in section 301(a), the requirements of section 1115 of the Social Security Act (42 U.S.C. 1315) shall not apply to activities conducted by a State through a State innovation program described in section 303.

(2) PREFERENCE FOR COMPETITIVE GRANTS.—Beginning 3 years after the date of the enactment of this Act, in the case of a competitive grant for which the only eligible entities are States, the Secretary, in awarding such grant to a State, shall give preference to any State with a program that meets the requirements of paragraphs (1) and (2) of section section 301(a).

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

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

(2) ADDITIONAL PAYMENTS FOR STATES IMPLEMENTING A STATE INNOVATION PROGRAM.—

(A) ANNUAL PAYMENTS.—

(i) IN GENERAL.—The Secretary shall make annual payments to a State that meets the requirements under subparagraph (B).

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

(B) REQUIREMENTS FOR ADDITIONAL PAYMENTS.—A State meets the requirements of this paragraph if the State—

(i) operates a State innovation program;

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

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

(iv) reduces the number of uninsured individuals in the State without significantly expanding programs that increase direct spending for the Federal government and State budgets.

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

to improve the State's universal access program.

SEC. 303. STATE INNOVATION PROGRAM DESCRIBED.

For purposes of this subtitle, a State innovation program is a program operated by a State that consists of any of the following:

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

(2) Assistance for small businesses jointly purchasing health insurance coverage through small business health plans under section 306.

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

(4) The offering in the State of a basic catastrophic health benefit plan as defined in section 308(1).

SEC. 304. STATE TRANSPARENCY PROGRAM DESCRIBED.

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

(1) partners with private groups (including State medical associations) and, through such partnerships, obtains pricing and quality information related to health care services that are provided in the State; and

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

SEC. 305. HEALTH PLAN FINDER.

A health plan finder described under this section is a program, operated by a State (or a State acting in cooperation with other States) that—

(1) provides consumers with information about the health insurance coverage available to such consumer (including information about basic catastrophic health benefit plans described in section 303(5));

(2) connects consumers with health insurance specialists who provide advice to such consumers on which health insurance coverage would best serve the individual needs of each such consumer (taking into account the quality of the health care providers participating in such in coverage); and

(3) may, at the option of the State, enroll individuals—

(A) who are eligible for the Medicaid program under title XIX of the Social Security Act in such program; and

(B) who are eligible for the State Children's Health Insurance Program under title XXI of such Act in such program.

SEC. 306. SMALL BUSINESS HEALTH PLANS.

For purposes of a State innovation program under this subtitle, a State may assist small businesses in jointly purchasing health insurance coverage through small business health plans that allow such businesses to combine purchasing and negotiating power and to pool risk in order to obtain more affordable health care benefits for the employees of such businesses.

SEC. 307. INTERSTATE COMPACTS ON HEALTH INSURANCE REGULATION.

For purposes of a State innovation program under this subtitle, a State may establish an interstate compact with one or more States to establish a common regulatory system for health insurance coverage for the purpose of increasing the availability and diversity of health insurance coverage in the State, including provisions allowing small businesses to form small business health plans (as described in section 306) and permitting individuals to purchase insurance across State lines.

SEC. 308. DEFINITIONS.

For purposes of this subtitle:

(1) BASIC CATASTROPHIC HEALTH BENEFIT PLAN.—The term ''basic catastrophic health benefits plan'' means health insurance coverage—

(A) that is a high deductible plan (as defined under section 223(c)(2) of the Internal Revenue Code of 1986); and

(B) that is not subject to benefit mandates otherwise applicable under State law.

(2) HEALTH INSURANCE COVERAGE.—The term ''health insurance coverage'' has the meaning given such term under section 2791(b)(1) of the Public Health Service Act.

(3) SECRETARY.—The term ''Secretary'' means the Secretary of Health and Human Services.

(4) STATE.—The term ''State'' means the several States, the District of Columbia, Guam, the Commonwealth of Puerto Rico, the Northern Mariana Islands, the Virgin Islands, American Samoa, and the Trust Territory of the Pacific Islands.

(5) STATE INNOVATION PROGRAM.—The term ''State innovation program'' means a program described in section 303.

(6) UNIVERSAL ACCESS PROGRAM.—The term ''universal access program'' means a program described in section 301.

SEC. 309. AUTHORIZATION FOR APPROPRIATIONS.

There is authorized to be appropriated such sums as are necessary to carry out the provisions of this subtitle.

Subtitle B—Interstate Market for Health Insurance

SEC. 311. SPECIFICATION OF CONSTITUTIONAL AUTHORITY FOR ENACTMENT OF LAW.

This subtitle is enacted pursuant to the power granted Congress under article I, section 8, clause 3, of the United States Constitution.

SEC. 312. FINDINGS.

Congress finds the following:

(1) The application of numerous and significant variations in State law impacts the ability of insurers to offer, and individuals to obtain, affordable individual health insurance coverage, thereby impeding commerce in individual health insurance coverage.

(2) Individual health insurance coverage is increasingly offered through the Internet, other electronic means, and by mail, all of which are inherently part of interstate commerce.

(3) In response to these issues, it is appropriate to encourage increased efficiency in the offering of individual health insurance coverage through a collaborative approach by the States in regulating this coverage.

(4) The establishment of risk-retention groups has provided a successful model for the sale of insur-

ance across State lines, as the acts establishing those groups allow insurance to be sold in multiple States but regulated by a single State.

SEC. 313. COOPERATIVE GOVERNING OF INDIVIDUAL HEALTH INSURANCE COVERAGE.

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

"PART D—COOPERATIVE GOVERNING OF INDIVIDUAL HEALTH INSURANCE COVERAGE

"SEC. 2795. DEFINITIONS.

''In this part:

''(1) PRIMARY STATE.—The term 'primary State' means, with respect to individual health insurance coverage offered by a health insurance issuer, the State designated by the issuer as the State whose covered laws shall govern the health insurance issuer in the sale of such coverage under this part. An issuer, with respect to a particular policy, may only designate one such State as its primary State with respect to all such coverage it offers. Such an issuer may not change the designated primary State with respect to individual health insurance coverage once the policy is issued, except that such a change may be made upon renewal of the policy. With re-

spect to such designated State, the issuer is deemed to be doing business in that State.

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

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

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

''(5) APPLICABLE STATE AUTHORITY.—The term 'applicable State authority' means, with respect to a health insurance issuer in a State, the State insurance commissioner or official or officials des-

ignated by the State to enforce the requirements of this title for the State with respect to the issuer.

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

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

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

''(7) COVERED LAWS.—

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

''(i) individual health insurance coverage issued by a health insurance issuer;

''(ii) the offer, sale, rating (including medical underwriting), renewal, and issuance of individual health insurance coverage to an individual;

''(iii) the provision to an individual in relation to individual health insurance cov-

erage of health care and insurance related services;

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

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

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

"(8) STATE.—The term 'State' means the 50 States and includes the District of Columbia, Puerto Rico, the Virgin Islands, Guam, American Samoa, and the Northern Mariana Islands.

"(9) UNFAIR CLAIMS SETTLEMENT PRACTICES.—The term 'unfair claims settlement practices' means only the following practices:

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

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

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

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

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

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

"(G) A pattern or practice of compelling insured individuals or their beneficiaries to institute suits to recover amounts due under its policies by offering substantially less than the

amounts ultimately recovered in suits brought by them.

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

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

"(J) Failing to provide forms necessary to present claims within 15 calendar days of a requests with reasonable explanations regarding their use.

"(K) Attempting to cancel a policy in less time than that prescribed in the policy or by the law of the primary State.

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

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

''(i) An application for the issuance or renewal of an insurance policy or reinsurance contract.

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

''(iii) A claim for payment or benefit pursuant to an insurance policy or reinsurance contract.

''(iv) Premiums paid on an insurance policy or reinsurance contract.

''(v) Payments made in accordance with the terms of an insurance policy or reinsurance contract.

''(vi) A document filed with the commissioner or the chief insurance regulatory official of another jurisdiction.

''(vii) The financial condition of an insurer or reinsurer.

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

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

''(x) The reinstatement of an insurance policy.

''(B) Solicitation or acceptance of new or renewal insurance risks on behalf of an insurer reinsurer or other person engaged in the business of insurance by a person who knows or should know that the insurer or other person responsible for the risk is insolvent at the time of the transaction.

''(C) Transaction of the business of insurance in violation of laws requiring a license, certificate of authority or other legal authority for the transaction of the business of insurance.

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

"SEC. 2796. APPLICATION OF LAW.

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

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

"(1) make unlawful, or regulate, directly or indirectly, the operation of the health insurance issuer operating in the secondary State, except that any secondary State may require such an issuer—

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

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

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

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

"(ii) any such examination is conducted in accordance with the examiners' handbook of the National Association of Insurance Commissioners and is coordinated to avoid unjustified duplication and unjustified repetition;

"(D) to comply with a lawful order issued—

"(i) in a delinquency proceeding commenced by the State insurance commissioner if there has been a finding of finan-

cial impairment under subparagraph (C); or

"(ii) in a voluntary dissolution proceeding;

"(E) to comply with an injunction issued by a court of competent jurisdiction, upon a petition by the State insurance commissioner alleging that the issuer is in hazardous financial condition;

"(F) to participate, on a nondiscriminatory basis, in any insurance insolvency guaranty association or similar association to which a health insurance issuer in the State is required to belong;

"(G) to comply with any State law regarding fraud and abuse (as defined in section 2795(10)), except that if the State seeks an injunction regarding the conduct described in this subparagraph, such injunction must be obtained from a court of competent jurisdiction;

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

"(I) to comply with the applicable requirements for independent review under section

2798 with respect to coverage offered in the State;

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

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

''(c) CLEAR AND CONSPICUOUS DISCLOSURE.—A health insurance issuer shall provide the following notice, in 12-point bold type, in any insurance coverage offered in a secondary State under this part by such a health insurance issuer and at renewal of the policy, with the 5 blank spaces therein being appropriately filled with the name of the health insurance issuer, the name of primary State, the name of the secondary State, the name of the secondary State, and the name of the secondary State, respectively, for the coverage concerned:

''Notice

'' 'This policy is issued by XXXXX and is governed by the laws and regulations of the State of XXXXX, and it has met all the laws of that State as determined by that State's Department of Insurance. This policy may be less expensive than others

because it is not subject to all of the insurance laws and regulations of the State of XXXXX, including coverage of some services or benefits mandated by the law of the State of XXXXX. Additionally, this policy is not subject to all of the consumer protection laws or restrictions on rate changes of the State of XXXXX. As with all insurance products, before purchasing this policy, you should carefully review the policy and determine what health care services the policy covers and what benefits it provides, including any exclusions, limitations, or conditions for such services or benefits.'.

''(d) PROHIBITION ON CERTAIN RECLASSIFICATIONS AND PREMIUM INCREASES.—

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

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

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

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

"(A) from terminating or discontinuing coverage or a class of coverage in accordance with subsections (b) and (c) of section 2742;

"(B) from raising premium rates for all policy holders within a class based on claims experience;

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

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

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

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

"(D) from reinstating lapsed coverage; or

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

"(e) PRIOR OFFERING OF POLICY IN PRIMARY STATE.—A health insurance issuer may not offer for sale individual health insurance coverage in a secondary State unless that coverage is currently offered for sale in the primary State.

"(f) LICENSING OF AGENTS OR BROKERS FOR HEALTH INSURANCE ISSUERS.—Any State may require that a person acting, or offering to act, as an agent or broker for a health insurance issuer with respect to the offering of individual health insurance coverage obtain a license from that State, with commissions or other compensation subject to the provisions of the laws of that State, except that a State may not impose any qualification or requirement which discriminates against a nonresident agent or broker.

"(g) DOCUMENTS FOR SUBMISSION TO STATE INSURANCE COMMISSIONER.—Each health insurance issuer

issuing individual health insurance coverage in both primary and secondary States shall submit—

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

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

''(B) written notice of any change in its designation of its primary State; and

''(C) written notice from the issuer of the issuer's compliance with all the laws of the primary State; and

''(2) to the insurance commissioner of each secondary State in which it offers individual health insurance coverage, a copy of the issuer's quarterly financial statement submitted to the primary State, which statement shall be certified by an independent public accountant and contain a statement of opinion on loss and loss adjustment expense reserves made by—

''(A) a member of the American Academy of Actuaries; or

''(B) a qualified loss reserve specialist.

''(h) POWER OF COURTS TO ENJOIN CONDUCT.—Nothing in this section shall be construed to affect the authority of any Federal or State court to enjoin—

''(1) the solicitation or sale of individual health insurance coverage by a health insurance issuer to any person or group who is not eligible for such insurance; or

''(2) the solicitation or sale of individual health insurance coverage that violates the requirements of the law of a secondary State which are described in subparagraphs (A) through (H) of section 2796(b)(1).

''(i) POWER OF SECONDARY STATES TO TAKE ADMINISTRATIVE ACTION.—Nothing in this section shall be construed to affect the authority of any State to enjoin conduct in violation of that State's laws described in section 2796(b)(1).

''(j) STATE POWERS TO ENFORCE STATE LAWS.—

''(1) IN GENERAL.—Subject to the provisions of subsection (b)(1)(G) (relating to injunctions) and paragraph (2), nothing in this section shall be construed to affect the authority of any State to make

use of any of its powers to enforce the laws of such State with respect to which a health insurance issuer is not exempt under subsection (b).

''(2) COURTS OF COMPETENT JURISDICTION.—If a State seeks an injunction regarding the conduct described in paragraphs (1) and (2) of subsection (h), such injunction must be obtained from a Federal or State court of competent jurisdiction.

''(k) STATES' AUTHORITY TO SUE.—Nothing in this section shall affect the authority of any State to bring action in any Federal or State court.

''(l) GENERALLY APPLICABLE LAWS.—Nothing in this section shall be construed to affect the applicability of State laws generally applicable to persons or corporations.

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

surance coverage offered in a secondary State under this part, comply with the guaranteed availability requirements for eligible individuals in section 2741.

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

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

"SEC. 2798. INDEPENDENT EXTERNAL APPEALS PROCEDURES.

"(a) RIGHT TO EXTERNAL APPEAL.—A health insurance issuer may not offer, sell, or issue individual health insurance coverage in a secondary State under the provisions of this title unless—

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

"(2) in any case in which the requirements of subparagraph (A) are not met with respect to the ei-

ther of such States, the issuer provides an independent review mechanism substantially identical (as determined by the applicable State authority of such State) to that prescribed in the 'Health Carrier External Review Model Act' of the National Association of Insurance Commissioners for all individuals who purchase insurance coverage under the terms of this part, except that, under such mechanism, the review is conducted by an independent medical reviewer, or a panel of such reviewers, with respect to whom the requirements of subsection (b) are met.

''(b) QUALIFICATIONS OF INDEPENDENT MEDICAL REVIEWERS.—In the case of any independent review mechanism referred to in subsection (a)(2)—

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

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

''(B) with respect to each review, each reviewer meets the requirements of paragraph (4) and the reviewer, or at least 1 reviewer on the

panel, meets the requirements described in paragraph (5); and

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

"(2) LICENSURE AND EXPERTISE.—Each independent medical reviewer shall be a physician (allopathic or osteopathic) or health care professional who—

"(A) is appropriately credentialed or licensed in 1 or more States to deliver health care services; and

"(B) typically treats the condition, makes the diagnosis, or provides the type of treatment under review.

"(3) INDEPENDENCE.—

"(A) IN GENERAL.—Subject to subparagraph (B), each independent medical reviewer in a case shall—

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

"(ii) not have a material familial, financial, or professional relationship with such a party; and

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

"(B) EXCEPTION.—Nothing in subparagraph (A) shall be construed to—

"(i) prohibit an individual, solely on the basis of affiliation with the issuer, from serving as an independent medical reviewer if—

"(I) a non-affiliated individual is not reasonably available;

"(II) the affiliated individual is not involved in the provision of items or services in the case under review;

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

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

"(ii) prohibit an individual who has staff privileges at the institution where the treatment involved takes place from serv-

ing as an independent medical reviewer merely on the basis of such affiliation if the affiliation is disclosed to the issuer and the enrollee (or authorized representative), and neither party objects; or

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

"(4) PRACTICING HEALTH CARE PROFESSIONAL IN SAME FIELD.—

"(A) IN GENERAL.—In a case involving treatment, or the provision of items or services—

"(i) by a physician, a reviewer shall be a practicing physician (allopathic or osteopathic) of the same or similar specialty, as a physician who, acting within the appropriate scope of practice within the State in which the service is provided or rendered, typically treats the condition, makes the diagnosis, or provides the type of treatment under review; or

"(ii) by a non-physician health care professional, the reviewer, or at least 1

member of the review panel, shall be a practicing non-physician health care professional of the same or similar specialty as the non-physician health care professional who, acting within the appropriate scope of practice within the State in which the service is provided or rendered, typically treats the condition, makes the diagnosis, or provides the type of treatment under review.

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

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

''(6) LIMITATIONS ON REVIEWER COMPENSATION.—Compensation provided by the issuer to an independent medical reviewer in connection with a review under this section shall—

''(A) not exceed a reasonable level; and

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

''(7) RELATED PARTY DEFINED.—For purposes of this section, the term 'related party' means, with respect to a denial of a claim under a coverage relating to an enrollee, any of the following:

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

''(B) The enrollee (or authorized representative).

''(C) The health care professional that provides the items or services involved in the denial.

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

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

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

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

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

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

"SEC. 2799. ENFORCEMENT.

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

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

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

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

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

(c) GAO ONGOING STUDY AND REPORTS.—

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

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

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

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

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

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

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

SEC. 314. SEVERABILITY.

If any provision of the Act or the application of such provision to any person or circumstance is held to be unconstitutional, the remainder of this subtitle and the application of the provisions of such to any other person or circumstance shall not be affected.

Subtitle C—Young Adult Healthcare Coverage

SEC. 321. REQUIRING THE OPTION OF EXTENSION OF DEPENDENT COVERAGE FOR CERTAIN UNMARRIED, UNINSURED YOUNG ADULTS.

(a) UNDER GROUP HEALTH PLANS.—

(1) EMPLOYEE RETIREMENT INCOME SECURITY ACT OF 1974 AMENDMENTS.—

(A) IN GENERAL.—The Employee Retirement Income Security Act of 1974 is amended

by inserting after section 703 the following new section:

"SEC. 704. REQUIRING THE OPTION OF EXTENSION OF DEPENDENT COVERAGE FOR CERTAIN UNMARRIED, UNINSURED YOUNG ADULTS.

''(a) IN GENERAL.—A group health plan and a health insurance issuer offering health insurance coverage in connection with a group health plan that provides coverage for dependent children shall make available such coverage, at the option of the participant involved, for one or more qualified children (as defined in subsection (b)) of the participant.

''(b) QUALIFIED CHILD DEFINED.—In this section, the term 'qualified child' means, with respect to a participant in a group health plan or group health insurance coverage, an individual who (but for age) would be treated as a dependent child of the participant under such plan or coverage and who—

''(1) is under 26 years of age;

''(2) is not married;

''(3) has no dependents;

''(4) is a citizen or national of the United States; and

''(5) is not provided coverage as a participant, beneficiary, or enrollee (other than under this sec-

tion) under any other creditable coverage (as defined in section 701(c)(1)).

''(c) PREMIUMS.—Nothing in this section shall be construed as preventing a group health plan or health insurance issuer with respect to group health insurance coverage from increasing the premiums otherwise required for coverage provided under this section.''.

(B) CLERICAL AMENDMENT.—The table of contents of such Act is amended by inserting after the item relating to section 703 the following new item:

''704. Requiring the option of extension of dependent coverage for certain unmarried young adults.''.

(2) PHSA.—Title XXVII of the Public Health Service Act is amended by inserting after section 2702 the following new section:

''SEC. 2703. REQUIRING THE OPTION OF EXTENSION OF DEPENDENT COVERAGE FOR CERTAIN UNMARRIED, UNINSURED YOUNG ADULTS.

''The provisions of section 704 of the Employee Retirement Income Security Act of 1974 shall apply to health insurance coverage offered by a health insurance issuer in the individual market in the same manner as they apply to health insurance coverage offered by a health insurance issuer in connection with a group health plan in the small or large group market.''.

(b) INDIVIDUAL HEALTH INSURANCE COVERAGE.—Title XXVII of the Public Health Service Act is amended by inserting after section 2745 the following new section:

"SEC. 2746. REQUIRING THE OPTION OF EXTENSION OF DEPENDENT COVERAGE FOR CERTAIN UNMARRIED YOUNG ADULTS.

''The provisions of section 2703 shall apply to health insurance coverage offered by a health insurance issuer in the individual market in the same manner as they apply to health insurance coverage offered by a health insurance issuer in connection with a group health plan in the small or large group market.''.

(c) EFFECTIVE DATES.—

(1) GROUP HEALTH PLANS.—

(A) IN GENERAL.—The amendments made by subsection (a) shall apply to group health plans for plan years beginning on or after the date that is 90 days after the date of enactment of this Act.

(B) SPECIAL RULE FOR COLLECTIVE BARGAINING AGREEMENTS.—In the case of a group health plan maintained pursuant to 1 or more collective bargaining agreements between employee representatives and 1 or more employers, any plan amendment made pursuant to a collec-

tive bargaining agreement relating to the plan which amends the plan solely to conform to any requirement added by an amendment made by subsection (a) shall not be treated as a termination of such collective bargaining agreement.

(2) INDIVIDUAL HEALTH INSURANCE COVERAGE.—Section 2746 of the Public Health Service Act, as inserted by subsection (b), shall apply with respect to health insurance coverage offered, sold, issued, renewed, in effect, or operated in the individual market after the first day of the first month that begins more than 90 days after the date of the enactment of this Act.

TITLE IV—OFFSETS

SEC. 401. TRANSFER OF UNOBILGATED STIMULUS FUNDS.

(a) RESCISSION.—Effective on the date of the enactment of this Act, any unobligated balances available on such date of funds made available by division A of the American Recovery and Reinvestment Act of 2009 (Public Law 111–5), other than under the heading ''Federal Highway Administration-Highway Infrastructure Investment'' in title XII of such division, are rescinded and such provisions are repealed.

(b) REPEAL.—The provisions of division B of the American Recovery and Reinvestment Act of 2009 (Public

Law 111–5), other than titles I and II of such division are repealed.

(c) TRANSFER OF FUNDS.—The total amount rescinded by this section shall be deposited in the Federal Treasury.

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