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111TH CONGRESS
2D SESSION

H. R. 4529

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

IN THE HOUSE OF REPRESENTATIVES

JANUARY 27, 2010

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

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A BILL

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

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

SECTION 1. SHORT TITLE; TABLE OF CONTENTS.

(a) SHORT TITLE.—This Act may be cited as the ''Roadmap for America's Future Act of 2010''.

(b) TABLE OF CONTENTS.—The table of contents for this Act is as follows:

Sec. 1. Short title; table of contents.
Sec. 2. Findings and purpose.

TITLE I—HEALTH CARE REFORM

Subtitle A—Expanding Patient's Health Care Choices

Part 1—State-Based Health Care Exchanges

Sec. 101. State-based health care exchanges.
Sec. 102. Requirements.
Sec. 103. State Exchange incentives.

Part 2—Fair Tax Treatment for All Americans to Afford Health Care

Sec. 111. Reference.

subpart a—refundable and advanceable credit for certain health insurance coverage

Sec. 112. Refundable and advanceable credit for certain health insurance coverage.
Sec. 113. Requiring employer transparency about employee benefits.
Sec. 114. Changes to existing tax preferences for medical coverage, etc., for individuals eligible for qualified health insurance credit.

subpart b—health savings accounts

Sec. 121. Improvements to health savings accounts.
Sec. 122. Exception to requirement for employers to make comparable health savings account contributions.

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

Sec. 131. Cooperative governing of individual health insurance coverage.
Sec. 132. Small business health fairness.
Sec. 133. Repeal of certain tax exemptions for health insurance payments.

Subtitle C—Health Care Services Commission

Part I—Establishment and General Duties

Sec. 141. Establishment.
Sec. 142. General authorities and duties.
Sec. 143. Dissemination.

Part II—Forum for Quality and Effectiveness in Health Care

Sec. 151. Establishment of office.
Sec. 152. Membership.
Sec. 153. Duties.
Sec. 154. Adoption and enforcement of guidelines and standards.
Sec. 155. Additional requirements.

Part III—General Provisions

Sec. 161. Certain administrative authorities.

Sec. 162. Funding.
Sec. 163. Definitions.

PART IV—TERMINATIONS AND TRANSITION

Sec. 171. Termination of Agency for Healthcare Research and Quality.
Sec. 172. Transition.

PART V—INDEPENDENT HEALTH RECORD TRUST

Sec. 181. Short title of part.
Sec. 182. Purpose.
Sec. 183. Definitions.
Sec. 184. Establishment, certification, and membership of independent health record trusts.
Sec. 185. Duties of IHRT to IHRT participants.
Sec. 186. Availability and use of information from records in IHRT consistent with privacy protections and agreements.
Sec. 187. Voluntary nature of trust participation and information sharing.
Sec. 188. Financing of activities.
Sec. 189. Regulatory oversight.

TITLE II—FAIRNESS FOR EVERY AMERICAN PATIENT

Subtitle A—Medicaid Modernization

Sec. 201. Medicaid modernization.
Sec. 202. Outreach.
Sec. 203. Transition rules; miscellaneous provisions.

Subtitle B—Supplemental Health Care Assistance for Low-Income Families

Sec. 211. Supplemental health care assistance for low-income families.

TITLE III—MEDICARE REFORM

Subtitle A—New Medicare Program

Sec. 301. Benefit changes.
Sec. 302. Increase in Medicare eligibility age.
Sec. 303. Unified Medicare Trust Fund.

Subtitle B—Changes in Current Medicare Program

Sec. 311. Income-related reduction in part D premium subsidy.
Sec. 312. Reduction in hospital marketbasket increases.
Sec. 313. Elimination of indexing of income thresholds for part B income-related premiums.
Sec. 314. Reinstatement of the Medicare trigger.
Sec. 315. Eliminating inefficiencies and increasing choice in Medicare Advantage.

Subtitle C—Medical Liability Reform

PART 1—ENACTING REAL MEDICAL LIABILITY REFORM

Sec. 321. Encouraging speedy resolution of claims.
Sec. 322. Compensating patient injury.
Sec. 323. Maximizing patient recovery.

Sec. 324. Additional health benefits.
Sec. 325. Punitive damages.
Sec. 326. Authorization of payment of future damages to claimants in health care lawsuits.
Sec. 327. Definitions.
Sec. 328. Effect on other laws.
Sec. 329. State flexibility and protection of States' rights.
Sec. 330. Applicability; effective date.

PART 2—ENDING LAWSUIT ABUSE

Sec. 331. State grants to create health court solutions.

TITLE IV—SOCIAL SECURITY REFORM

Sec. 401. Short title.
Sec. 402. Establishment of Personal Social Security Savings Program.
Sec. 403. Monthly insurance benefits for participating individuals.
Sec. 404. Tax treatment of accounts.
Sec. 405. Self-Liquidating Social Security Transition Fund.
Sec. 406. Budgetary treatment of Social Security.
Sec. 407. Accounting for the Old-Age, Survivors, and Disability Insurance Program and the Personal Social Security Savings Program.
Sec. 408. Progressive indexing of benefits for old-age, wife's, and husband's insurance benefits.
Sec. 409. Adjustments to schedule for increases in normal retirement age.

TITLE V—SIMPLIFIED INCOME TAX

Sec. 501. Short title.
Sec. 502. Repeal of alternative minimum tax for noncorporate taxpayers.
Sec. 503. Simplified income tax system.
Sec. 504. Exclusion for capital gains, dividends, and interest.
Sec. 505. Repeal of estate and gift taxes.

TITLE VI—BUSINESS CONSUMPTION TAX

Sec. 601. Short title.
Sec. 602. Repeal of corporate income tax; new tax paid by corporations and other businesses.
Sec. 603. Repeal of chapter 6.

TITLE VII—JOB TRAINING RESULTS ACT OF 2010

Sec. 701. Short title.
Sec. 702. Purpose.
Sec. 703. Improvement of job training programs; performance metrics for WIA job training programs.
Sec. 704. Other job training programs.
Sec. 705. Transparency.
Sec. 706. Evaluations.
Sec. 707. Encouraging innovation.
Sec. 708. Making WIA Training Vouchers more accessible and flexible.
Sec. 709. Life long learning awareness campaigns.
Sec. 710. GAO reports.

TITLE VIII—SPENDING LIMITS AND DEFICIT CONTROL

Sec. 800. Short title.

Subtitle A—Spending Limits and Deficit Control

Sec. 801. Discretionary spending limits.
Sec. 802. Total spending limits.

Subtitle B—Reports and Orders

Sec. 811. Reports and orders.
Sec. 812. Spending limits enforcement.
Sec. 813. Spending reduction orders.
Sec. 814. Alternate spending reduction legislation in the House of Representatives.
Sec. 815. Alternate spending reduction legislation in the Senate.

Subtitle C—Long-Term Budgeting

Sec. 821. CBO and OMB projections.
Sec. 822. GAO and OMB statements of the Federal Government's financial condition.
Sec. 823. Five-year fiscal sustainability review.
Sec. 824. Long-term reconciliation.
Sec. 825. Long-term spending increase point of order.

SEC. 2. FINDINGS AND PURPOSE.

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

(1) The Congressional Budget Office, the Government Accountability Office, and the Federal Reserve have all found that Social Security, Medicare, and Medicaid, as currently structured, will result in unsustainable levels of spending, deficits, and debt.

(2) Although Americans remain committed to the missions of these initiatives, the goals can no longer be met on models created nearly 80 years ago—with large, centralized institutions, especially government, serving as sole providers for an increasingly dependent population.

(3) The continuing failure to enact solutions makes these problems more intractable with each succeeding year.

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

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

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

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

(1) HEALTH CARE REFORM.—To provide access to health care coverage for uninsured Americans by establishing a new tax credit; to reform health insur-

ance markets, high-risk pools, and electronic health records; and to create a new agency to promote the dissemination of industry-defined health care price and quality data.

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

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

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

(5) INDIVIDUAL INCOME TAX REFORM.—To offer taxpayers a choice in paying their Federal income taxes; to allow individuals to choose between

the current tax code or a highly simplified tax system with virtually no deductions or credits (apart from an individual health care credit), two low tax rates and a generous standard deduction and personal exemption; to fully repeal the alternative minimum tax (AMT), eliminate the tax on interest, capital gains and dividends in order to promote saving; and to repeal the estate tax.

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

(7) JOB TRAINING.—To assist working Americans in an increasingly global economy, reforms 49 job training programs across eight agencies to enhance transparency, accountability, and performance.

(8) BUDGET PROCESS.—To keep total spending of the Government under control, nondefense discretionary spending limits are set forth, a limit on total outlays as a percentage of the gross domestic

produce is established, and the process is reformed to put a greater focus on long-term budgetary trends.

TITLE I—HEALTH CARE REFORM

Subtitle A—Expanding Patient's Health Care Choices

PART 1—STATE-BASED HEALTH CARE EXCHANGES

SEC. 101. STATE-BASED HEALTH CARE EXCHANGES.

(a) STATE-BASED HEALTH CARE EXCHANGES.—

(1) IN GENERAL.—The Secretary of Health and Human Services (referred to in this part as the ''Secretary'') shall establish a process for the review of applications submitted by States for the establishment and implementation of State-based health care Exchanges (referred to in this part as a ''State Exchange'') and for the certification of such Exchanges. The Secretary shall certify a State Exchange if the Secretary determines that such Exchange meets the requirements of this part.

(2) CONTINUED CERTIFICATION.—The certification of a State Exchange under subsection (a) shall remain in effect until the Secretary determines that the Exchange has failed to meet any of the requirements under this part.

SEC. 102. REQUIREMENTS.

(a) GENERAL REQUIREMENTS FOR CERTIFICATION.—An application for certification under section 101(a) shall demonstrate compliance with the following:

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

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

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

(4) PREMIUMS.—

(A) AMOUNT.—A State shall not determine premium or cost sharing amounts for health in-

1 surance coverage offered through the State Ex-
2 change.
3 (B) COLLECTION METHOD.—A State shall
4 ensure the existence of an effective and efficient
5 method for the collection of premiums for
6 health insurance coverage offered through the
7 State Exchange.
8 (b) BENEFIT PARITY WITH MEMBERS OF CON-
9 GRESS.—With respect to health insurance issuers offering
10 health insurance coverage through the State Exchange,
11 the State shall not impose any requirement that such
12 issuers provide coverage that includes benefits different
13 than requirements on plans offered to Members of Con-
14 gress under chapter 89 of title 5, United States Code.
15 (c) FACILITATING UNIVERSAL COVERAGE FOR
16 AMERICANS.—
17 (1) AUTOMATIC ENROLLMENT.—The State Ex-
18 change shall ensure that health insurance coverage
19 offered through the Exchange provides for the appli-
20 cation of uniform mechanisms that are designed to
21 encourage and facilitate the enrollment of all eligible
22 individuals in Exchange-based health insurance cov-
23 erage. Such mechanisms shall include automatic en-
24 rollment through various venues, which may include
25 emergency rooms, the submission of State tax forms,

1 places of employment in the State, and State depart-
2 ments of motor vehicles.
3 (2) OTHER ENROLLMENT OPPORTUNITIES.—
4 (A) IN GENERAL.—The State Exchange
5 shall ensure that health insurance coverage of-
6 fered through the Exchange permits enrollment,
7 and changes in enrollment, of individuals at the
8 time such individuals become eligible individuals
9 in the State.
10 (B) ANNUAL OPEN ENROLLMENT PERI-
11 ODS.—The State Exchange shall ensure that
12 health insurance coverage offered through the
13 Exchange permits eligible individuals to annu-
14 ally change enrollment among the coverage of-
15 fered through the Exchange, subject to sub-
16 paragraph (A).
17 (C) INCENTIVES FOR CONTINUOUS AN-
18 NUAL COVERAGE.—The State Exchange shall
19 include an incentive for eligible individuals to
20 remain insured from plan year to plan year,
21 and may include incentives such as State tax
22 incentives or premium-based incentives.
23 (3) GUARANTEED ACCESS FOR INDIVIDUALS.—
24 The State Exchange shall ensure that, with respect
25 to health insurance coverage offered through the Ex-

1 change, all eligible individuals are able to enroll in
2 the coverage of their choice provided that such indi-
3 viduals agree to make applicable premium and cost
4 sharing payments.

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

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

14 (d) LIMITATION ON EXORBITANT PREMIUMS.—

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

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

24 (A) INDEPENDENT RISK ADJUSTMENT.—
25 The implementation of risk-adjustment among

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

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

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

(e) MEDICAID AND SCHIP BENEFICIARIES.—The State Exchange shall include procedures to permit eligible individuals who are receiving (or who are eligible to receive) health care under title XIX or XXI of the Social Security Act to enroll in health insurance coverage offered through the Exchange.

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

(g) REGIONAL OPTIONS.—

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

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

(3) MULTI-STATE POOLING ARRANGEMENTS.—State Exchanges may implement a multi-state health care coverage pooling arrangement under this part.

(h) ELIGIBLE INDIVIDUAL.—In this part, the term ''eligible individual'' means an individual who is—

(1) a citizen or national of the United States or an alien lawfully admitted to the United States for

permanent residence or otherwise residing in the United States under color of law;

(2) a resident of the State involved;

(3) not incarcerated; and

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

SEC. 103. STATE EXCHANGE INCENTIVES.

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

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

PART 2—FAIR TAX TREATMENT FOR ALL AMERICANS TO AFFORD HEALTH CARE

SEC. 111. REFERENCE.

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

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

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

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

"SEC. 25E. QUALIFIED HEALTH INSURANCE CREDIT.

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

"(b) MONTHLY LIMITATION.—

"(1) IN GENERAL.—The monthly limitation for each month during the taxable year for an eligible individual is 1/12th of—

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

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

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

"(2) LIMITATION ON AGGREGATE AMOUNT.—Notwithstanding paragraph (1), the aggregate monthly limitations for the taxpayer and the taxpayer's spouse and dependents for any month shall not exceed 1/12th of the applicable aggregate amount.

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

"(4) APPLICABLE AMOUNT.—

"(A) IN GENERAL.—For purposes of this section—

"(i) APPLICABLE ADULT AMOUNT.—The applicable adult amount is $2,300.

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

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

"(B) COST-OF-LIVING ADJUSTMENTS.—

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

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

"(I) the cost-of-living adjustment determined under section 1(f)(3) for the calendar year in which the taxable year begins by substituting 'calendar year 2010' for 'calendar year 1992' in subparagraph (B) thereof, plus

"(II) the cost-of-living adjustment determined under section 213(d)(10)(B)(ii) for the calendar year in which the taxable year begins by substituting '2010' for '1996' in subclause (II) thereof.

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

"(C) REVENUE NEUTRALITY ADJUSTMENTS.—

"(i) IN GENERAL.—In the case of any taxable year beginning in a calendar year after 2011, each dollar amount contained in subparagraph (A), as adjusted under subparagraph (B), shall be further adjusted (if necessary) such that the aggregate of such dollar amounts allowed as credits under this section for such taxable year equals but does not exceed the total increase in revenues in the Treasury resulting from the amendments made by sections 124 and 201 of the Roadmap for America's Future Act of 2010 for such taxable year as estimated by the Secretary.

"(ii) DATE OF ADJUSTMENT.—The Secretary shall announce the adjustments for any taxable year under this subparagraph not later than the preceding October 1.

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

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

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

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

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

"(2) the limitation imposed by section 26 or subsection (c) for the taxable year,

such excess shall be paid by the Secretary into the designated account of the taxpayer.

"(e) ELIGIBLE INDIVIDUAL.—For purposes of this section—

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

"(A) is the taxpayer, the taxpayer's spouse, or the taxpayer's dependent, and

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

"(2) MEDICARE COVERAGE, MEDICAID DISABILITY COVERAGE, AND MILITARY COVERAGE.—The term 'eligible individual' shall not include any individual who for any month is—

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

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

"(C) entitled to benefits under chapter 55 of title 10, United States Code, including under

the TRICARE program (as defined in section 1072(7) of such title).

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

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

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

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

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

"(A) has a reasonable annual and lifetime benefit maximum, and

"(B) provides coverage for inpatient and outpatient care, emergency benefits, and physician care.

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

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

"(g) DESIGNATED ACCOUNTS.—

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

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

"(B) which, under the terms of the account, accepts the payment described in subsection (d) on behalf of the taxpayer, and

"(C) which, under such terms, provides for the payment of expenses by the taxpayer or on behalf of such taxpayer by the trustee or custodian of such account, including payment to such provider.

"(2) SPECIFIED ACCOUNT.—For purposes of this paragraph, the term 'specified account' means—

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

"(B) any health insurance reserve account.

"(3) HEALTH INSURANCE RESERVE ACCOUNT.—For purposes of this subsection, the term 'health insurance reserve account' means a trust created or organized in the United States as a health insurance reserve account exclusively for the purpose of paying the qualified medical expenses (within the meaning of section 223(d)(2)) of the account beneficiary (as defined in section 223(d)(3)), but only if the written governing instrument creating the trust meets the requirements described in subparagraphs (B), (C), (D), and (E) of section 223(d)(1). Rules similar to the rules under subsections (g) and (h) of section 408 shall apply for purposes of this subparagraph.

"(4) TREATMENT OF PAYMENT.—Any payment under subsection (d) to a designated account shall not be taken into account with respect to any dollar limitation which applies with respect to contributions to such account (or to tax benefits with respect to such contributions).

"(h) OTHER DEFINITIONS.—For purposes of this section—

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

"(2) ADULT.—The term 'adult' means an individual who is not a child.

"(3) CHILD.—The term 'child' means a qualifying child (as defined in section 152(c)).

"(i) SPECIAL RULES.—

"(1) COORDINATION WITH MEDICAL DEDUCTION.—Any amount paid by a taxpayer for insurance which is taken into account for purposes of determining the credit allowable to the taxpayer under

subsection (a) shall not be taken into account in computing the amount allowable to the taxpayer as a deduction under section 213(a) or 162(l).

"(2) COORDINATION WITH HEALTH CARE TAX CREDIT.—No credit shall be allowed under subsection (a) for any taxable year to any taxpayer and qualifying family members with respect to whom a credit under section 35 is allowed for such taxable year.

"(3) DENIAL OF CREDIT TO DEPENDENTS.—No credit shall be allowed under this section to any individual with respect to whom a deduction under section 151 is allowable to another taxpayer for a taxable year beginning in the calendar year in which such individual's taxable year begins.

"(4) MARRIED COUPLES MUST FILE JOINT RETURN.—

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

"(B) MARITAL STATUS; CERTAIN MARRIED INDIVIDUALS LIVING APART.—Rules similar to the rules of paragraphs (3) and (4) of section

21(e) shall apply for purposes of this paragraph.

"(5) VERIFICATION OF COVERAGE, ETC.—No credit shall be allowed under this section with respect to any individual unless such individual's coverage (and such related information as the Secretary may require) is verified in such manner as the Secretary may prescribe.

"(6) INSURANCE WHICH COVERS OTHER INDIVIDUALS; TREATMENT OF PAYMENTS.—Rules similar to the rules of paragraphs (7) and (8) of section 35(g) shall apply for purposes of this section.

"(j) COORDINATION WITH ADVANCE PAYMENTS.—

"(1) REDUCTION IN CREDIT FOR ADVANCE PAYMENTS.—With respect to any taxable year, the amount which would (but for this subsection) be allowed as a credit to the taxpayer under subsection (a) shall be reduced (but not below zero) by the aggregate amount paid on behalf of such taxpayer under section 7527A for months beginning in such taxable year.

"(2) RECAPTURE OF EXCESS ADVANCE PAYMENTS.—If the aggregate amount paid on behalf of the taxpayer under section 7527A for months beginning in the taxable year exceeds the sum of the

monthly limitations determined under subsection (b) for the taxpayer and the taxpayer's spouse and dependents for such months, then the tax imposed by this chapter for such taxable year shall be increased by the sum of—

"(A) such excess, plus

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

For purposes of subparagraph (B), an equal part of the aggregate amount of the excess shall be deemed to be attributable to payments made under section 7527A on the first day of each month beginning in such taxable year, unless the taxpayer establishes the date on which each such payment giving rise to such excess occurred, in which case subparagraph (B) shall be applied with respect to each date so established. The Secretary may rescind or waive all or any portion of any amount imposed by reason of subparagraph (B) if such excess was not the result of the actions of the taxpayer.".

(b) ADVANCE PAYMENT OF CREDIT.—Chapter 77 (relating to miscellaneous provisions) is amended by inserting after section 7527 the following new section:

"SEC. 7527A. ADVANCE PAYMENT OF CREDIT FOR QUALIFIED REFUND ELIGIBLE HEALTH INSURANCE.

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

"(b) LIMITATION.—The Secretary may make payments under subsection (a) only to the extent that the Secretary determines that the amount of such payments made on behalf of any taxpayer for any month does not exceed the sum of the monthly limitations determined under section 25E(b) for the taxpayer and taxpayer's spouse and dependents for such month.".

(c) INFORMATION REPORTING.—

(1) IN GENERAL.—Subpart B of part III of subchapter A of chapter 61 (relating to information concerning transactions with other persons) is amended by inserting after section 6050W the following new section:

"SEC. 6050X. RETURNS RELATING TO CREDIT FOR QUALIFIED REFUND ELIGIBLE HEALTH INSURANCE.

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

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

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

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

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

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

"(C) the amount of each such payment,

"(D) the type of insurance coverage provided by such person with respect to such individual and the policy number associated with such coverage,

"(E) the name, address, and TIN of the spouse and each dependent covered under such coverage, and

"(F) such other information as the Secretary may prescribe.

"(c) STATEMENTS TO BE FURNISHED TO INDIVIDUALS WITH RESPECT TO WHOM INFORMATION IS REQUIRED.—Every person required to make a return under subsection (a) shall furnish to each individual whose name is required to be set forth in such return a written statement showing—

"(1) the contact information of the person required to make such return, and

"(2) the information required to be shown on the return with respect to such individual.

The written statement required under the preceding sentence shall be furnished on or before January 31 of the year following the calendar year for which the return under subsection (a) is required to be made.

"(d) RETURNS WHICH WOULD BE REQUIRED TO BE MADE BY 2 OR MORE PERSONS.—Except to the extent provided in regulations prescribed by the Secretary, in the case of any amount received by any person on behalf of another person, only the person first receiving such

amount shall be required to make the return under subsection (a).''.

(2) ASSESSABLE PENALTIES.—

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

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

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

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

(d) CONFORMING AMENDMENTS.—

(1) Paragraph (2) of section 1324(b) of title 31, United States Code, is amended by inserting ''25E,'' before ''35,''.

(2)(A) Section 24(b)(3)(B) is amended by inserting ", 25E," after "25D".

(B) Section 25(e)(1)(C)(ii) is amended by inserting "25E," after "25D,".

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

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

(E) Section 30(c)(2)(B)(ii) is amended by inserting "25E," after "25D,".

(F) Section 30D(c)(2)(B)(ii) is amended by striking "and 25D" and inserting ", 25D, and 25E".

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

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

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

"Sec. 25E. Qualified health insurance credit.".

(4) The table of sections for chapter 77 is amended by inserting after the item relating to section 7527 the following new item:

"Sec. 7527A. Advance payment of credit for qualified refund eligible health insurance.".

(5) The table of sections for subpart B of part III of subchapter A of chapter 61 is amended by adding at the end the following new item:

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

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

SEC. 113. REQUIRING EMPLOYER TRANSPARENCY ABOUT EMPLOYEE BENEFITS.

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

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

(b) EFFECTIVE DATE.—The amendments made by this section shall apply to statements for calendar years beginning after 2010.

SEC. 114. CHANGES TO EXISTING TAX PREFERENCES FOR MEDICAL COVERAGE, ETC., FOR INDIVIDUALS ELIGIBLE FOR QUALIFIED HEALTH INSURANCE CREDIT.

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

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

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

(2) CONFORMING AMENDMENTS.—

(A) Section 106(b)(1) is amended—

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

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

(B) Section 106(d)(1) is amended—

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

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

(b) AMOUNTS RECEIVED UNDER ACCIDENT AND HEALTH PLANS.—Section 105 (relating to amounts received under accident and health plans) is amended by adding at the end the following new subsection:

''(k) NO EXCLUSION FOR INDIVIDUALS ELIGIBLE FOR QUALIFIED HEALTH INSURANCE CREDIT.—Subsection (b) shall not apply with respect to any employer-provided coverage under an accident or health plan for any individual for any month unless such individual is described in paragraph (2) or (5) of section 25E(e) for such month.''.

(c) SPECIAL RULES FOR HEALTH INSURANCE COSTS OF SELF-EMPLOYED INDIVIDUALS.—Subsection (l) of section 162 (relating to special rules for health insurance

costs of self-employed individuals) is amended by adding at the end the following new paragraph:

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

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

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

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

"(12) PREMIUMS FOR QUALIFIED HEALTH INSURANCE.—The term 'medical care' does not include any amount paid as a premium for coverage of an eligible individual (as defined in section 25E(e)) under qualified health insurance (as defined in section 25E(f)) for any month.".

(f) REPORTING REQUIREMENT.—Subsection (a) of section 6051 is amended by striking ''and'' at the end of paragraph (12), by striking the period at the end of paragraph (13) and inserting ''and'', and by inserting after paragraph (13) the following new paragraph:

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

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

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

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

Subpart B—Health Savings Accounts

SEC. 121. IMPROVEMENTS TO HEALTH SAVINGS ACCOUNTS.

(a) INCREASE IN MONTHLY CONTRIBUTION LIMIT.—

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

"(2) MONTHLY LIMITATION.—

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

"(i) the greater of—

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

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

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

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

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

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

"(II) $1,000.

"(B) SPECIAL RULES RELATING TO OUT-OF-POCKET EXPENSES.—

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

"(ii) SECRETARIAL AUTHORITY.—The Secretary may by regulations provide that annual out-of-pocket expenses will not be taken into account under subparagraph (A)(i)(I) to the extent that there is only a

remote likelihood that such amounts will be required to be paid.''.

(2) APPLICATION OF SPECIAL RULES FOR MARRIED INDIVIDUALS.—Paragraph (5) of section 223(b) (relating to limitations) is amended to read as follows:

''(5) SPECIAL RULES FOR MARRIED INDIVIDUALS.—

''(A) IN GENERAL.—In the case of individuals who are married to each other and who are both eligible individuals, the limitation under paragraph (1) for each spouse shall be equal to the spouse's applicable share of the combined marital limit.

''(B) COMBINED MARITAL LIMIT.—For purposes of subparagraph (A), the combined marital limit is the excess (if any) of—

''(i) the lesser of—

''(I) subject to subparagraph (C), the sum of the limitations computed separately under paragraph (1) for each spouse (including any additional contribution amount under paragraph (3)), or

"(II) the dollar amount in effect under subsection (c)(2)(A)(ii)(II), over

"(ii) the aggregate amount paid to Archer MSAs of such spouses for the taxable year.

"(C) SPECIAL RULE WHERE BOTH SPOUSES HAVE FAMILY COVERAGE.—For purposes of subparagraph (B)(i)(I), if either spouse has family coverage which covers both spouses, both spouses shall be treated as having only such coverage (and if both spouses each have such coverage under different plans, shall be treated as having only family coverage with the plan with respect to which the lowest amount is determined under paragraph (2)(A)(i)(I)).

"(D) APPLICABLE SHARE.—For purposes of subparagraph (A), a spouse's applicable share is ½ of the combined marital limit unless both spouses agree on a different division.

"(E) COUPLES NOT MARRIED ENTIRE YEAR.—The Secretary shall prescribe rules for the application of this paragraph in the case of any taxable year for which the individuals were not married to each other during all months in-

cluded in the taxable year, including rules which allow individuals in appropriate cases to take into account coverage prior to marriage in computing the combined marital limit for purposes of this paragraph.''.

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

''(4) COVERAGE.—

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

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

(4) CONFORMING AMENDMENTS.—

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

(B) Section 223(c)(2)(A) is amended—

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

(ii) by striking ''$5,000'' in clause (ii)(I) and inserting ''$5,800''.

(C) Section 223(d)(1)(A)(ii)(I) is amended by striking "subsection (b)(2)(B)(ii)" and inserting "subsection (c)(2)(A)(ii)(II)".

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

"(ii) CERTAIN ITEMS DISREGARDED IN COMPUTING MONTHLY LIMITATION.—Such plan's annual deductible, and such plan's annual out-of-pocket limitation, for services provided outside of such network shall not be taken into account for purposes of subsection (b)(2)."

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

"(g) COST-OF-LIVING ADJUSTMENTS.—

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

"(2) BLENDED COST-OF-LIVING ADJUSTMENT.—For purposes of paragraph (1), the blended cost-of-living adjustment means one-half of the sum of—

"(A) the cost-of-living adjustment determined under section 1(f)(3) for the calendar year in which the taxable year begins by substituting 'calendar year 2008' for 'calendar year 1992' in subparagraph (B) thereof, plus

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

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

(b) USE OF ACCOUNT FOR INDIVIDUAL HIGH DEDUCTIBLE HEALTH PLAN PREMIUMS.—Section 223(d)(2)(C) (relating to exceptions) is amended by striking "or" at the end of clause (iii), by striking the period at the end of clause (iv) and inserting ", or", and by adding at the end the following new clause:

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

"(I) the plan is not a group health plan (as defined in section 5000(b)(1) without regard to section 5000(d)), and

"(II) the expenses are for coverage for a month with respect to which the account beneficiary is an eligible individual by reason of the coverage under the plan.

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

(c) SAFE HARBOR FOR ABSENCE OF MAINTENANCE OF CHRONIC DISEASE.—Section 223(c)(2)(C) (safe harbor for absence of preventive care deductible) is amended—

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

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

(d) CLARIFICATION OF TREATMENT OF CAPITATED PRIMARY CARE PAYMENTS AS AMOUNTS PAID FOR MEDICAL CARE.—Section 213(d) (relating to definitions) is amended by adding at the end the following new paragraph:

"(12) TREATMENT OF CAPITATED PRIMARY CARE PAYMENTS.—Capitated primary care payments shall be treated as amounts paid for medical care.".

(e) SPECIAL RULE FOR INDIVIDUALS ELIGIBLE FOR VETERANS OR INDIAN HEALTH BENEFITS.—Section 223(c)(1) (defining eligible individual) is amended by adding at the end the following new subparagraph:

"(C) SPECIAL RULE FOR INDIVIDUALS ELIGIBLE FOR VETERANS OR INDIAN HEALTH BENEFITS.—For purposes of subparagraph (A)(ii), an individual shall not be treated as covered under a health plan described in such subparagraph merely because the individual receives periodic hospital care or medical services under any law administered by the Secretary of Veterans Affairs or the Bureau of Indian Affairs.".

(f) CERTAIN PHYSICIAN FEES TO BE TREATED AS MEDICAL CARE.—

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

"(12) PRE-PAID PHYSICIAN FEES.—The term 'medical care' shall include amounts paid by patients to their primary physician in advance for the right to receive medical services on an as-needed basis.".

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

(g) EFFECTIVE DATES.—

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

(2) CAPITATED PRIMARY CARE PAYMENTS.—The amendment made by subsection (d) shall apply to amounts paid before, on, or after the date of the enactment of this Act.

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

(a) GREATER EMPLOYER-PROVIDED CONTRIBUTIONS TO HSAS FOR CHRONICALLY ILL EMPLOYEES TREATED AS MEETING COMPARABILITY REQUIREMENTS.—Subsection (b) of section 4980G (relating to failure of employer to make comparable health savings account contributions) is amended to read as follows:

"(b) RULES AND REQUIREMENTS.—

"(1) IN GENERAL.—Except as provided in paragraph (2), rules and requirements similar to the

rules and requirements of section 4980E shall apply for purposes of this section.

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

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

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

"(C) CHRONICALLY ILL INDIVIDUAL.—For purposes of this paragraph, the term 'chronically ill individual' means any individual whose qualified medical expenses for any taxable year are more than 50 percent greater than the av-

erage qualified medical expenses of all employees of the employer for such year.''.

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

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

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

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

"PART D—COOPERATIVE GOVERNING OF INDIVIDUAL HEALTH INSURANCE COVERAGE

"SEC. 2795. DEFINITIONS.

''In this part:

''(1) PRIMARY STATE.—The term 'primary State' means, with respect to individual health insurance coverage offered by a health insurance issuer, the State designated by the issuer as the State whose covered laws shall govern the health insurance issuer in the sale of such coverage under this part. An issuer, with respect to a particular policy, may only designate one such State as its primary State

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

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

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

"(4) INDIVIDUAL HEALTH INSURANCE COVERAGE.—The term 'individual health insurance coverage' means health insurance coverage offered in

1 the individual market, as defined in section
2 2791(e)(1).
3 "(5) APPLICABLE STATE AUTHORITY.—The
4 term 'applicable State authority' means, with respect
5 to a health insurance issuer in a State, the State in-
6 surance commissioner or official or officials des-
7 ignated by the State to enforce the requirements of
8 this title for the State with respect to the issuer.
9 "(6) HAZARDOUS FINANCIAL CONDITION.—The
10 term 'hazardous financial condition' means that,
11 based on its present or reasonably anticipated finan-
12 cial condition, a health insurance issuer is unlikely
13 to be able—
14 "(A) to meet obligations to policyholders
15 with respect to known claims and reasonably
16 anticipated claims; or
17 "(B) to pay other obligations in the normal
18 course of business.
19 "(7) COVERED LAWS.—
20 "(A) IN GENERAL.—The term 'covered
21 laws' means the laws, rules, regulations, agree-
22 ments, and orders governing the insurance busi-
23 ness pertaining to—
24 "(i) individual health insurance cov-
25 erage issued by a health insurance issuer;

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

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

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

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

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

adequacy, health care data collection, or quality assurance.

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

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

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

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

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

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

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

"(F) Failing to affirm or deny coverage of claims within a reasonable period of time after

1 having completed an investigation related to
2 those claims.

3 "(G) A pattern or practice of compelling
4 insured individuals or their beneficiaries to in-
5 stitute suits to recover amounts due under its
6 policies by offering substantially less than the
7 amounts ultimately recovered in suits brought
8 by them.

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

16 "(I) Attempting to settle or settling claims
17 on the basis of an application that was materi-
18 ally altered without notice to, or knowledge or
19 consent of, the insured.

20 "(J) Failing to provide forms necessary to
21 present claims within 15 calendar days of a re-
22 quests with reasonable explanations regarding
23 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'

1 handbook of the National Association of
2 Insurance Commissioners and is coordi-
3 nated to avoid unjustified duplication and
4 unjustified repetition;
5 ''(D) to comply with a lawful order
6 issued—
7 ''(i) in a delinquency proceeding com-
8 menced by the State insurance commis-
9 sioner if there has been a finding of finan-
10 cial impairment under subparagraph (C);
11 or
12 ''(ii) in a voluntary dissolution pro-
13 ceeding;
14 ''(E) to comply with an injunction issued
15 by a court of competent jurisdiction, upon a pe-
16 tition by the State insurance commissioner al-
17 leging that the issuer is in hazardous financial
18 condition;
19 ''(F) to participate, on a nondiscriminatory
20 basis, in any insurance insolvency guaranty as-
21 sociation or similar association to which a
22 health insurance issuer in the State is required
23 to belong;
24 ''(G) to comply with any State law regard-
25 ing fraud and abuse (as defined in section

2795(10)), except that if the State seeks an injunction regarding the conduct described in this subparagraph, such injunction must be obtained from a court of competent jurisdiction;

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

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

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

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

"(c) CLEAR AND CONSPICUOUS DISCLOSURE.—A health insurance issuer shall provide the following notice, in 12-point bold type, in any insurance coverage offered in a secondary State under this part by such a health insurance issuer and at renewal of the policy, with the 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 _____ and is governed by the laws and regulations of the State of _____, and it has met all the laws of that State as determined by that State's Department of Insurance. This policy may be less expensive than others because it is not subject to all of the insurance laws and regulations of the State of _____, including coverage of some services or benefits mandated by the law of the State of _____. Additionally, this policy is not subject to all of the consumer protection laws or restrictions on rate changes of the State of _____. As with all insurance products, before purchasing this policy, you should carefully review the policy and determine what health care services the policy covers and what benefits it provides, including any exclusions, limitations, or conditions for such services or benefits.**'.

1 "(d) PROHIBITION ON CERTAIN RECLASSIFICATIONS
2 AND PREMIUM INCREASES.—
3 "(1) IN GENERAL.—For purposes of this sec-
4 tion, a health insurance issuer that provides indi-
5 vidual health insurance coverage to an individual
6 under this part in a primary or secondary State may
7 not upon renewal—
8 "(A) move or reclassify the individual in-
9 sured under the health insurance coverage from
10 the class such individual is in at the time of
11 issue of the contract based on the health-status
12 related factors of the individual; or
13 "(B) increase the premiums assessed the
14 individual for such coverage based on a health
15 status-related factor or change of a health sta-
16 tus-related factor or the past or prospective
17 claim experience of the insured individual.
18 "(2) CONSTRUCTION.—Nothing in paragraph
19 (1) shall be construed to prohibit a health insurance
20 issuer—
21 "(A) from terminating or discontinuing
22 coverage or a class of coverage in accordance
23 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.

1 "(f) LICENSING OF AGENTS OR BROKERS FOR
2 HEALTH INSURANCE ISSUERS.—Any State may require
3 that a person acting, or offering to act, as an agent or
4 broker for a health insurance issuer with respect to the
5 offering of individual health insurance coverage obtain a
6 license from that State, with commissions or other com-
7 pensation subject to the provisions of the laws of that
8 State, except that a State may not impose any qualifica-
9 tion or requirement which discriminates against a non-
10 resident agent or broker.

11 "(g) DOCUMENTS FOR SUBMISSION TO STATE IN-
12 SURANCE COMMISSIONER.—Each health insurance issuer
13 issuing individual health insurance coverage in both pri-
14 mary and secondary States shall submit—

15 "(1) to the insurance commissioner of each
16 State in which it intends to offer such coverage, be-
17 fore it may offer individual health insurance cov-
18 erage in such State—

19 "(A) a copy of the plan of operation or fea-
20 sibility study or any similar statement of the
21 policy being offered and its coverage (which
22 shall include the name of its primary State and
23 its principal place of business);

24 "(B) written notice of any change in its
25 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 insurance coverage offered in a secondary State under this part, comply with the guaranteed availability requirements for eligible individuals in section 2741.

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

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

"SEC. 2798. INDEPENDENT EXTERNAL APPEALS PROCEDURES.

"(a) RIGHT TO EXTERNAL APPEAL.—A health insurance issuer may not offer, sell, or issue individual health insurance coverage in a secondary State under the provisions of this title unless—

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

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

1 "(b) QUALIFICATIONS OF INDEPENDENT MEDICAL
2 REVIEWERS.—In the case of any independent review
3 mechanism referred to in subsection (a)(2)—
4 "(1) IN GENERAL.—In referring a denial of a
5 claim to an independent medical reviewer, or to any
6 panel of such reviewers, to conduct independent
7 medical review, the issuer shall ensure that—
8 "(A) each independent medical reviewer
9 meets the qualifications described in paragraphs
10 (2) and (3);
11 "(B) with respect to each review, each re-
12 viewer meets the requirements of paragraph (4)
13 and the reviewer, or at least 1 reviewer on the
14 panel, meets the requirements described in
15 paragraph (5); and
16 "(C) compensation provided by the issuer
17 to each reviewer is consistent with paragraph
18 (6).
19 "(2) LICENSURE AND EXPERTISE.—Each inde-
20 pendent medical reviewer shall be a physician
21 (allopathic or osteopathic) or health care profes-
22 sional who—
23 "(A) is appropriately credentialed or li-
24 censed in 1 or more States to deliver health
25 care services; and

1 "(B) typically treats the condition, makes
2 the diagnosis, or provides the type of treatment
3 under review.
4 "(3) INDEPENDENCE.—
5 "(A) IN GENERAL.—Subject to subpara-
6 graph (B), each independent medical reviewer
7 in a case shall—
8 "(i) not be a related party (as defined
9 in paragraph (7));
10 "(ii) not have a material familial, fi-
11 nancial, or professional relationship with
12 such a party; and
13 "(iii) not otherwise have a conflict of
14 interest with such a party (as determined
15 under regulations).
16 "(B) EXCEPTION.—Nothing in subpara-
17 graph (A) shall be construed to—
18 "(i) prohibit an individual, solely on
19 the basis of affiliation with the issuer,
20 from serving as an independent medical re-
21 viewer if—
22 "(I) a non-affiliated individual is
23 not reasonably available;

1 "(II) the affiliated individual is
2 not involved in the provision of items
3 or services in the case under review;
4 "(III) the fact of such an affili-
5 ation is disclosed to the issuer and the
6 enrollee (or authorized representative)
7 and neither party objects; and
8 "(IV) the affiliated individual is
9 not an employee of the issuer and
10 does not provide services exclusively or
11 primarily to or on behalf of the issuer;
12 "(ii) prohibit an individual who has
13 staff privileges at the institution where the
14 treatment involved takes place from serv-
15 ing as an independent medical reviewer
16 merely on the basis of such affiliation if
17 the affiliation is disclosed to the issuer and
18 the enrollee (or authorized representative),
19 and neither party objects; or
20 "(iii) prohibit receipt of compensation
21 by an independent medical reviewer from
22 an entity if the compensation is provided
23 consistent with paragraph (6).
24 "(4) PRACTICING HEALTH CARE PROFESSIONAL
25 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.

1 "(B) PRACTICING DEFINED.—For pur-
2 poses of this paragraph, the term 'practicing'
3 means, with respect to an individual who is a
4 physician or other health care professional, that
5 the individual provides health care services to
6 individual patients on average at least 2 days
7 per week.
8 "(5) PEDIATRIC EXPERTISE.—In the case of an
9 external review relating to a child, a reviewer shall
10 have expertise under paragraph (2) in pediatrics.
11 "(6) LIMITATIONS ON REVIEWER COMPENSA-
12 TION.—Compensation provided by the issuer to an
13 independent medical reviewer in connection with a
14 review under this section shall—
15 "(A) not exceed a reasonable level; and
16 "(B) not be contingent on the decision ren-
17 dered by the reviewer.
18 "(7) RELATED PARTY DEFINED.—For purposes
19 of this section, the term 'related party' means, with
20 respect to a denial of a claim under a coverage relat-
21 ing to an enrollee, any of the following:
22 "(A) The issuer involved, or any fiduciary,
23 officer, director, or employee of the issuer.
24 "(B) The enrollee (or authorized represent-
25 ative).

1 "(C) The health care professional that pro-
2 vides the items or services involved in the de-
3 nial.
4 "(D) The institution at which the items or
5 services (or treatment) involved in the denial
6 are provided.
7 "(E) The manufacturer of any drug or
8 other item that is included in the items or serv-
9 ices involved in the denial.
10 "(F) Any other party determined under
11 any regulations to have a substantial interest in
12 the denial involved.
13 "(8) DEFINITIONS.—For purposes of this sub-
14 section:
15 "(A) ENROLLEE.—The term 'enrollee'
16 means, with respect to health insurance cov-
17 erage offered by a health insurance issuer, an
18 individual enrolled with the issuer to receive
19 such coverage.
20 "(B) HEALTH CARE PROFESSIONAL.—The
21 term 'health care professional' means an indi-
22 vidual who is licensed, accredited, or certified
23 under State law to provide specified health care
24 services and who is operating within the scope
25 of such licensure, accreditation, or certification.

"SEC. 2799. ENFORCEMENT.

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

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

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

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

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

(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).

(d) SEVERABILITY.—If any provision of this subtitle or the application of such provision to any person or circumstance is held to be unconstitutional, the remainder

of this subtitle and the application of the provisions of such to any other person or circumstance shall not be affected.

SEC. 132. SMALL BUSINESS HEALTH FAIRNESS.

(a) RULES GOVERNING ASSOCIATION HEALTH PLANS.—

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

"PART 8—RULES GOVERNING ASSOCIATION HEALTH PLANS

"SEC. 801. ASSOCIATION HEALTH PLANS.

''(a) IN GENERAL.—For purposes of this part, the term 'association health plan' means a group health plan whose sponsor is (or is deemed under this part to be) described in subsection (b).

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

''(1) is organized and maintained in good faith, with a constitution and bylaws specifically stating its purpose and providing for periodic meetings on at least an annual basis, as a bona fide trade association, a bona fide industry association (including a rural electric cooperative association or a rural tele-

phone cooperative association), a bona fide professional association, or a bona fide chamber of commerce (or similar bona fide business association, including a corporation or similar organization that operates on a cooperative basis (within the meaning of section 1381 of the Internal Revenue Code of 1986)), for substantial purposes other than that of obtaining or providing medical care;

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

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

Any sponsor consisting of an association of entities which meet the requirements of paragraphs (1), (2), and (3) shall be deemed to be a sponsor described in this subsection.

"SEC. 802. CERTIFICATION OF ASSOCIATION HEALTH PLANS.

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

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

"(c) REQUIREMENTS APPLICABLE TO CERTIFIED PLANS.—An association health plan with respect to which certification under this part is in effect shall meet the applicable requirements of this part, effective on the date of certification (or, if later, on the date on which the plan is to commence operations).

"(d) REQUIREMENTS FOR CONTINUED CERTIFICATION.—The applicable authority may provide by regulation for continued certification of association health plans under this part.

1 "(e) CLASS CERTIFICATION FOR FULLY INSURED
2 PLANS.—The applicable authority shall establish a class
3 certification procedure for association health plans under
4 which all benefits consist of health insurance coverage.
5 Under such procedure, the applicable authority shall pro-
6 vide for the granting of certification under this part to
7 the plans in each class of such association health plans
8 upon appropriate filing under such procedure in connec-
9 tion with plans in such class and payment of the pre-
10 scribed fee under section 807(a).

11 "(f) CERTIFICATION OF SELF-INSURED ASSOCIATION
12 HEALTH PLANS.—An association health plan which offers
13 one or more benefit options which do not consist of health
14 insurance coverage may be certified under this part only
15 if such plan consists of any of the following:

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

18 "(2) a plan under which the sponsor does not
19 restrict membership to one or more trades and busi-
20 nesses or industries and whose eligible participating
21 employers represent a broad cross-section of trades
22 and businesses or industries, or

23 "(3) a plan whose eligible participating employ-
24 ers represent one or more trades or businesses, or
25 one or more industries, consisting of any of the fol-

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

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

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

1 "(b) BOARD OF TRUSTEES.—The requirements of
2 this subsection are met with respect to an association
3 health plan if the following requirements are met:
4 "(1) FISCAL CONTROL.—The plan is operated,
5 pursuant to a trust agreement, by a board of trust-
6 ees which has complete fiscal control over the plan
7 and which is responsible for all operations of the
8 plan.
9 "(2) RULES OF OPERATION AND FINANCIAL
10 CONTROLS.—The board of trustees has in effect
11 rules of operation and financial controls, based on a
12 3-year plan of operation, adequate to carry out the
13 terms of the plan and to meet all requirements of
14 this title applicable to the plan.
15 "(3) RULES GOVERNING RELATIONSHIP TO
16 PARTICIPATING EMPLOYERS AND TO CONTRAC-
17 TORS.—
18 "(A) BOARD MEMBERSHIP.—
19 "(i) IN GENERAL.—Except as pro-
20 vided in clauses (ii) and (iii), the members
21 of the board of trustees are individuals se-
22 lected from individuals who are the owners,
23 officers, directors, or employees of the par-
24 ticipating employers or who are partners in

1 the participating employers and actively
2 participate in the business.
3 "(ii) LIMITATION.—
4 "(I) GENERAL RULE.—Except as
5 provided in subclauses (II) and (III),
6 no such member is an owner, officer,
7 director, or employee of, or partner in,
8 a contract administrator or other
9 service provider to the plan.
10 "(II) LIMITED EXCEPTION FOR
11 PROVIDERS OF SERVICES SOLELY ON
12 BEHALF OF THE SPONSOR.—Officers
13 or employees of a sponsor which is a
14 service provider (other than a contract
15 administrator) to the plan may be
16 members of the board if they con-
17 stitute not more than 25 percent of
18 the membership of the board and they
19 do not provide services to the plan
20 other than on behalf of the sponsor.
21 "(III) TREATMENT OF PRO-
22 VIDERS OF MEDICAL CARE.—In the
23 case of a sponsor which is an associa-
24 tion whose membership consists pri-
25 marily of providers of medical care,

subclause (I) shall not apply in the case of any service provider described in subclause (I) who is a provider of medical care under the plan.

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

"(B) SOLE AUTHORITY.—The board has sole authority under the plan to approve applications for participation in the plan and to contract with a service provider to administer the day-to-day affairs of the plan.

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

"(1) the requirements of subsection (a) and section 801(a) shall be deemed met if such requirements would otherwise be met if the franchiser were deemed to be the sponsor referred to in section 801(b), such network were deemed to be an association described in section 801(b), and each franchisee were deemed to be a member (of the association and the sponsor) referred to in section 801(b); and

"(2) the requirements of section 804(a)(1) shall be deemed met.

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

"SEC. 804. PARTICIPATION AND COVERAGE REQUIREMENTS.

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

"(1) each participating employer must be—

"(A) a member of the sponsor,

"(B) the sponsor, or

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

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

1 pating employers may also include such employer;
2 and
3 "(2) all individuals commencing coverage under
4 the plan after certification under this part must
5 be—
6 "(A) active or retired owners (including
7 self-employed individuals), officers, directors, or
8 employees of, or partners in, participating em-
9 ployers; or
10 "(B) the beneficiaries of individuals de-
11 scribed in subparagraph (A).
12 "(b) COVERAGE OF PREVIOUSLY UNINSURED EM-
13 PLOYEES.—In the case of an association health plan in
14 existence on the date of the enactment of this part, an
15 affiliated member of the sponsor of the plan may be of-
16 fered coverage under the plan as a participating employer
17 only if—
18 "(1) the affiliated member was an affiliated
19 member on the date of certification under this part;
20 or
21 "(2) during the 12-month period preceding the
22 date of the offering of such coverage, the affiliated
23 member has not maintained or contributed to a
24 group health plan with respect to any of its employ-

1 ees who would otherwise be eligible to participate in
2 such association health plan.

3 "(c) INDIVIDUAL MARKET UNAFFECTED.—The re-
4 quirements of this subsection are met with respect to an
5 association health plan if, under the terms of the plan,
6 no participating employer may provide health insurance
7 coverage in the individual market for any employee not
8 covered under the plan which is similar to the coverage
9 contemporaneously provided to employees of the employer
10 under the plan, if such exclusion of the employee from cov-
11 erage under the plan is based on a health status-related
12 factor with respect to the employee and such employee
13 would, but for such exclusion on such basis, be eligible
14 for coverage under the plan.

15 "(d) PROHIBITION OF DISCRIMINATION AGAINST
16 EMPLOYERS AND EMPLOYEES ELIGIBLE TO PARTICI-
17 PATE.—The requirements of this subsection are met with
18 respect to an association health plan if—

19 "(1) under the terms of the plan, all employers
20 meeting the preceding requirements of this section
21 are eligible to qualify as participating employers for
22 all geographically available coverage options, unless,
23 in the case of any such employer, participation or
24 contribution requirements of the type referred to in

section 2711 of the Public Health Service Act are not met;

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

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

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

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

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

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

"(B) provides that the sponsor of the plan is to serve as plan sponsor (referred to in section 3(16)(B)); and

"(C) incorporates the requirements of section 806.

"(2) CONTRIBUTION RATES MUST BE NONDISCRIMINATORY.—

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

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

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

"(ii) varying contribution rates for small employers in a State to the extent that such rates could vary using the same

1 methodology employed in such State for
2 regulating premium rates in the small
3 group market with respect to health insur-
4 ance coverage offered in connection with
5 bona fide associations (within the meaning
6 of section 2791(d)(3) of the Public Health
7 Service Act),
8 subject to the requirements of section 702(b)
9 relating to contribution rates.
10 "(3) FLOOR FOR NUMBER OF COVERED INDI-
11 VIDUALS WITH RESPECT TO CERTAIN PLANS.—If
12 any benefit option under the plan does not consist
13 of health insurance coverage, the plan has as of the
14 beginning of the plan year not fewer than 1,000 par-
15 ticipants and beneficiaries.
16 "(4) MARKETING REQUIREMENTS.—
17 "(A) IN GENERAL.—If a benefit option
18 which consists of health insurance coverage is
19 offered under the plan, State-licensed insurance
20 agents shall be used to distribute to small em-
21 ployers coverage which does not consist of
22 health insurance coverage in a manner com-
23 parable to the manner in which such agents are
24 used to distribute health insurance coverage.

"(B) STATE-LICENSED INSURANCE AGENTS.—For purposes of subparagraph (A), the term 'State-licensed insurance agents' means one or more agents who are licensed in a State and are subject to the laws of such State relating to licensure, qualification, testing, examination, and continuing education of persons authorized to offer, sell, or solicit health insurance coverage in such State.

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

"(b) ABILITY OF ASSOCIATION HEALTH PLANS TO DESIGN BENEFIT OPTIONS.—Subject to section 514(d), nothing in this part or any provision of State law (as defined in section 514(c)(1)) shall be construed to preclude an association health plan, or a health insurance issuer offering health insurance coverage in connection with an association health plan, from exercising its sole discretion in selecting the specific items and services consisting of medical care to be included as benefits under such plan or coverage, except (subject to section 514) in the case of (1) any law to the extent that it is not preempted under

1 section 731(a)(1) with respect to matters governed by sec-
2 tion 711, 712, or 713, or (2) any law of the State with
3 which filing and approval of a policy type offered by the
4 plan was initially obtained to the extent that such law pro-
5 hibits an exclusion of a specific disease from such cov-
6 erage.

7 **"SEC. 806. MAINTENANCE OF RESERVES AND PROVISIONS**
8 **FOR SOLVENCY FOR PLANS PROVIDING**
9 **HEALTH BENEFITS IN ADDITION TO HEALTH**
10 **INSURANCE COVERAGE.**

11 "(a) IN GENERAL.—The requirements of this section
12 are met with respect to an association health plan if—
13 "(1) the benefits under the plan consist solely
14 of health insurance coverage; or
15 "(2) if the plan provides any additional benefit
16 options which do not consist of health insurance cov-
17 erage, the plan—
18 "(A) establishes and maintains reserves
19 with respect to such additional benefit options,
20 in amounts recommended by the qualified actu-
21 ary, consisting of—
22 "(i) a reserve sufficient for unearned
23 contributions;
24 "(ii) a reserve sufficient for benefit li-
25 abilities which have been incurred, which

have not been satisfied, and for which risk of loss has not yet been transferred, and for expected administrative costs with respect to such benefit liabilities;

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

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

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

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

1 serves in excess of the amounts required
2 under subparagraph (A).
3 ''(ii) The plan shall secure specific ex-
4 cess/stop loss insurance for the plan with
5 an attachment point which is at least equal
6 to an amount recommended by the plan's
7 qualified actuary. The applicable authority
8 may by regulation provide for adjustments
9 in the amount of such insurance in speci-
10 fied circumstances in which the plan spe-
11 cifically provides for and maintains re-
12 serves in excess of the amounts required
13 under subparagraph (A).
14 ''(iii) The plan shall secure indem-
15 nification insurance for any claims which
16 the plan is unable to satisfy by reason of
17 a plan termination.
18 Any person issuing to a plan insurance described in clause
19 (i), (ii), or (iii) of subparagraph (B) shall notify the Sec-
20 retary of any failure of premium payment meriting can-
21 cellation of the policy prior to undertaking such a cancella-
22 tion. Any regulations prescribed by the applicable author-
23 ity pursuant to clause (i) or (ii) of subparagraph (B) may
24 allow for such adjustments in the required levels of excess/
25 stop loss insurance as the qualified actuary may rec-

1 ommend, taking into account the specific circumstances
2 of the plan.

3 "(b) MINIMUM SURPLUS IN ADDITION TO CLAIMS
4 RESERVES.—In the case of any association health plan de-
5 scribed in subsection (a)(2), the requirements of this sub-
6 section are met if the plan establishes and maintains sur-
7 plus in an amount at least equal to—

8 "(1) $500,000, or

9 "(2) such greater amount (but not greater than
10 $2,000,000) as may be set forth in regulations pre-
11 scribed by the applicable authority, considering the
12 level of aggregate and specific excess/stop loss insur-
13 ance provided with respect to such plan and other
14 factors related to solvency risk, such as the plan's
15 projected levels of participation or claims, the nature
16 of the plan's liabilities, and the types of assets avail-
17 able to assure that such liabilities are met.

18 "(c) ADDITIONAL REQUIREMENTS.—In the case of
19 any association health plan described in subsection (a)(2),
20 the applicable authority may provide such additional re-
21 quirements relating to reserves, excess/stop loss insurance,
22 and indemnification insurance as the applicable authority
23 considers appropriate. Such requirements may be provided
24 by regulation with respect to any such plan or any class
25 of such plans.

"(d) ADJUSTMENTS FOR EXCESS/STOP LOSS INSURANCE.—The applicable authority may provide for adjustments to the levels of reserves otherwise required under subsections (a) and (b) with respect to any plan or class of plans to take into account excess/stop loss insurance provided with respect to such plan or plans.

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

1 "(f) MEASURES TO ENSURE CONTINUED PAYMENT
2 OF BENEFITS BY CERTAIN PLANS IN DISTRESS.—
3 "(1) PAYMENTS BY CERTAIN PLANS TO ASSO-
4 CIATION HEALTH PLAN FUND.—
5 "(A) IN GENERAL.—In the case of an as-
6 sociation health plan described in subsection
7 (a)(2), the requirements of this subsection are
8 met if the plan makes payments into the Asso-
9 ciation Health Plan Fund under this subpara-
10 graph when they are due. Such payments shall
11 consist of annual payments in the amount of
12 $5,000, and, in addition to such annual pay-
13 ments, such supplemental payments as the Sec-
14 retary may determine to be necessary under
15 paragraph (2). Payments under this paragraph
16 are payable to the Fund at the time determined
17 by the Secretary. Initial payments are due in
18 advance of certification under this part. Pay-
19 ments shall continue to accrue until a plan's as-
20 sets are distributed pursuant to a termination
21 procedure.
22 "(B) PENALTIES FOR FAILURE TO MAKE
23 PAYMENTS.—If any payment is not made by a
24 plan when it is due, a late payment charge of
25 not more than 100 percent of the payment

which was not timely paid shall be payable by the plan to the Fund.

"(C) CONTINUED DUTY OF THE SECRETARY.—The Secretary shall not cease to carry out the provisions of paragraph (2) on account of the failure of a plan to pay any payment when due.

"(2) PAYMENTS BY SECRETARY TO CONTINUE EXCESS/STOP LOSS INSURANCE COVERAGE AND INDEMNIFICATION INSURANCE COVERAGE FOR CERTAIN PLANS.—In any case in which the applicable authority determines that there is, or that there is reason to believe that there will be: (A) a failure to take necessary corrective actions under section 809(a) with respect to an association health plan described in subsection (a)(2); or (B) a termination of such a plan under section 809(b) or 810(b)(8) (and, if the applicable authority is not the Secretary, certifies such determination to the Secretary), the Secretary shall determine the amounts necessary to make payments to an insurer (designated by the Secretary) to maintain in force excess/stop loss insurance coverage or indemnification insurance coverage for such plan, if the Secretary determines that there is a reasonable expectation that, without such

payments, claims would not be satisfied by reason of termination of such coverage. The Secretary shall, to the extent provided in advance in appropriation Acts, pay such amounts so determined to the insurer designated by the Secretary.

"(3) ASSOCIATION HEALTH PLAN FUND.—

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

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

"(g) EXCESS/STOP LOSS INSURANCE.—For purposes of this section—

1 "(1) AGGREGATE EXCESS/STOP LOSS INSUR-
2 ANCE.—The term 'aggregate excess/stop loss insur-
3 ance' means, in connection with an association
4 health plan, a contract—
5 "(A) under which an insurer (meeting such
6 minimum standards as the applicable authority
7 may prescribe by regulation) provides for pay-
8 ment to the plan with respect to aggregate
9 claims under the plan in excess of an amount
10 or amounts specified in such contract;
11 "(B) which is guaranteed renewable; and
12 "(C) which allows for payment of pre-
13 miums by any third party on behalf of the in-
14 sured plan.
15 "(2) SPECIFIC EXCESS/STOP LOSS INSUR-
16 ANCE.—The term 'specific excess/stop loss insur-
17 ance' means, in connection with an association
18 health plan, a contract—
19 "(A) under which an insurer (meeting such
20 minimum standards as the applicable authority
21 may prescribe by regulation) provides for pay-
22 ment to the plan with respect to claims under
23 the plan in connection with a covered individual
24 in excess of an amount or amounts specified in

1 such contract in connection with such covered
2 individual;
3 "(B) which is guaranteed renewable; and
4 "(C) which allows for payment of pre-
5 miums by any third party on behalf of the in-
6 sured plan.
7 "(h) INDEMNIFICATION INSURANCE.—For purposes
8 of this section, the term 'indemnification insurance'
9 means, in connection with an association health plan, a
10 contract—
11 "(1) under which an insurer (meeting such min-
12 imum standards as the applicable authority may pre-
13 scribe by regulation) provides for payment to the
14 plan with respect to claims under the plan which the
15 plan is unable to satisfy by reason of a termination
16 pursuant to section 809(b) (relating to mandatory
17 termination);
18 "(2) which is guaranteed renewable and
19 noncancellable for any reason (except as the applica-
20 ble authority may prescribe by regulation); and
21 "(3) which allows for payment of premiums by
22 any third party on behalf of the insured plan.
23 "(i) RESERVES.—For purposes of this section, the
24 term 'reserves' means, in connection with an association
25 health plan, plan assets which meet the fiduciary stand-

1 ards under part 4 and such additional requirements re-
2 garding liquidity as the applicable authority may prescribe
3 by regulation.

4 "(j) SOLVENCY STANDARDS WORKING GROUP.—

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

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

18 "(A) a representative of the National Asso-
19 ciation of Insurance Commissioners;

20 "(B) a representative of the American
21 Academy of Actuaries;

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

24 "(D) a representative of existing self-in-
25 sured arrangements, or their interests;

"(E) a representative of associations of the type referred to in section 801(b)(1), or their interests; and

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

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

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

"(b) INFORMATION TO BE INCLUDED IN APPLICATION FOR CERTIFICATION.—An application for certification under this part meets the requirements of this section only if it includes, in a manner and form which shall be prescribed by the applicable authority by regulation, at least the following information:

"(1) IDENTIFYING INFORMATION.—The names and addresses of—

"(A) the sponsor; and

"(B) the members of the board of trustees of the plan.

"(2) STATES IN WHICH PLAN INTENDS TO DO BUSINESS.—The States in which participants and beneficiaries under the plan are to be located and the number of them expected to be located in each such State.

"(3) BONDING REQUIREMENTS.—Evidence provided by the board of trustees that the bonding requirements of section 412 will be met as of the date of the application or (if later) commencement of operations.

"(4) PLAN DOCUMENTS.—A copy of the documents governing the plan (including any bylaws and trust agreements), the summary plan description, and other material describing the benefits that will be provided to participants and beneficiaries under the plan.

"(5) AGREEMENTS WITH SERVICE PROVIDERS.—A copy of any agreements between the plan and contract administrators and other service providers.

"(6) FUNDING REPORT.—In the case of association health plans providing benefits options in ad-

1 dition to health insurance coverage, a report setting
2 forth information with respect to such additional
3 benefit options determined as of a date within the
4 120-day period ending with the date of the applica-
5 tion, including the following:

6 "(A) RESERVES.—A statement, certified
7 by the board of trustees of the plan, and a
8 statement of actuarial opinion, signed by a
9 qualified actuary, that all applicable require-
10 ments of section 806 are or will be met in ac-
11 cordance with regulations which the applicable
12 authority shall prescribe.

13 "(B) ADEQUACY OF CONTRIBUTION
14 RATES.—A statement of actuarial opinion,
15 signed by a qualified actuary, which sets forth
16 a description of the extent to which contribution
17 rates are adequate to provide for the payment
18 of all obligations and the maintenance of re-
19 quired reserves under the plan for the 12-
20 month period beginning with such date within
21 such 120-day period, taking into account the
22 expected coverage and experience of the plan. If
23 the contribution rates are not fully adequate,
24 the statement of actuarial opinion shall indicate

the extent to which the rates are inadequate and the changes needed to ensure adequacy.

"(C) CURRENT AND PROJECTED VALUE OF ASSETS AND LIABILITIES.—A statement of actuarial opinion signed by a qualified actuary, which sets forth the current value of the assets and liabilities accumulated under the plan and a projection of the assets, liabilities, income, and expenses of the plan for the 12-month period referred to in subparagraph (B). The income statement shall identify separately the plan's administrative expenses and claims.

"(D) COSTS OF COVERAGE TO BE CHARGED AND OTHER EXPENSES.—A statement of the costs of coverage to be charged, including an itemization of amounts for administration, reserves, and other expenses associated with the operation of the plan.

"(E) OTHER INFORMATION.—Any other information as may be determined by the applicable authority, by regulation, as necessary to carry out the purposes of this part.

"(c) FILING NOTICE OF CERTIFICATION WITH STATES.—A certification granted under this part to an association health plan shall not be effective unless written

1 notice of such certification is filed with the applicable
2 State authority of each State in which at least 25 percent
3 of the participants and beneficiaries under the plan are
4 located. For purposes of this subsection, an individual
5 shall be considered to be located in the State in which a
6 known address of such individual is located or in which
7 such individual is employed.

8 "(d) NOTICE OF MATERIAL CHANGES.—In the case
9 of any association health plan certified under this part,
10 descriptions of material changes in any information which
11 was required to be submitted with the application for the
12 certification under this part shall be filed in such form
13 and manner as shall be prescribed by the applicable au-
14 thority by regulation. The applicable authority may re-
15 quire by regulation prior notice of material changes with
16 respect to specified matters which might serve as the basis
17 for suspension or revocation of the certification.

18 "(e) REPORTING REQUIREMENTS FOR CERTAIN AS-
19 SOCIATION HEALTH PLANS.—An association health plan
20 certified under this part which provides benefit options in
21 addition to health insurance coverage for such plan year
22 shall meet the requirements of section 103 by filing an
23 annual report under such section which shall include infor-
24 mation described in subsection (b)(6) with respect to the
25 plan year and, notwithstanding section 104(a)(1)(A), shall

1 be filed with the applicable authority not later than 90
2 days after the close of the plan year (or on such later date
3 as may be prescribed by the applicable authority). The ap-
4 plicable authority may require by regulation such interim
5 reports as it considers appropriate.

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

19 "(1) are in the aggregate reasonably related to
20 the experience of the plan and to reasonable expecta-
21 tions; and

22 "(2) represent such actuary's best estimate of
23 anticipated experience under the plan.

24 The opinion by the qualified actuary shall be made with
25 respect to, and shall be made a part of, the annual report.

"SEC. 808. NOTICE REQUIREMENTS FOR VOLUNTARY TERMINATION.

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

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

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

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

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

"SEC. 809. CORRECTIVE ACTIONS AND MANDATORY TERMINATION.

"(a) ACTIONS TO AVOID DEPLETION OF RESERVES.—An association health plan which is certified under this part and which provides benefits other than

1 health insurance coverage shall continue to meet the re-
2 quirements of section 806, irrespective of whether such
3 certification continues in effect. The board of trustees of
4 such plan shall determine quarterly whether the require-
5 ments of section 806 are met. In any case in which the
6 board determines that there is reason to believe that there
7 is or will be a failure to meet such requirements, or the
8 applicable authority makes such a determination and so
9 notifies the board, the board shall immediately notify the
10 qualified actuary engaged by the plan, and such actuary
11 shall, not later than the end of the next following month,
12 make such recommendations to the board for corrective
13 action as the actuary determines necessary to ensure com-
14 pliance with section 806. Not later than 30 days after re-
15 ceiving from the actuary recommendations for corrective
16 actions, the board shall notify the applicable authority (in
17 such form and manner as the applicable authority may
18 prescribe by regulation) of such recommendations of the
19 actuary for corrective action, together with a description
20 of the actions (if any) that the board has taken or plans
21 to take in response to such recommendations. The board
22 shall thereafter report to the applicable authority, in such
23 form and frequency as the applicable authority may speci-
24 fy to the board, regarding corrective action taken by the
25 board until the requirements of section 806 are met.

1 "(b) MANDATORY TERMINATION.—In any case in
2 which—
3 "(1) the applicable authority has been notified
4 under subsection (a) (or by an issuer of excess/stop
5 loss insurance or indemnity insurance pursuant to
6 section 806(a)) of a failure of an association health
7 plan which is or has been certified under this part
8 and is described in section 806(a)(2) to meet the re-
9 quirements of section 806 and has not been notified
10 by the board of trustees of the plan that corrective
11 action has restored compliance with such require-
12 ments; and
13 "(2) the applicable authority determines that
14 there is a reasonable expectation that the plan will
15 continue to fail to meet the requirements of section
16 806,
17 the board of trustees of the plan shall, at the direction
18 of the applicable authority, terminate the plan and, in the
19 course of the termination, take such actions as the appli-
20 cable authority may require, including satisfying any
21 claims referred to in section 806(a)(2)(B)(iii) and recov-
22 ering for the plan any liability under subsection
23 (a)(2)(B)(iii) or (e) of section 806, as necessary to ensure
24 that the affairs of the plan will be, to the maximum extent

1 possible, wound up in a manner which will result in timely
2 provision of all benefits for which the plan is obligated.

3 **"SEC. 810. TRUSTEESHIP BY THE SECRETARY OF INSOL-**
4 **VENT ASSOCIATION HEALTH PLANS PRO-**
5 **VIDING HEALTH BENEFITS IN ADDITION TO**
6 **HEALTH INSURANCE COVERAGE.**

7 "(a) APPOINTMENT OF SECRETARY AS TRUSTEE FOR
8 INSOLVENT PLANS.—Whenever the Secretary determines
9 that an association health plan which is or has been cer-
10 tified under this part and which is described in section
11 806(a)(2) will be unable to provide benefits when due or
12 is otherwise in a financially hazardous condition, as shall
13 be defined by the Secretary by regulation, the Secretary
14 shall, upon notice to the plan, apply to the appropriate
15 United States district court for appointment of the Sec-
16 retary as trustee to administer the plan for the duration
17 of the insolvency. The plan may appear as a party and
18 other interested persons may intervene in the proceedings
19 at the discretion of the court. The court shall appoint such
20 Secretary trustee if the court determines that the trustee-
21 ship is necessary to protect the interests of the partici-
22 pants and beneficiaries or providers of medical care or to
23 avoid any unreasonable deterioration of the financial con-
24 dition of the plan. The trusteeship of such Secretary shall
25 continue until the conditions described in the first sen-

1 tence of this subsection are remedied or the plan is termi-
2 nated.

3 "(b) POWERS AS TRUSTEE.—The Secretary, upon
4 appointment as trustee under subsection (a), shall have
5 the power—

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

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

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

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

22 "(5) to collect for the plan any amounts due the
23 plan and to recover reasonable expenses of the trust-
24 eeship;

"(6) to commence, prosecute, or defend on behalf of the plan any suit or proceeding involving the plan;

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

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

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

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

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

"(1) the sponsor and plan administrator;

"(2) each participant;

1 "(3) each participating employer; and

2 "(4) if applicable, each employee organization
3 which, for purposes of collective bargaining, rep-
4 resents plan participants.

5 "(d) ADDITIONAL DUTIES.—Except to the extent in-
6 consistent with the provisions of this title, or as may be
7 otherwise ordered by the court, the Secretary, upon ap-
8 pointment as trustee under this section, shall be subject
9 to the same duties as those of a trustee under section 704
10 of title 11, United States Code, and shall have the duties
11 of a fiduciary for purposes of this title.

12 "(e) OTHER PROCEEDINGS.—An application by the
13 Secretary under this subsection may be filed notwith-
14 standing the pendency in the same or any other court of
15 any bankruptcy, mortgage foreclosure, or equity receiver-
16 ship proceeding, or any proceeding to reorganize, conserve,
17 or liquidate such plan or its property, or any proceeding
18 to enforce a lien against property of the plan.

19 "(f) JURISDICTION OF COURT.—

20 "(1) IN GENERAL.—Upon the filing of an appli-
21 cation for the appointment as trustee or the issuance
22 of a decree under this section, the court to which the
23 application is made shall have exclusive jurisdiction
24 of the plan involved and its property wherever lo-
25 cated with the powers, to the extent consistent with

the purposes of this section, of a court of the United States having jurisdiction over cases under chapter 11 of title 11, United States Code. Pending an adjudication under this section such court shall stay, and upon appointment by it of the Secretary as trustee, such court shall continue the stay of, any pending mortgage foreclosure, equity receivership, or other proceeding to reorganize, conserve, or liquidate the plan, the sponsor, or property of such plan or sponsor, and any other suit against any receiver, conservator, or trustee of the plan, the sponsor, or property of the plan or sponsor. Pending such adjudication and upon the appointment by it of the Secretary as trustee, the court may stay any proceeding to enforce a lien against property of the plan or the sponsor or any other suit against the plan or the sponsor.

"(2) VENUE.—An action under this section may be brought in the judicial district where the sponsor or the plan administrator resides or does business or where any asset of the plan is situated. A district court in which such action is brought may issue process with respect to such action in any other judicial district.

1 "(g) PERSONNEL.—In accordance with regulations
2 which shall be prescribed by the Secretary, the Secretary
3 shall appoint, retain, and compensate accountants, actu-
4 aries, and other professional service personnel as may be
5 necessary in connection with the Secretary's service as
6 trustee under this section.

7 **"SEC. 811. STATE ASSESSMENT AUTHORITY.**

8 "(a) IN GENERAL.—Notwithstanding section 514, a
9 State may impose by law a contribution tax on an associa-
10 tion health plan described in section 806(a)(2), if the plan
11 commenced operations in such State after the date of the
12 enactment of this part.

13 "(b) CONTRIBUTION TAX.—For purposes of this sec-
14 tion, the term 'contribution tax' imposed by a State on
15 an association health plan means any tax imposed by such
16 State if—

17 "(1) such tax is computed by applying a rate to
18 the amount of premiums or contributions, with re-
19 spect to individuals covered under the plan who are
20 residents of such State, which are received by the
21 plan from participating employers located in such
22 State or from such individuals;

23 "(2) the rate of such tax does not exceed the
24 rate of any tax imposed by such State on premiums
25 or contributions received by insurers or health main-

1 tenance organizations for health insurance coverage
2 offered in such State in connection with a group
3 health plan;
4 ''(3) such tax is otherwise nondiscriminatory;
5 and
6 ''(4) the amount of any such tax assessed on
7 the plan is reduced by the amount of any tax or as-
8 sessment otherwise imposed by the State on pre-
9 miums, contributions, or both received by insurers or
10 health maintenance organizations for health insur-
11 ance coverage, aggregate excess/stop loss insurance
12 (as defined in section 806(g)(1)), specific excess/stop
13 loss insurance (as defined in section 806(g)(2)),
14 other insurance related to the provision of medical
15 care under the plan, or any combination thereof pro-
16 vided by such insurers or health maintenance organi-
17 zations in such State in connection with such plan.
18 **''SEC. 812. DEFINITIONS AND RULES OF CONSTRUCTION.**
19 ''(a) DEFINITIONS.—For purposes of this part—
20 ''(1) GROUP HEALTH PLAN.—The term 'group
21 health plan' has the meaning provided in section
22 733(a)(1) (after applying subsection (b) of this sec-
23 tion).
24 ''(2) MEDICAL CARE.—The term 'medical care'
25 has the meaning provided in section 733(a)(2).

"(3) HEALTH INSURANCE COVERAGE.—The term 'health insurance coverage' has the meaning provided in section 733(b)(1).

"(4) HEALTH INSURANCE ISSUER.—The term 'health insurance issuer' has the meaning provided in section 733(b)(2).

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

"(6) HEALTH STATUS-RELATED FACTOR.—The term 'health status-related factor' has the meaning provided in section 733(d)(2).

"(7) INDIVIDUAL MARKET.—

"(A) IN GENERAL.—The term 'individual market' means the market for health insurance coverage offered to individuals other than in connection with a group health plan.

"(B) TREATMENT OF VERY SMALL GROUPS.—

"(i) IN GENERAL.—Subject to clause (ii), such term includes coverage offered in

connection with a group health plan that has fewer than 2 participants as current employees or participants described in section 732(d)(3) on the first day of the plan year.

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

"(8) PARTICIPATING EMPLOYER.—The term 'participating employer' means, in connection with an association health plan, any employer, if any individual who is an employee of such employer, a partner in such employer, or a self-employed individual who is such employer (or any dependent, as defined under the terms of the plan, of such individual) is or was covered under such plan in connection with the status of such individual as such an employee, partner, or self-employed individual in relation to the plan.

1 "(9) APPLICABLE STATE AUTHORITY.—The
2 term 'applicable State authority' means, with respect
3 to a health insurance issuer in a State, the State in-
4 surance commissioner or official or officials des-
5 ignated by the State to enforce the requirements of
6 title XXVII of the Public Health Service Act for the
7 State involved with respect to such issuer.
8 "(10) QUALIFIED ACTUARY.—The term 'quali-
9 fied actuary' means an individual who is a member
10 of the American Academy of Actuaries.
11 "(11) AFFILIATED MEMBER.—The term 'affili-
12 ated member' means, in connection with a sponsor—
13 "(A) a person who is otherwise eligible to
14 be a member of the sponsor but who elects an
15 affiliated status with the sponsor,
16 "(B) in the case of a sponsor with mem-
17 bers which consist of associations, a person who
18 is a member of any such association and elects
19 an affiliated status with the sponsor, or
20 "(C) in the case of an association health
21 plan in existence on the date of the enactment
22 of this part, a person eligible to be a member
23 of the sponsor or one of its member associa-
24 tions.

1 "(12) LARGE EMPLOYER.—The term 'large em-
2 ployer' means, in connection with a group health
3 plan with respect to a plan year, an employer who
4 employed an average of at least 51 employees on
5 business days during the preceding calendar year
6 and who employs at least 2 employees on the first
7 day of the plan year.
8 "(13) SMALL EMPLOYER.—The term 'small em-
9 ployer' means, in connection with a group health
10 plan with respect to a plan year, an employer who
11 is not a large employer.
12 "(b) RULES OF CONSTRUCTION.—
13 "(1) EMPLOYERS AND EMPLOYEES.—For pur-
14 poses of determining whether a plan, fund, or pro-
15 gram is an employee welfare benefit plan which is an
16 association health plan, and for purposes of applying
17 this title in connection with such plan, fund, or pro-
18 gram so determined to be such an employee welfare
19 benefit plan—
20 "(A) in the case of a partnership, the term
21 'employer' (as defined in section 3(5)) includes
22 the partnership in relation to the partners, and
23 the term 'employee' (as defined in section 3(6))
24 includes any partner in relation to the partner-
25 ship; and

"(B) in the case of a self-employed individual, the term 'employer' (as defined in section 3(5)) and the term 'employee' (as defined in section 3(6)) shall include such individual.

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

(2) CONFORMING AMENDMENTS TO PREEMPTION RULES.—

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

"(E) The preceding subparagraphs of this paragraph do not apply with respect to any State law in the case

of an association health plan which is certified under part 8.''.

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

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

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

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

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

''(d)(1) Except as provided in subsection (b)(4), the provisions of this title shall supersede any and all State laws insofar as they may now or hereafter preclude, or have the effect of precluding, a health insurance issuer from offering health insurance coverage in connection with

1 an association health plan which is certified under part
2 8.

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

5 "(A) In any case in which health insurance cov-
6 erage of any policy type is offered under an associa-
7 tion health plan certified under part 8 to a partici-
8 pating employer operating in such State, the provi-
9 sions of this title shall supersede any and all laws
10 of such State insofar as they may preclude a health
11 insurance issuer from offering health insurance cov-
12 erage of the same policy type to other employers op-
13 erating in the State which are eligible for coverage
14 under such association health plan, whether or not
15 such other employers are participating employers in
16 such plan.

17 "(B) In any case in which health insurance cov-
18 erage of any policy type is offered in a State under
19 an association health plan certified under part 8 and
20 the filing, with the applicable State authority (as de-
21 fined in section 812(a)(9)), of the policy form in
22 connection with such policy type is approved by such
23 State authority, the provisions of this title shall su-
24 persede any and all laws of any other State in which
25 health insurance coverage of such type is offered, in-

1 sofar as they may preclude, upon the filing in the
2 same form and manner of such policy form with the
3 applicable State authority in such other State, the
4 approval of the filing in such other State.

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

9 ''(A) providing solvency standards or similar
10 standards regarding the adequacy of insurer capital,
11 surplus, reserves, or contributions, or

12 ''(B) relating to prompt payment of claims.

13 ''(4) For additional provisions relating to association
14 health plans, see subsections (a)(2)(B) and (b) of section
15 805.

16 ''(5) For purposes of this subsection, the term 'asso-
17 ciation health plan' has the meaning provided in section
18 801(a), and the terms 'health insurance coverage', 'par-
19 ticipating employer', and 'health insurance issuer' have
20 the meanings provided such terms in section 812, respec-
21 tively.''.

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

24 (i) in clause (i)(II), by striking ''and''
25 at the end;

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

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

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

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

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

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

''(2) Nothing in any other provision of law enacted on or after the date of the enactment of part 8 shall be construed to alter, amend, modify, invalidate, impair, or supersede any provision of this title, except by specific cross-reference to the affected section.''.

(3) PLAN SPONSOR.—Section 3(16)(B) of such Act (29 U.S.C. 102(16)(B)) is amended by adding at the end the following new sentence: ''Such term also includes a person serving as the sponsor of an association health plan under part 8.''.

(4) DISCLOSURE OF SOLVENCY PROTECTIONS RELATED TO SELF-INSURED AND FULLY INSURED OPTIONS UNDER ASSOCIATION HEALTH PLANS.—Section 102(b) of such Act (29 U.S.C. 102(b)) is amended by adding at the end the following: ''An association health plan shall include in its summary plan description, in connection with each benefit option, a description of the form of solvency or guarantee fund protection secured pursuant to this Act or applicable State law, if any.''.

(5) SAVINGS CLAUSE.—Section 731(c) of such Act is amended by inserting ''or part 8'' after ''this part''.

(6) REPORT TO THE CONGRESS REGARDING CERTIFICATION OF SELF-INSURED ASSOCIATION HEALTH PLANS.—Not later than January 1, 2012, the Secretary of Labor shall report to the Committee on Education and the Workforce of the House of Representatives and the Committee on Health, Education, Labor, and Pensions of the Senate the effect

1 association health plans have had, if any, on reduc-
2 ing the number of uninsured individuals.
3 (7) CLERICAL AMENDMENT.—The table of con-
4 tents in section 1 of the Employee Retirement In-
5 come Security Act of 1974 is amended by inserting
6 after the item relating to section 734 the following
7 new items:

"PART 8—RULES GOVERNING ASSOCIATION HEALTH PLANS

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

8 (b) CLARIFICATION OF TREATMENT OF SINGLE EM-
9 PLOYER ARRANGEMENTS.—Section 3(40)(B) of the Em-
10 ployee Retirement Income Security Act of 1974 (29
11 U.S.C. 1002(40)(B)) is amended—
12 (1) in clause (i), by inserting after "control
13 group," the following: "except that, in any case in
14 which the benefit referred to in subparagraph (A)
15 consists of medical care (as defined in section
16 812(a)(2)), two or more trades or businesses, wheth-
17 er or not incorporated, shall be deemed a single em-

ployer for any plan year of such plan, or any fiscal year of such other arrangement, if such trades or businesses are within the same control group during such year or at any time during the preceding 1-year period,'';

(2) in clause (iii), by striking ''(iii) the determination'' and inserting the following:

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

''(II) in any other case, the determination'';

(3) by redesignating clauses (iv) and (v) as clauses (v) and (vi), respectively; and

(4) by inserting after clause (iii) the following new clause:

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

(c) ENFORCEMENT PROVISIONS RELATING TO ASSOCIATION HEALTH PLANS.—

(1) CRIMINAL PENALTIES FOR CERTAIN WILLFUL MISREPRESENTATIONS.—Section 501 of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1131) is amended—

(A) by inserting ''(a)'' after ''Sec. 501.''; and

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

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

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

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

"(3) being a plan or arrangement described in section 3(40)(A)(i),

shall, upon conviction, be imprisoned not more than 5 years, be fined under title 18, United States Code, or both.".

1 (2) CEASE ACTIVITIES ORDERS.—Section 502
2 of such Act (29 U.S.C. 1132) is amended by adding
3 at the end the following new subsection:
4 "(n) ASSOCIATION HEALTH PLAN CEASE AND DE-
5 SIST ORDERS.—
6 "(1) IN GENERAL.—Subject to paragraph (2),
7 upon application by the Secretary showing the oper-
8 ation, promotion, or marketing of an association
9 health plan (or similar arrangement providing bene-
10 fits consisting of medical care (as defined in section
11 733(a)(2))) that—
12 "(A) is not certified under part 8, is sub-
13 ject under section 514(b)(6) to the insurance
14 laws of any State in which the plan or arrange-
15 ment offers or provides benefits, and is not li-
16 censed, registered, or otherwise approved under
17 the insurance laws of such State; or
18 "(B) is an association health plan certified
19 under part 8 and is not operating in accordance
20 with the requirements under part 8 for such
21 certification,
22 a district court of the United States shall enter an
23 order requiring that the plan or arrangement cease
24 activities.

1 "(2) EXCEPTION.—Paragraph (1) shall not
2 apply in the case of an association health plan or
3 other arrangement if the plan or arrangement shows
4 that—
5 "(A) all benefits under it referred to in
6 paragraph (1) consist of health insurance cov-
7 erage; and
8 "(B) with respect to each State in which
9 the plan or arrangement offers or provides ben-
10 efits, the plan or arrangement is operating in
11 accordance with applicable State laws that are
12 not superseded under section 514.
13 "(3) ADDITIONAL EQUITABLE RELIEF.—The
14 court may grant such additional equitable relief, in-
15 cluding any relief available under this title, as it
16 deems necessary to protect the interests of the pub-
17 lic and of persons having claims for benefits against
18 the plan.".
19 (3) RESPONSIBILITY FOR CLAIMS PROCE-
20 DURE.—Section 503 of such Act (29 U.S.C. 1133)
21 is amended by inserting "(a) IN GENERAL.—" be-
22 fore "In accordance", and by adding at the end the
23 following new subsection:
24 "(b) ASSOCIATION HEALTH PLANS.—The terms of
25 each association health plan which is or has been certified

1 under part 8 shall require the board of trustees or the
2 named fiduciary (as applicable) to ensure that the require-
3 ments of this section are met in connection with claims
4 filed under the plan.''.

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

9 ''(d) CONSULTATION WITH STATES WITH RESPECT
10 TO ASSOCIATION HEALTH PLANS.—

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

15 ''(A) the Secretary's authority under sec-
16 tions 502 and 504 to enforce the requirements
17 for certification under part 8; and

18 ''(B) the Secretary's authority to certify
19 association health plans under part 8 in accord-
20 ance with regulations of the Secretary applica-
21 ble to certification under part 8.

22 ''(2) RECOGNITION OF PRIMARY DOMICILE
23 STATE.—In carrying out paragraph (1), the Sec-
24 retary shall ensure that only one State will be recog-
25 nized, with respect to any particular association

health plan, as the State with which consultation is required. In carrying out this paragraph—

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

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

(e) EFFECTIVE DATE AND TRANSITIONAL AND OTHER RULES.—

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

(2) TREATMENT OF CERTAIN EXISTING HEALTH BENEFITS PROGRAMS.—

(A) IN GENERAL.—In any case in which, as of the date of the enactment of this Act, an arrangement is maintained in a State for the

purpose of providing benefits consisting of medical care for the employees and beneficiaries of its participating employers, at least 200 participating employers make contributions to such arrangement, such arrangement has been in existence for at least 10 years, and such arrangement is licensed under the laws of one or more States to provide such benefits to its participating employers, upon the filing with the applicable authority (as defined in section 812(a)(5) of the Employee Retirement Income Security Act of 1974 (as amended by this subtitle)) by the arrangement of an application for certification of the arrangement under part 8 of subtitle B of title I of such Act—

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

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

(iii) the requirements of section 803(b) of such Act shall be deemed met, if

the arrangement is operated by a board of directors which—

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

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

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

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

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

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

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

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

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

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

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

Subtitle C—Health Care Services Commission

PART I—ESTABLISHMENT AND GENERAL DUTIES

SEC. 141. ESTABLISHMENT.

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

enactment of this subtitle shall expire as designated by the President at the time of nomination, one at the end of one year, one at the end of two years, one at the end of three years, one at the end of four years, and one at the end of five years, after the date of the enactment of this Act.

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

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

SEC. 142. GENERAL AUTHORITIES AND DUTIES.

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

(1) the effectiveness, efficiency, and quality of health care services;

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

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

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

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

(6) health promotion and disease prevention;

(7) health statistics and epidemiology; and

(8) medical liability.

(b) REQUIREMENTS WITH RESPECT TO RURAL AREAS AND UNDERSERVED POPULATIONS.—In carrying out subsection (a), the Commissioners shall undertake and support research, demonstration projects, and evaluations with respect to—

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

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

SEC. 143. DISSEMINATION.

(a) IN GENERAL.—The Commissioners shall—

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

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

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

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

(c) LIMITATION ON USE OF CERTAIN INFORMATION.—No information, if an establishment or person supplying the information or described in it is identifiable, obtained in the course of activities undertaken or supported under this subtitle may be used for any purpose other than the purpose for which it was supplied unless

such establishment or person has consented (as determined under regulations of the Secretary) to its use for such other purpose. Such information may not be published or released in other form if the person who supplied the information or who is described in it is identifiable unless such person has consented (as determined under regulations of the Secretary) to its publication or release in other form.

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

PART II—FORUM FOR QUALITY AND EFFECTIVENESS IN HEALTH CARE

SEC. 151. ESTABLISHMENT OF OFFICE.

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

SEC. 152. MEMBERSHIP.

(a) IN GENERAL.—The Office of the Forum for Quality and Effectiveness in Health Care shall be composed of 15 individuals nominated by private sector health care

1 organizations and appointed by the Commission and shall
2 include representation from at least the following:
3 (1) Health insurance industry.
4 (2) Health care provider groups.
5 (3) Non-profit organizations.
6 (4) Rural health organizations.
7 (b) TERMS.—
8 (1) IN GENERAL.—Except as provided in sub-
9 paragraph (B), members of the Office of the Forum
10 for Quality and Effectiveness in Health Care shall
11 serve for a term of 5 years.
12 (2) STAGGERED ROTATION.—Of the members
13 first appointed to the Office of the Forum for Qual-
14 ity and Effectiveness in Health Care, the Commis-
15 sion shall appoint 5 members to serve for a term of
16 2 years, 5 members to serve for a term of 3 years,
17 and 5 members to serve for a term of 4 years.
18 (c) TREATMENT OF OTHER EMPLOYMENT.—Each
19 member of the Office of the Forum for Quality and Effec-
20 tiveness in Health Care shall serve the Office independ-
21 ently from any other position of employment.
22 **SEC. 153. DUTIES.**
23 (a) ESTABLISHMENT OF FORUM PROGRAM.—The
24 Commissioners, acting through the Director, shall estab-
25 lish a program to be known as the Forum for Quality and

1 Effectiveness in Health Care. For the purpose of pro-
2 moting transparency in price, quality, appropriateness,
3 and effectiveness of health care, the Director, using the
4 process set forth in section 154, shall arrange for the de-
5 velopment and periodic review and updating of standards
6 of quality, performance measures, and medical review cri-
7 teria through which health care providers and other appro-
8 priate entities may assess or review the provision of health
9 care and assure the quality of such care.

10 (b) CERTAIN REQUIREMENTS.—Guidelines, stand-
11 ards, performance measures, and review criteria under
12 subsection (a) shall—

13 (1) be based on the best available research and
14 professional judgment regarding the effectiveness
15 and appropriateness of health care services and pro-
16 cedures; and

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

22 (c) AUTHORITY FOR CONTRACTS.—In carrying out
23 this part, the Director may enter into contracts with pub-
24 lic or nonprofit private entities.

(d) PUBLIC DISCLOSURE OF RECOMMENDATIONS.—For each fiscal year beginning with 2010, the Director shall make publicly available the following:

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

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

(e) DATE CERTAIN FOR INITIAL GUIDELINES AND STANDARDS.—The Commissioners, by not later than January 1, 2012, shall assure the development of an initial set of guidelines, standards, performance measures, and review criteria under subsection (a).

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

(a) ADOPTION OF RECOMMENDATIONS OF FORUM FOR QUALITY AND EFFECTIVENESS IN HEALTH CARE.—For each fiscal year, the Commissioners shall adopt the recommendations made for such year in the final report under subsection (d)(2) of section 153 for guidelines,

1 standards, performance measures, and review criteria de-
2 scribed in subsection (a) of such section.

3 (b) ENFORCEMENT AUTHORITY.—The Commis-
4 sioners , in consultation with the Secretary of Health and
5 Human Services, have the authority to make recommenda-
6 tions to the Secretary to enforce compliance of health care
7 providers with the guidelines, standards, performance
8 measures, and review criteria adopted under subsection
9 (a). Such recommendations may include the following,
10 with respect to a health care provider who is not in compli-
11 ance with such guidelines, standards, measures, and cri-
12 teria:

13 (1) Exclusion from participation in Federal
14 health care programs (as defined in section
15 1128B(f) of the Social Security Act).

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

18 **SEC. 155. ADDITIONAL REQUIREMENTS.**

19 (a) PROGRAM AGENDA.—The Commissioners shall
20 provide for an agenda for the development of the guide-
21 lines, standards, performance measures, and review cri-
22 teria described in section 153(a), including with respect
23 to the standards, performance measures, and review cri-
24 teria, identifying specific aspects of health care for which
25 the standards, performance measures, and review criteria

are to be developed and those that are to be given priority in the development of the standards, performance measures, and review criteria.

PART III—GENERAL PROVISIONS

SEC. 161. CERTAIN ADMINISTRATIVE AUTHORITIES.

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

SEC. 162. FUNDING.

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

SEC. 163. DEFINITIONS.

For purposes of this subtitle:

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

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

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

(4) The term ''Secretary'' means the Secretary of Health and Human Services.

PART IV—TERMINATIONS AND TRANSITION

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

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

SEC. 172. TRANSITION.

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

PART V—INDEPENDENT HEALTH RECORD TRUST

SEC. 181. SHORT TITLE OF PART.

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

SEC. 182. PURPOSE.

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

(1) improves health care quality, reduces medical errors, increases the efficiency of care, and advances the delivery of appropriate, evidence-based health care services;

(2) promotes wellness, disease prevention, and the management of chronic illnesses by increasing the availability and transparency of information related to the health care needs of an individual;

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

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

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

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

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

SEC. 183. DEFINITIONS.

In this part:

1 (1) ACCESS.—The term ''access'' means, with
2 respect to an electronic health record, entering infor-
3 mation into such account as well as retrieving infor-
4 mation from such account.
5 (2) ACCOUNT.—The term ''account'' means an
6 electronic health record of an individual contained in
7 an independent health record trust.
8 (3) AFFIRMATIVE CONSENT.—The term ''af-
9 firmative consent'' means, with respect to an elec-
10 tronic health record of an individual contained in an
11 IHRT, express consent given by the individual for
12 the use of such record in response to a clear and
13 conspicuous request for such consent or at the indi-
14 vidual's own initiative.
15 (4) AUTHORIZED EHR DATA USER.—The term
16 ''authorized EHR data user'' means, with respect to
17 an electronic health record of an IHRT participant
18 contained as part of an IHRT, any entity (other
19 than the participant) authorized (in the form of af-
20 firmative consent) by the participant to access the
21 electronic health record.
22 (5) CONFIDENTIALITY.—The term ''confiden-
23 tiality'' means, with respect to individually identifi-
24 able health information of an individual, the obliga-

1 tion of those who receive such information to respect
2 the health information privacy of the individual.
3 (6) ELECTRONIC HEALTH RECORD.—The term
4 ''electronic health record'' means a longitudinal col-
5 lection of information concerning a single individual,
6 including medical records and personal health infor-
7 mation, that is stored electronically.
8 (7) HEALTH INFORMATION PRIVACY.—The
9 term ''health information privacy'' means, with re-
10 spect to individually identifiable health information
11 of an individual, the right of such individual to con-
12 trol the acquisition, uses, or disclosures of such in-
13 formation.
14 (8) HEALTH PLAN.—The term ''health plan''
15 means a group health plan (as defined in section
16 2208(1) of the Public Health Service Act (42 U.S.C.
17 300bb–8(1))) as well as a plan that offers health in-
18 surance coverage in the individual market.
19 (9) HIPAA PRIVACY REGULATIONS.—The term
20 ''HIPAA privacy regulations'' means the regulations
21 promulgated under section 264(c) of the Health In-
22 surance Portability and Accountability Act of 1996
23 (42 U.S.C. 1320d–2 note).
24 (10) INDEPENDENT HEALTH RECORD TRUST;
25 IHRT.—The terms ''independent health record trust''

and ''IHRT'' mean a legal arrangement under the administration of an IHRT operator that meets the requirements of this part with respect to electronic health records of individuals participating in the trust or IHRT.

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

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

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

(14) SECURITY.—The term ''security'' means, with respect to individually identifiable health information of an individual, the physical, technological, or administrative safeguards or tools used to protect such information from unwarranted access or disclosure.

SEC. 184. ESTABLISHMENT, CERTIFICATION, AND MEMBERSHIP OF INDEPENDENT HEALTH RECORD TRUSTS.

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

(b) CERTIFICATION.—

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

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

(c) MEMBERSHIP.—

(1) IN GENERAL.—To be eligible to be a participant in an IHRT, an individual shall—

(A) submit to the IHRT information as required by the IHRT to establish an electronic health record with the IHRT; and

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

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

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

SEC. 185. DUTIES OF IHRT TO IHRT PARTICIPANTS.

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

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

formation in such participant's electronic health record in accordance with the requirements of this part.

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

(A) Loss of certification of the IHRT.

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

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

(b) ELECTRONIC HEALTH RECORD DEEMED TO BE HELD IN TRUST BY IHRT.—With respect to an individual, an electronic health record maintained by an IHRT shall be deemed to be held in trust by the IHRT for the benefit of the individual and the IHRT shall have no legal or equitable interest in such electronic health record.

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

(a) PROTECTED ELECTRONIC HEALTH RECORDS USE AND ACCESS.—

(1) GENERAL RIGHTS REGARDING USES OF INFORMATION.—

1 (A) IN GENERAL.—With respect to the
2 electronic health record of an IHRT participant
3 maintained by an IHRT, subject to paragraph
4 (2)(C), primary uses and secondary uses (de-
5 scribed in subparagraphs (B) and (C), respec-
6 tively) of information within such record (other
7 than by such participant) shall be permitted
8 only upon the authorization of such use, prior
9 to such use, by such participant.
10 (B) PRIMARY USES.—For purposes of sub-
11 paragraph (A) and with respect to an electronic
12 health record of an individual, a primary use is
13 a use for purposes of the individual's self-care
14 or care by health care professionals.
15 (C) SECONDARY USES.—For purposes of
16 subparagraph (B) and with respect to an elec-
17 tronic health record of an individual, a sec-
18 ondary use is any use not described in subpara-
19 graph (B) and includes a use for purposes of
20 public health research or other related activi-
21 ties. Additional authorization is required for a
22 secondary use extending beyond the original
23 purpose of the secondary use authorized by the
24 IHRT participant involved. Nothing in this
25 paragraph shall be construed as requiring au-

1 thorization for every secondary use that is with-
2 in the authorized original purpose.
3 (2) RULES FOR PRIMARY USE OF RECORDS FOR
4 HEALTH CARE PURPOSES.—With respect to the elec-
5 tronic health record of an IHRT participant (or
6 specified parts of such electronic health record)
7 maintained by an IHRT standards for access to
8 such record shall provide for the following:
9 (A) ACCESS BY IHRT PARTICIPANTS TO
10 THEIR ELECTRONIC HEALTH RECORDS.—
11 (i) OWNERSHIP.—The participant
12 maintains ownership over the entire elec-
13 tronic health record (and all portions of
14 such record) and shall have the right to
15 electronically access and review the con-
16 tents of the entire record (and any portion
17 of such record) at any time, in accordance
18 with this subparagraph.
19 (ii) ADDITION OF PERSONAL INFOR-
20 MATION.—The participant may add per-
21 sonal health information to the health
22 record of that participant, except that such
23 participant shall not alter information that
24 is entered into the electronic health record
25 by any authorized EHR data user. Such

1 participant shall have the right to propose
2 an amendment to information that is en-
3 tered by an authorized EHR data user
4 pursuant to standards prescribed by the
5 Federal Trade Commission for purposes of
6 amending such information.
7 (iii) IDENTIFICATION OF INFORMA-
8 TION ENTERED BY PARTICIPANT.—Any ad-
9 ditions or amendments made by the partic-
10 ipant to the health record shall be identi-
11 fied and disclosed within such record as
12 being made by such participant.
13 (B) ACCESS BY ENTITIES OTHER THAN
14 IHRT PARTICIPANT.—
15 (i) AUTHORIZED ACCESS ONLY.—Ex-
16 cept as provided under subparagraph (C)
17 and paragraph (4), access to the electronic
18 health record (or any portion of the
19 record)—
20 (I) may be made only by author-
21 ized EHR data users and only to such
22 portions of the record as specified by
23 the participant; and
24 (II) may be limited by the partic-
25 ipant for purposes of entering infor-

1 mation into such record, retrieving in-
2 formation from such record, or both.
3 (ii) IDENTIFICATION OF ENTITY THAT
4 ENTERS INFORMATION.—Any information
5 that is added by an authorized EHR data
6 user to the health record shall be identified
7 and disclosed within such record as being
8 made by such user.
9 (iii) SATISFACTION OF HIPAA PRIVACY
10 REGULATIONS.—In the case of a record of
11 a covered entity (as defined for purposes of
12 HIPAA privacy regulations), with respect
13 to an individual, if such individual is an
14 IHRT participant with an independent
15 health record trust and such covered entity
16 is an authorized EHR data user, the re-
17 quirement under the HIPAA privacy regu-
18 lations for such entity to provide the
19 record to the participant shall be deemed
20 met if such entity, without charge to the
21 IHRT or the participant—
22 (I) forwards to the trust an ap-
23 propriately formatted electronic copy
24 of the record (and updates to such
25 records) for inclusion in the electronic

1 health record of the participant main-
2 tained by the trust;
3 (II) enters such record into the
4 electronic health record of the partici-
5 pant so maintained; or
6 (III) otherwise makes such
7 record available for electronic access
8 by the IHRT or the individual in a
9 manner that permits such record to
10 be included in the account of the indi-
11 vidual contained in the IHRT.
12 (iv) NOTIFICATION OF SENSITIVE IN-
13 FORMATION.—Any information, with re-
14 spect to the participant, that is sensitive
15 information, as specified by the Federal
16 Trade Commission, shall not be forwarded
17 or entered by an authorized EHR data
18 user into the electronic health record of the
19 participant maintained by the trust unless
20 the user certifies that the participant has
21 been notified of such information.
22 (C) DEEMED AUTHORIZATION FOR ACCESS
23 FOR EMERGENCY HEALTH CARE.—
24 (i) FINDINGS.—Congress finds that—

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

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

(ii) USE OF INFORMATION.—With respect to the electronic health record of an IHRT participant (or specified parts of such electronic health record) maintained by an IHRT, the participant shall be deemed as providing authorization (in the form of affirmative consent) for health care providers to access, in connection with providing emergency care services to the participant, a limited, authenticated information set concerning the participant for emergency response purposes, unless the participant specifies that such information

1 set (or any portion of such information
2 set) may not be so accessed. Such limited
3 information set may include information—
4 (I) patient identification data, as
5 determined appropriate by the partici-
6 pant;
7 (II) provider identification that
8 includes the use of unique provider
9 identifiers;
10 (III) payment information;
11 (IV) information related to the
12 individual's vitals, allergies, and medi-
13 cation history;
14 (V) information related to exist-
15 ing chronic problems and active clin-
16 ical conditions of the participant; and
17 (VI) information concerning
18 physical examinations, procedures, re-
19 sults, and diagnosis data.
20 (3) RULES FOR SECONDARY USES OF RECORDS
21 FOR RESEARCH AND OTHER PURPOSES.—
22 (A) IN GENERAL.—With respect to the
23 electronic health record of an IHRT participant
24 (or specified parts of such electronic health
25 record) maintained by an IHRT, the IHRT

may sell such record (or specified parts of such record) only if—

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

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

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

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

(v) the transfer otherwise meets the requirements and standards prescribed by the Federal Trade Commission.

(B) TREATMENT OF PUBLIC HEALTH REPORTING.—Nothing in this paragraph shall be construed as prohibiting or limiting the use of health care information of an individual, including an individual who is an IHRT participant, for public health reporting (or other research) purposes prior to the inclusion of such information in an electronic health record maintained by an IHRT.

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

(5) RULE OF CONSTRUCTION.—Nothing in this section shall be construed to require a health care provider that does not utilize electronic methods or appropriate levels of health information technology on the date of the enactment of this Act to adopt such electronic methods or technology as a requirement for participation or compliance under this part.

1 (b) PRIVACY PROTECTION AGREEMENT; TREATMENT
2 OF STATE PRIVACY AND SECURITY LAWS.—
3 (1) PRIVACY PROTECTION AGREEMENT.—A pri-
4 vacy protection agreement described in this sub-
5 section is an agreement, with respect to an electronic
6 health record of an IHRT participant to be main-
7 tained by an independent health record trust, be-
8 tween the participant and the trust—
9 (A) that is consistent with the standards
10 described in subsection (a)(2);
11 (B) under which the participant specifies
12 the portions of the record that may be accessed,
13 under what circumstances such portions may be
14 accessed, any authorizations for indicated au-
15 thorized EHR data users to access information
16 contained in the record, and the purposes for
17 which the information (or portions of the infor-
18 mation) in the record may be used;
19 (C) which provides a process for the au-
20 thorization of the transfer of information con-
21 tained in the record to a third party, including
22 for the sale of such information for purposes of
23 research, by an authorized EHR data user and
24 reuse of such information by such third party,
25 including a provision requiring that such trans-

fer and reuse is not in violation of any privacy or transfer restrictions placed by the participant on the independent health record of such participant; and

(D) under which the trust provides assurances that the trust will not transfer, disclose, or provide access to the record (or any portion of the record) in violation of the parameters established in the agreement or to any person or entity who has not agreed to use and transfer such record (or portion of such record) in accordance with such agreement.

(2) TREATMENT OF STATE LAWS.—

(A) IN GENERAL.—Except as provided under subparagraph (B), the provisions of a privacy protection agreement entered into between an IHRT and an IHRT participant shall preempt any provision of State law (or any State regulation) relating to the privacy and confidentiality of individually identifiable health information or to the security of such health information.

(B) EXCEPTION FOR PRIVILEGED INFORMATION.—The provisions of a privacy protection agreement shall not preempt any provision

of State law (or any State regulation) that recognizes privileged communications between physicians, health care practitioners, and patients of such physicians or health care practitioners, respectively.

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

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

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

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

1 section (a) in the same manner as such penalties apply
2 to a person in violation of subsection (a) of such section.

3 **SEC. 188. FINANCING OF ACTIVITIES.**

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

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

9 (2) charging authorized EHR data users for ac-
10 cessing electronic health records maintained in the
11 trust;

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

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

16 (b) PROHIBITION AGAINST ACCESS FEES FOR
17 HEALTH CARE PROVIDERS.—For purposes of providing
18 incentives to health care providers to access information
19 maintained in an IHRT, as authorized by the IHRT par-
20 ticipants involved, the IHRT may not charge a fee for
21 services specified by the IHRT. Such services shall include
22 the transmittal of information from a health care provider
23 to be included in an independent electronic health record
24 maintained by the IHRT (or permitting such provider to
25 input such information into the record), including the

1 transmission of or access to information described in sec-
2 tion 186(a)(2)(C)(ii) by appropriate emergency respond-
3 ers.

4 (c) REQUIRED DISCLOSURES.—The sources and
5 amounts of revenue derived under subsection (a) for the
6 operations of an IHRT shall be fully disclosed to each
7 IHRT participant of such IHRT and to the public.

8 (d) TREATMENT OF INCOME.—For purposes of the
9 Internal Revenue Code of 1986, any revenue described in
10 subsection (a) shall not be included in gross income of any
11 IHRT, IHRT participant, or authorized EHR data user.

12 **SEC. 189. REGULATORY OVERSIGHT.**

13 (a) IN GENERAL.—In carrying out this part, the Fed-
14 eral Trade Commission shall promulgate regulations for
15 independent health record trusts.

16 (b) ESTABLISHMENT OF INTERAGENCY STEERING
17 COMMITTEE.—

18 (1) IN GENERAL.—The Secretary of Health and
19 Human Services shall establish an Interagency
20 Steering Committee in accordance with this sub-
21 section.

22 (2) CHAIRPERSON.—The Secretary of Health
23 and Human Services shall serve as the chairperson
24 of the Interagency Steering Committee.

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

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

(c) FEDERAL ADVISORY COMMITTEE.—

(1) IN GENERAL.—The National Committee for Vital and Health Statistics shall serve as an advisory committee for the IHRTs. The membership of such advisory committee shall include a representative from the Federal Trade Commission and the chairperson of the Interagency Steering Committee. Not less than 60 percent of such membership shall consist of representatives of nongovernment entities, at least one of whom shall be a representative from an organization representing health care consumers.

1 (2) DUTIES.—The National Committee for
2 Vital and Health Statistics shall issue periodic re-
3 ports and review policies concerning IHRTs based
4 on each of the following factors:
5 (A) Privacy and security policies.
6 (B) Economic progress.
7 (C) Interoperability standards.
8 (d) POLICIES RECOMMENDED BY FEDERAL TRADE
9 COMMISSION.—The Federal Trade Commission, in con-
10 sultation with the National Committee for Vital and
11 Health Statistics, shall recommend policies to—
12 (1) provide assistance to encourage the growth
13 of independent health record trusts;
14 (2) track economic progress as it pertains to
15 operators of independent health records trusts and
16 individuals receiving nontaxable income with respect
17 to accounts;
18 (3) conduct public education activities regarding
19 the creation and usage of the independent health
20 records trusts;
21 (4) establish standards for the interoperability
22 of health information technology to ensure that in-
23 formation contained in such record may be shared
24 between the trust involved, the participant, and au-
25 thorized EHR data users, including for the stand-

1 ardized collection and transmission of individual
2 health records (or portions of such records) to au-
3 thorized EHR data users through a common inter-
4 face and for the portability of such records among
5 independent health record trusts; and
6 (5) carry out any other activities determined
7 appropriate by the Federal Trade Commission.
8 (e) REGULATIONS PROMULGATED BY FEDERAL
9 TRADE COMMISSION.—The Federal Trade Commission
10 shall promulgate regulations based on, at a minimum, the
11 following factors:
12 (1) Requiring that an IHRT participant, who
13 has an electronic health record that is maintained by
14 an IHRT, be notified of a security breech with re-
15 spect to such record, and any corrective action taken
16 on behalf of the participant.
17 (2) Requiring that information sent to, or re-
18 ceived from, an IHRT that has been designated as
19 high-risk should be authenticated through the use of
20 methods such as the periodic changing of passwords,
21 the use of biometrics, the use of tokens or other
22 technology as determined appropriate by the council.
23 (3) Requiring a delay in releasing sensitive
24 health care test results and other similar informa-

1 tion to patients directly in order to give physicians
2 time to contact the patient.
3 (4) Recommendations for entities operating
4 IHRTs, including requiring analysis of the potential
5 risk of health transaction security breeches based on
6 set criteria.
7 (5) The conduct of audits of IHRTs to ensure
8 that they are in compliance with the requirements
9 and standards established under this part.
10 (6) Disclosure to IHRT participants of the
11 means by which such trusts are financed, including
12 revenue from the sale of patient data.
13 (7) Prevention of certification of an entity seek-
14 ing independent heath record trust certification
15 based on—
16 (A) the potential for conflicts between the
17 interests of such entity and the security of the
18 health information involved; and
19 (B) the involvement of the entity in any
20 activity that is contrary to the best interests of
21 a patient.
22 (8) Prevention of the use of revenue sources
23 that are contrary to a patient's interests.

(9) Public disclosure of audits in a manner similar to financial audits required for publicly traded stock companies.

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

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

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

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

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

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

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

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

(1) regulations, rulings, and interpretations issued by Federal officials relating to the same matter over which 2 or more such officials have respon-

sibility under this part are administered so as to have the same effect at all times; and

(2) the memorandum provides for the coordination of policies related to enforcing the same requirements through such officials in order to have coordinated enforcement strategy that avoids duplication of enforcement efforts and assigns priorities in enforcement.

TITLE II—FAIRNESS FOR EVERY AMERICAN PATIENT

Subtitle A—Medicaid Modernization

SEC. 201. MEDICAID MODERNIZATION.

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

"TITLE XIX—GRANTS TO STATES FOR MEDICAL ASSISTANCE PROGRAMS

"TABLE OF CONTENTS OF TITLE

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

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

"Sec. 1901. Purpose; appropriation.
"Sec. 1902. Payments to States for acute care medical assistance.
"Sec. 1903. Definitions of eligible individuals and acute care medical assistance.
"Sec. 1904. State plan requirements for acute care medical assistance.
"Sec. 1905. Definitions.

"Sec. 1906. Enrollment of individuals under group health plans and other arrangements.
"Sec. 1907. Drug rebates.
"Sec. 1908. Managed care.
"Sec. 1909. Annual reports.

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

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

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

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

"PART D—GRANTS TO STATES FOR PROGRAM INTEGRITY

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

"PART E—GRANTS TO STATES FOR ADMINISTRATION

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

"PART F—OTHER PROVISIONS

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

1 **"SEC. 1900. REFERENCES TO PRE-MODERNIZED MEDICAID**
2 **PROVISIONS; CONTINUITY FOR COMMON-**
3 **WEALTHS AND TERRITORIES.**

4 "(a) IN GENERAL.—In this title, if a reference to this
5 title or to a provision of this title is prefaced by the term

1 'old', such reference is to this title or a provision of this
2 title as in effect on December 31, 2010.

3 "(b) REGULATIONS.—The Secretary shall promul-
4 gate regulations to bring requirements imposed under an
5 old provision of this title that applies under this title after
6 December 31, 2010, into conformity with the policies em-
7 bodied in this title as in effect on and after January 1,
8 2011.

9 "(c) CONTINUITY FOR COMMONWEALTHS AND TER-
10 RITORIES.—In the case of Puerto Rico, the United States
11 Virgin Islands, Guam, the Northen Mariana Islands, and
12 American Samoa, this title as in effect on and after Janu-
13 ary 1, 2011, shall not apply to such commonwealths and
14 territories, and old title XIX shall apply to a Medicaid pro-
15 gram operated by such commonwealths or territories on
16 and after that date.

17 **"PART A—GRANTS TO STATES FOR ACUTE CARE**
18 **FOR INDIVIDUALS WITH DISABILITIES AND**
19 **CERTAIN LOW-INCOME INDIVIDUALS**

20 **"SEC. 1901. PURPOSE; APPROPRIATION.**

21 "(a) PURPOSE.—It is the purpose of this part to en-
22 able each State, as far as practicable under the conditions
23 in the State, to provide acute care medical assistance to
24 eligible individuals described in section 1903 whose income
25 and resources are insufficient to meet the costs of nec-

essary medical services, and (2) rehabilitation and other services to help such individuals attain or retain capability for independence or self-care.

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

"SEC. 1902. PAYMENTS TO STATES FOR ACUTE CARE MEDICAL ASSISTANCE.

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

"(b) ADMINISTRATIVE EXPENSES.—Each State with a plan approved under this part shall receive a payment determined in accordance with part E for administrative expenses incurred in carrying out the plan under this part and part B (if the State has a plan approved under that part).

1 **"SEC. 1903. DEFINITIONS OF ELIGIBLE INDIVIDUALS AND**
2 **ACUTE CARE MEDICAL ASSISTANCE.**

3 "(a) ELIGIBLE INDIVIDUALS.—

4 "(1) IN GENERAL.—In this part, the term 'eli-
5 gible individual' means an individual—

6 "(A) who is—

7 "(i) a blind or disabled individual; or

8 "(ii) an individual described in para-
9 graph (2); and

10 "(B) who the State determines satisfies—

11 "(i) the income and resources eligi-
12 bility requirements established by the State
13 under the State plan under this part; and

14 "(ii) such other requirements for as-
15 sistance as are imposed under this title, in-
16 cluding documentation of citizenship or
17 status as a qualified alien under title IV of
18 the Personal Responsibility and Work Op-
19 portunity Reconciliation Act of 1996.

20 "(2) INDIVIDUALS DESCRIBED.—For purposes
21 of paragraph (1)(A)(ii), the following individuals are
22 described in this paragraph:

23 "(A) A child in foster care under the re-
24 sponsibility of the State.

1 "(B) A low-income woman with breast or
2 cervical cancer described in old section
3 1902(aa).
4 "(C) Certain TB-infected individuals de-
5 scribed in old section 1902(z)(1).
6 "(3) GRANDFATHERED INDIVIDUALS.—An indi-
7 vidual shall be an eligible individual under the State
8 plan under this part if—
9 "(A) the individual is described in para-
10 graph (1)(A);
11 "(B) the individual satisfies the docu-
12 mentation requirements referred to in para-
13 graph (1)(B)(ii); and
14 "(C) the State would have provided med-
15 ical assistance under the State plan under old
16 title XIX to the individual, but only so long as
17 the individual continues to satisfy such old eligi-
18 bility requirements.
19 "(4) CONCURRENT ELIGIBILITY FOR PART B.—
20 An eligible individual under this part may be eligible
21 under part B, but only if the individual satisfies the
22 eligibility requirements of part B in addition to sat-
23 isfying the requirements for eligibility under this
24 part.

"(5) PRESUMPTIVE ELIGIBILITY FOR CERTAIN BREAST OR CERVICAL CANCER PATIENTS.—Old section 1920B (relating to presumptive eligibility for certain breast or cervical cancer patients) shall apply under this part.

"(b) BENEFITS.—Subject to paragraph (3), in this part, the term 'acute care medical assistance' means the following:

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

"(2) OPTIONAL BENEFITS.—Any care or services listed in a paragraph of old section 1905(a) (other than paragraph (16)).

"(3) EXCEPTIONS.—

"(A) CERTAIN SERVICES LIMITED TO PART B.—Services described in paragraphs (15), (22), (23), (24), and (26) of old section 1905(a) shall only be provided under the State plan under part B.

"(B) LIMIT ON PROVISION OF LONG-TERM CARE SERVICES AND SUPPORTS.—A care or

service that the Secretary determines is a long-term care service and support (including nursing facility services described in old section 1905(a)(4)(A)) shall not be provided to an individual under the State plan under this part for more than 30 days within any 12-month period.

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

"SEC. 1904. STATE PLAN REQUIREMENTS FOR ACUTE CARE MEDICAL ASSISTANCE.

"(a) IN GENERAL.—In order to receive payments under this part, a State shall have an approved State plan for acute care medical assistance. For purposes of this part, such assistance includes payments for preventive care, primary care, diagnosis and treatment of acute and chronic health conditions, emergency care, diagnosis and treatment of mental illnesses and related conditions, and rehabilitation and other services to help eligible individuals attain or retain capability for independence or self-care. A State medical assistance plan shall include a description, consistent with the requirements of this part of—

1 "(1) eligibility standards, including income and
2 asset standards;
3 "(2) benefits, including the amount, duration,
4 and scope of covered items and services;
5 "(3) strategies for improving access and quality
6 of care; and
7 "(4) methods of service delivery.
8 "(b) PUBLIC AVAILABILITY OF STATE PLAN.—The
9 State shall make available to the public the State plan
10 under this part and any amendments submitted by the
11 State to the plan.
12 "(c) AMOUNT, DURATION, AND SCOPE.—The State
13 plan shall provide that the acute care medical assistance
14 made available to any eligible individual shall not be less
15 in amount, duration, or scope than the acute care medical
16 assistance made available to any other eligible individual.
17 "(d) APPLICATION OF CERTAIN PRE-MODERNIZED
18 MEDICAID REQUIREMENTS.—
19 "(1) OLD STATE PLAN REQUIREMENTS.—The
20 following provisions of old section 1902 shall apply
21 to the State plans under this part:
22 "(A) Old section 1902(a)(10)(C) (relating
23 to certain eligibility and other requirements).
24 "(B) Old section 1902(a)(10)(D) (relating
25 to home health services).

"(C) Old section 1902(a)(10)(G) (relating to nonapplication of certain supplemental security income eligibility criteria).

"(D) The subclauses in the flush matter following old section 1902(a)(10)(G) (relating to the provision of certain services) other than subclauses (V), (VII), (VIII), and (IX).

"(E) Old section 1902(a)(17) (relating to reasonable standards for determining eligibility).

"(F) Old section 1902(a)(19) (relating to eligibility safeguards).

"(G) Old section 1902(a)(34) (relating to eligibility beginning with the third month prior to the month of application).

"(H) Subparagraphs (A), (B), and (C) of old section 1902(a)(43) (relating to early and periodic screening, diagnostic, and treatment services).

"(I) Old section 1902(a)(46)(A) (relating to compliance with section 1137 requirements).

"(J) The fourth and sixth sentences of old section 1902(a) (relating to eligibility for certain individuals).

"(2) OTHER OLD TITLE XIX REQUIREMENTS.—

"(A) Old section 1902(e)(3) (relating to optional eligibility for certain disabled individuals).

"(B) Old section 1902(e)(9) (relating to optional respiratory care services).

"(C) Old section 1902(f) (relating to eligibility of certain aged, blind, or disabled individuals).

"(D) Old section 1902(m) (relating to eligibility of certain aged or disabled individuals), other than paragraph (4).

"(E) Old section 1902(o) (relating to disregard of certain supplemental security income benefits).

"(F) Old section 1902(v) (relating to eligibility determinations of blind or disabled individuals).

"(e) OTHER REQUIREMENTS.—The State plan under this part shall—

"(1) comply with the requirements of the other parts of this title; and

"(2) provide that the State will make the contributions specified under section 340A–1(e) of the Public Health Service Act .

"SEC. 1905. DEFINITIONS.

"(a) IN GENERAL.—The definitions specified in this section shall apply for purposes of this part and, to the extent applicable and consistent with the policy embodied in such part, parts B, C, D, E, and F.

"(b) FEDERAL MEDICAL ASSISTANCE PERCENTAGE.—The term 'Federal medical assistance percentage' for any State shall be 100 percent less the State percentage; and the State percentage shall be that percentage which bears the same ratio to 45 percent as the square of the per capita income of such State bears to the square of the per capita income of the continental United States (including Alaska) and Hawaii, except that the Federal medical assistance percentage shall in no case be less than 50 percent or more than 83 percent. The Federal medical assistance percentage for any State shall be determined and promulgated in accordance with the provisions of section 1101(a)(8)(B).

"(c) APPLICATION OF CERTAIN PRE-MODERNIZED MEDICAID PROVISIONS.—The following old provisions shall apply under this part:

"(1) OLD SECTION 1905 PROVISIONS.—The following provisions of old section 1905:

"(A) Old section 1905(d) (relating to the definition of an intermediate care facility for the mentally retarded).

"(B) Old section 1905(e) (relating to the definition of physicians services).

"(C) Old section 1905(f) (relating to the definition of nursing facility services).

"(D) Old section 1905(g) (relating to the provision of chiropractors' services).

"(E) Old section 1905(j) (relating to State supplementary payments).

"(F) Old section 1905(k) (relating to supplemental security income benefits payable pursuant to section 211 of Public Law 93–66).

"(G) Old section 1905(l)(1) (relating to rural health clinic services).

"(H) Old section 1905(o) (relating to hospice care).

"(I) Old section 1905(q) (relating to the definition of a qualified severely impaired individual).

"(J) Old section 1905(r) (relating to the definition of early and periodic screening, diagnostic, and treatment services).

"(K) Old section 1905(s) (relating to the definition of a qualified disabled and working individual).

"(L) Old section 1905(t) (relating to the definition of primary care case management services).

"(M) Old section 1905(v) (relating to the definition of an employed individual with a medically improved disability).

"(N) Paragraphs (1) and (3) of old section 1905(w) (relating to the definition of an independent foster care adolescent).

"(O) Old section 1905(x) (relating to strategies, treatment, and services for individuals with Sickle Cell Disease).

"(2) OTHER OLD PROVISIONS.—

"(A) Old section 1903(m) (relating to the definition of a medicaid managed care organization).

"SEC. 1906. ENROLLMENT OF INDIVIDUALS UNDER GROUP HEALTH PLANS AND OTHER ARRANGEMENTS.

"The following old provisions shall apply under this part:

"(1) Old section 1906 (relating to enrollment of individuals under group health plans).

"(2) Old section 1902(a)(70) (relating to State option to establish a non-emergency medical transportation brokerage program).

"(3) Paragraphs (2) and (11) of old section 1902(e) (relating to eligibility for individuals enrolled with a group health plan or under a managed care arrangement during a minimum enrollment period).

"SEC. 1907. DRUG REBATES.

"Old sections 1902(a)(54) and 1927 (relating to payment for covered outpatient drugs and rebates) shall apply under this part.

"SEC. 1908. MANAGED CARE.

"The following old provisions shall apply under this part:

"(1) Old section 1932 (relating to managed care), other than subsection (a)(2) of such section.

"(2) Old section 1903(k) (relating to technical and actuarial assistance for States).

"SEC. 1909. ANNUAL REPORTS.

"(a) IN GENERAL.—Each State that receives payments under this part shall submit an annual report to the Secretary, in such form and manner as the Secretary shall specify.

"(b) APPLICATION OF OLD EPSDT REPORTING REQUIREMENTS.—Each annual report shall include the information required to be reported under old section 1902(a)(43)(D)(iv).

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

"SEC. 1911. PURPOSE.

"(a) IN GENERAL.—The purpose of this part is to increase the flexibility of States in operating a system of long-term care services and supports designed to—

"(1) provide assistance to needy families so that individuals with disabilities and low-income senior citizens may be served and supported in their own homes and communities;

"(2) emphasize the independence and dignity of the person served by public programs;

"(3) end the institutional bias that existed under the Medicaid program prior to January 1, 2011;

"(4) provide stable and predictable funding for States as they rebalance their long-term care systems from institutions to communities;

"(5) provide flexibility to States to adopt new and innovative service delivery methods; and

"(6) promote independence and support activities that will enable individuals to return or maintain ties to the community, including through employment.

"(b) NO INDIVIDUAL ENTITLEMENT.—No individual determined eligible for long-term care services and sup-

1 ports under this part shall be entitled to a specific service
2 or type of delivery of service.

3 **"SEC. 1912. STATE PLAN.**

4 "(a) IN GENERAL.—In order to receive payments
5 under this part, a State must have an approved State plan
6 for long-term care services and supports. A State long
7 term care services and supports plan shall include a de-
8 scription, consistent with the requirements of this part,
9 of—

10 "(1) income and assets eligibility standards and
11 spousal impoverishment protections consistent with
12 subsection (b);

13 "(2) the standardized assessments tools used to
14 determine eligibility for specific long-term care serv-
15 ices and supports;

16 "(3) the person-centered plans used to provide
17 such services and supports;

18 "(4) the proposed uses of funding, if applicable,
19 to provide targeted methods to meet individual level
20 of support needs including tiering (preventive, emer-
21 gency, low, medium, high); and

22 "(5) the long-term care services and supports to
23 be available under the plan based on individual as-
24 sessment of need in accordance with sections 1916
25 and 1917.

1 "(b) MINIMUM ELIGIBILITY STANDARDS.—

2 "(1) POPULATIONS COVERED.—The State plan
3 shall specify the disabled and elderly populations
4 who are eligible for long-term care services and sup-
5 ports.

6 "(2) NEEDS-BASED CRITERIA.—The plan shall
7 include a description of the needs-based criteria the
8 State will use to assess an individual's need for spe-
9 cific services and supports available under the State
10 plan.

11 "(3) OTHER ELIGIBILITY REQUIREMENTS.—

12 "(A) INCOME AND ASSETS.—A State may
13 use different income and asset standards and
14 methodologies for determining eligibility than
15 those used for determining eligibility for acute
16 care medical assistance under part A. A State
17 may not make eligibility standards related to
18 income, asset, and spousal impoverishment pro-
19 tection more restrictive than the Federal min-
20 imum requirements of December 31, 2008.

21 "(B) APPLICATION OF SPOUSAL IMPOVER-
22 ISHMENT PROTECTIONS.—The State plan shall
23 provide that the State shall comply with the re-
24 quirements of section 1918 (relating to spousal
25 impoverishment protections).

1 "(C) STATEWIDENESS.—The State plan
2 shall provide that, except with respect to meth-
3 ods used for determining homestead exemp-
4 tions, the income and asset standards and
5 methodologies shall be in effect in all political
6 subdivisions of the State.
7 "(4) TRANSITION ASSISTANCE.—The State plan
8 shall specify how the State will provide transition as-
9 sistance for individuals who, on December 31, 2010,
10 are enrolled under the State plan under old title
11 XIX (or under a waiver of that plan) and receiving
12 long-term care services or supports on that date.
13 The State shall provide such assistance to individ-
14 uals who are and are not likely to be determined eli-
15 gible for long-term care services and supports under
16 the State plan under this part, as in effect on Janu-
17 ary 1, 2011 (or the first day on which the State plan
18 is in effect under this part).
19 "(c) PAYMENT METHODOLOGIES TO PROVIDERS.—
20 "(1) IN GENERAL.—The State plan shall de-
21 scribe the methodologies used to determine payments
22 to providers. Such methodologies—
23 "(A) may be varied to assist in
24 transitioning from facilities-based to commu-
25 nity-based care; and

1 "(B) shall not be subject to Secretarial ap-
2 proval.
3 "(2) TRANSPARENCY.—The State plan shall
4 provide that the State shall make publicly avail-
5 able—
6 "(A) the payment methodologies applicable
7 under the plan; and
8 "(B) the name of any provider that re-
9 ceives $1,000,000 or more in any 12-month pe-
10 riod and the actual amount paid to the provider
11 during that period.
12 "(d) COORDINATION OF EFFORT WITH OTHER RE-
13 LATED PUBLIC AND PRIVATE PROGRAMS.—The plan shall
14 include a description of the State's efforts to coordinate
15 the delivery of services and supports under the plan with
16 other related public and private programs that serve indi-
17 viduals with disabilities or aged populations that need or
18 may be at risk of needing long term care.
19 "(e) PUBLIC AVAILABILITY OF STATE PLAN.—The
20 State shall make available to the public the State plan
21 under this part and any amendments submitted by the
22 State to the plan.
23 "(f) APPLICATION OF OLD TITLE XIX REQUIRE-
24 MENTS.—The following old title XIX provisions shall
25 apply to a State plan under this part:

1 "(1) Subsections (a)(50) and (q) of old section
2 1902 (relating to a monthly personal needs allow-
3 ance for certain institutionalized individuals and
4 couples).
5 "(2) Old section 1902(a)(67) (relating to pay-
6 ment for certain services furnished to a PACE pro-
7 gram eligible individual).
8 "(3) Paragraph (1) of old section 1902(r) (re-
9 lating to the post-eligibility treatment of income for
10 certain individuals) and paragraph (2) of such sec-
11 tion (relating to methodologies for determining in-
12 come and resource eligibility for individuals, but only
13 with respect to individuals who are eligible under
14 this part on or after January 1, 2011).
15 "(4) Old section 1905(i) (relating to the defini-
16 tion of an institution for mental diseases).
17 "(g) OTHER REQUIREMENTS OF OTHER PARTS.—
18 The State plan under this part shall—
19 "(1) comply with the requirements of the other
20 parts of this title; and
21 "(2) provide that the State will make the con-
22 tributions specified under section 340A–1(e) of the
23 Public Health Service Act.

"SEC. 1913. STATE ALLOTMENTS.

"(a) APPROPRIATION.—For the purpose of providing allotments to States under this section, there is appropriated out of any money in the Treasury not otherwise appropriated—

"(1) for fiscal year 2011, $65,274,560,000;

"(2) for fiscal year 2012, $67,885,540,000;

"(3) for fiscal year 2013, $70,600,964,100;

"(4) for fiscal year 2014, $73,425,000,000;

"(5) for fiscal year 2015, $76,362,000,000;

"(6) for fiscal year 2016, $79,416,480,000;

"(7) for fiscal year 2017, $82,593,140,000;

"(8) for fiscal year 2018, $85,896,870,000; and

"(9) for fiscal year 2019, $89,332,743,000.

"(b) ALLOTMENTS TO 50 STATES AND THE DISTRICT OF COLUMBIA.—

"(1) FISCAL YEAR 2011 ALLOTMENTS.—Subject to subsection (e), the Secretary shall allot to each State with a long term care plan approved under this title an amount in fiscal year 2011 equal to the Federal expenditures made by the State for long-term care as defined in section 1916 in fiscal year 2008, increased by 8 percent.

"(2) SUBSEQUENT FISCAL YEAR ALLOTMENTS.—For fiscal year 2012 and each subsequent fiscal year through fiscal year 2019, the allotment

for a State under this section is equal to the allotment for the State determined for the preceding fiscal year, increased by 4 percent.

"(c) LIMITATION.—

"(1) IN GENERAL.—Except as provided in paragraph (2), no other Federal funds are available under this title for expenditures incurred for long-term care services and supports after December 31, 2010, except as provided under a State plan approved under this part.

"(2) EXCEPTION.—

"(A) IN GENERAL.—If a State does not have an approved State plan by October 1, 2010, the Secretary may make payments equal to 85 percent of the State's estimated quarterly allotment until June 30, 2011.

"(B) FULL FUNDING.—A State shall receive 100 percent of its allotment for fiscal year 2011 if the State has a plan approved under this part by June 30, 2011.

"(d) MAINTENANCE OF EFFORT.—In order to qualify for the grant payable under this section, the State must demonstrate in each fiscal year that it made long-term care service and supports expenditures (including funding from local government sources) equal to the amount of

1 not less than 95 percent of the nonfederal share amount
2 spent in fiscal year 2009 under the State plan under old
3 title XIX on long term care services and supports (as de-
4 fined in section 1916). Expenditures not made under this
5 part shall not be recognized by the Secretary for purposes
6 of this requirement.

7 "(e) GRANTS REDUCED IF INSUFFICIENT APPRO-
8 PRIATIONS.—

9 "(1) IN GENERAL.—If the amount appropriated
10 for fiscal year 2011 under subsection (a)(1) is less
11 than the amount necessary to fund each State's al-
12 lotment for that fiscal year, the Secretary shall re-
13 duce the allotment for each State for that fiscal year
14 based on the applicable percentage determined for
15 the State under paragraph (2) provide a reduced
16 percentage basis as follows: Each state shall receive
17 a percentage of its allotment based on the ratio of
18 non-institutional spending to total long term care
19 spending in FY 2009.

20 "(2) APPLICABLE PERCENTAGE.—For purposes
21 of paragraph (1), the applicable percentage deter-
22 mined with respect to a State is as follows:

"If the ratio of the State's non-institutional spending to total long-term care spending for fiscal year 2009 is:	The applicable percentage is:
50 percent or greater	100
at least 46, but less than 50 percent	99
at least 40, but less than 46 percent	98
at least 36, but less than 40	97

at least 30, but less than 36	96
less than 30 percent	95.

1 "(f) ADMINISTRATIVE EXPENSES.—

2 "(1) IN GENERAL.—Each State with a plan ap-
3 proved under this part shall receive a payment deter-
4 mined in accordance with amounts appropriated for
5 part E for administrative expenses incurred in car-
6 rying out the plan under this part and part A.

7 "(2) ASSESSMENT-RELATED COSTS.—Costs at-
8 tributable to providing an individualized needs-based
9 assessment for purposes of identifying the long-term
10 care services and supports to be provided under the
11 State plan to an individual shall be considered a
12 long-term care service and support and shall not be
13 treated as an administrative expense.

14 **"SEC. 1914. USE OF GRANTS.**

15 "(a) IN GENERAL.—A State shall use funds for long-
16 term care services and supports as defined in section
17 1916.

18 "(b) SELF-DIRECTION.—A State shall offer individ-
19 uals the opportunity to self-direct their long-term care
20 services and supports.

21 **"SEC. 1915. ADMINISTRATIVE PROVISIONS.**

22 "(a) FUNDING ON A QUARTERLY BASIS.—The Sec-
23 retary shall make payments to States in equal amounts
24 of a State's annual allotment on a quarterly basis. Each

1 quarterly payment shall remain available for use by the
2 State for twelve succeeding fiscal year quarters.
3 "(b) PUBLICATION.—The Secretary shall public each
4 State's applicable allotment.

5 **"SEC. 1916. DEFINITION OF LONG-TERM CARE SERVICES**
6 **AND SUPPORTS.**

7 "(a) DEFINITION.—
8 "(1) IN GENERAL.—Subject to subsection (e),
9 in this part, the term 'long-term care services and
10 supports' means any of the services or supports
11 specified in paragraphs (2) or (3) that may be pro-
12 vided in a nursing facility, an institution, a home, or
13 other setting.
14 "(2) SERVICES AND SUPPORTS DESCRIBED.—
15 For purposes of paragraph (1), the services and sup-
16 ports described in this paragraph include assistive
17 technology, adaptive equipment, remote monitoring
18 equipment, case management for the aged, case
19 management for individuals with disabilities, nursing
20 home services, long-term rehabilitative services nec-
21 essary to restore functional abilities, services pro-
22 vided in intermediate care facilities for people with
23 disabilities, habilitation services (including adult day
24 care programs), community treatment teams for in-
25 dividuals with mental illness, home health services,

1 services provided in an institution for mental dis-
2 ease, a Program of All-Inclusive Care for the Elderly
3 (PACE), personal care (including personal assist-
4 ance services), recovery support including peer coun-
5 seling, supportive employment, training skills nec-
6 essary to assist the individual in achieving or main-
7 taining independence, training of family members in-
8 cluding foster parents in supportive and behavioral
9 modification skills, ongoing and periodic training to
10 maintain life skills, transitional care including room
11 and board not to exceed 60 days within a 12-month
12 period.

13 "(3) INCLUSION OF CERTAIN BENEFITS UNDER
14 OLD TITLE XIX.—Such services and supports may
15 include any of the following services:

16 "(A) Old section 1905(a)(15) (relating to
17 services in an intermediate care facility for the
18 mentally retarded).

19 "(B) Services described in subsections
20 (a)(16) and (h) of old section 1905, but without
21 regard to any restriction on such services on
22 the basis of age (relating to inpatient psy-
23 chiatric hospital services).

24 "(C) Old section 1905(a)(22) (relating to
25 home and community care (to the extent al-

lowed and as defined in old section 1929) for functionally disabled elderly individuals).

"(D) Old section 1905(a)(23) (relating to community supported living arrangements services (to the extent allowed and as defined in old section 1930)).

"(E) Subject to subsection (e), old section 1905(a)(24) but without regard to any restriction on furnishing services to patients or residents of facilities or institutions (relating to personal care services).

"(F) Old sections 1905(a)(26) and 1934 (relating to services furnished under a PACE program under old section 1934 to PACE program eligible individuals enrolled under the program under such old section).

"(G) Old section 1915(c)(5) (relating to the definition of habilitation services).

"(4) LIMITATION.—Long-term care services and supports cannot be used for services and administrative costs provided through the foster care (with the exception of training of foster care parents), child welfare, adult protective services, juvenile justice, public guardianship, or correctional systems.

1 "(b) REHABILITATIVE CARE.—For purposes of reha-
2 bilitation due to acute care medical needs, a State may
3 claim rehabilitative services provided in an institutional
4 setting, nursing home, or as part of home health expendi-
5 tures as acute care benefits under the State plan under
6 part A rather than under the State plan under this part
7 for a cumulative period of 30 days within a 12-month pe-
8 riod if such care is directly related to the onset of an acute
9 care need. A State shall demonstrate the services were
10 provided as a direct result of an acute care need.

11 "(c) MANAGED CARE.—If a State provides long-term
12 care services and supports through managed care, the
13 State shall submit a methodology for determining the level
14 of expenditures attributed to long term care for approval
15 by the Secretary.

16 "(d) APPLICATION OF PART A DEFINITIONS.—A def-
17 inition specified in section 1905 shall apply to the same
18 term used in this part, unless the Secretary determines
19 that the application of such definition would be incon-
20 sistent with the purpose of this part.

21 "(e) EXCLUSION.—No payments shall be made under
22 the State plan under this part with respect to long-term
23 care supports and services provided for any individual who
24 is an inmate of a public institution. Nothing in the pre-
25 ceding sentence shall be construed as precluding the provi-

1 sion of long-term care services and supports under the
2 State plan under this part to an individual who is a pa-
3 tient in an institution for mental diseases.

4 **"SEC. 1917. PROVISION REQUIREMENTS FOR LONG-TERM**
5 **CARE SERVICES AND SUPPORT, INCLUDING**
6 **OPTION FOR SELF-DIRECTED SERVICES AND**
7 **SUPPORTS.**

8 "(a) REQUIREMENTS FOR THE PROVISION OF LONG-
9 TERM CARE SERVICES AND SUPPORTS.—

10 "(1) IN GENERAL.—Subject to the succeeding
11 provisions of this subsection, a State may provide
12 through a State plan amendment for the provision
13 of long-term care services and supports for individ-
14 uals eligible under the State plan under this part,
15 subject to the following requirements:

16 "(A) NEEDS-BASED CRITERIA FOR ELIGI-
17 BILITY FOR, AND RECEIPT OF, LONG-TERM
18 CARE SERVICES AND SUPPORTS.—The State es-
19 tablishes needs-based criteria for determining
20 an individual's eligibility under the State plan
21 for medical assistance for such long-term care
22 services and supports, and if the individual is
23 eligible for such services and supports, the spe-
24 cific services and supports that will be available
25 under the State plan to the individual.

"(B) CRITERIA FOR INSTITUTIONALIZED VERSUS NON-INSTITUTIONALIZED SERVICES.—In establishing needs-based criteria, the State may establish criteria for determining eligibility for, and receipt of, services and supports provided in a facility or institution that are more stringent that the criteria established for eligibility and receipt of services and supports in a non-facility or non-institutionalized setting.

"(C) AUTHORITY TO LIMIT NUMBER OF ELIGIBLE INDIVIDUALS.—A State may limit the number of individuals who are eligible for such services and supports and may establish waiting lists for the receipt of such services and supports.

"(D) CRITERIA BASED ON INDIVIDUAL ASSESSMENT.—

"(i) IN GENERAL.—The criteria established by the State shall require an assessment of an individual's support needs and capabilities, and may take into account the inability of the individual to perform 2 or more activities of daily living (as defined in section 7702B(c)(2)(B) of the Internal Revenue Code of 1986) or the need for sig-

1 nificant assistance to perform such activi-
2 ties, and such other risk factors as the
3 State determines to be appropriate.
4 "(ii) ADJUSTMENT AUTHORITY.—The
5 State plan amendment provides the State
6 with the option to modify the criteria es-
7 tablished under subparagraph (A) (without
8 having to obtain prior approval from the
9 Secretary) in the event that the enrollment
10 of individuals eligible for services exceeds
11 the projected enrollment, but only if—
12 "(I) the State provides at least
13 60 days notice to the Secretary and
14 the public of the proposed modifica-
15 tion;
16 "(II) the State deems an indi-
17 vidual receiving long-term care serv-
18 ices and supports on the basis of the
19 most recent version of the criteria in
20 effect prior to the effective date of the
21 modification to be eligible for such
22 services and supports for a period of
23 at least 12 months beginning on the
24 date the individual first received med-

ical assistance for such services and supports; and

"(III) after the effective date of such modification, the State, at a minimum, applies the criteria for determining whether an individual requires the level of care provided in a facility or institutionalized setting which applied under the State plan immediately prior to the application of the modified criteria.

"(E) INDEPENDENT EVALUATION AND ASSESSMENT.—

"(i) ELIGIBILITY DETERMINATION.—The State uses an independent evaluation for making the determinations described in subparagraph (A).

"(ii) ASSESSMENT.—In the case of an individual who is determined to be eligible for long-term care services and supports, the State uses an independent assessment, based on the needs of the individual to—

"(I) determine a necessary level of services and supports to be pro-

1 vided, consistent with an individual's
2 physical and mental capacity;
3 "(II) prevent the provision of un-
4 necessary or inappropriate care; and
5 "(III) establish an individualized
6 care plan for the individual in accord-
7 ance with subparagraph (G).
8 "(F) ASSESSMENT.—The independent as-
9 sessment required under subparagraph (E)(ii)
10 shall include the following:
11 "(i) An objective evaluation of an in-
12 dividual's inability to perform 2 or more
13 activities of daily living (as defined in sec-
14 tion 7702B(c)(2)(B) of the Internal Rev-
15 enue Code of 1986) or the need for signifi-
16 cant assistance to perform such activities.
17 "(ii) A face-to-face evaluation of the
18 individual by an individual trained in the
19 assessment and evaluation of individuals
20 whose physical or mental conditions trigger
21 a potential need for long-term care services
22 and supports.
23 "(iii) Where appropriate, consultation
24 with the individual's family, spouse, guard-
25 ian, or other responsible individual.

1 "(iv) Consultation with appropriate
2 treating and consulting health and support
3 professionals caring for the individual.
4 "(v) An examination of the individ-
5 ual's relevant history, medical records, and
6 care and support needs, guided by best
7 practices and research on effective strate-
8 gies that result in improved health and
9 quality of life outcomes.
10 "(vi) An evaluation of the ability of
11 the individual or the individual's represent-
12 ative to self-direct the purchase of, or con-
13 trol the receipt of, such services and sup-
14 ports if the individual so elects.
15 "(G) INDIVIDUALIZED CARE PLAN.—
16 "(i) IN GENERAL.—In the case of an
17 individual who is determined to be eligible
18 for long-term care services and supports,
19 the State uses the independent assessment
20 required under subparagraph (E)(ii) to es-
21 tablish a written individualized care plan
22 for the individual.
23 "(ii) PLAN REQUIREMENTS.—The
24 State ensures that the individualized care
25 plan for an individual—

"(I) is developed—

"(aa) in consultation with the individual, the individual's treating physician, health care or support professional, or other appropriate individuals, as defined by the State, and, where appropriate the individual's family, caregiver, or representative; and

"(bb) taking into account the extent of, and need for, any family or other supports for the individual;

"(II) identifies the long-term care services and supports to be furnished to the individual (or, if the individual elects to self-direct the purchase of, or control the receipt of, such services and supports, funded for the individual); and

"(III) is reviewed at least annually and as needed when there is a significant change in the individual's circumstances.

1 "(iii) STATE REQUIREMENT TO OFFER
2 ELECTION FOR SELF-DIRECTED SERVICES
3 AND SUPPORTS.—
4 "(I) INDIVIDUAL CHOICE.—The
5 State shall allow an individual or the
6 individual's representative the oppor-
7 tunity to elect to receive self-directed
8 long-term care services and supports
9 in a manner which gives them the
10 most control over such services and
11 supports consistent with the individ-
12 ual's abilities and the requirements of
13 subclauses (II) and (III).
14 "(II) SELF-DIRECTED.—The
15 term 'self-directed' means, with re-
16 spect to the long-term care services
17 and supports offered under the State
18 plan amendment, such services and
19 supports for the individual which are
20 planned and purchased under the di-
21 rection and control of such individual
22 or the individual's authorized rep-
23 resentative, including the amount, du-
24 ration, scope, provider, and location of
25 such services and supports, under the

State plan consistent with the following requirements:

"(aa) ASSESSMENT.—There is an assessment of the needs, capabilities, and preferences of the individual with respect to such services and supports.

"(bb) SERVICE PLAN.—Based on such assessment, there is developed jointly with such individual or the individual's authorized representative a plan for such services and supports for such individual that is approved by the State and that satisfies the requirements of subclause (III).

"(III) PLAN REQUIREMENTS.—For purposes of subclause (II)(bb), the requirements of this subclause are that the plan—

"(aa) specifies those services and supports which the individual or the individual's authorized

representative would be responsible for directing;

"(bb) identifies the methods by which the individual or the individual's authorized representative will select, manage, and dismiss providers of such services and supports;

"(cc) specifies the role of family members and others whose participation is sought by the individual or the individual's authorized representative with respect to such services and supports;

"(dd) is developed through a person-centered process that is directed by the individual or the individual's authorized representative, builds upon the individual's capacity to engage in activities that promote community life and that respects the individual's preferences, choices, and abilities, and involves families, friends,

and professionals as desired or required by the individual or the individual's authorized representative;

"(ee) includes appropriate risk management techniques that recognize the roles and sharing of responsibilities in obtaining services and supports in a self-directed manner and assure the appropriateness of such plan based upon the resources and capabilities of the individual or the individual's authorized representative; and

"(ff) may include an individualized budget which identifies the dollar value of the services and supports under the control and direction of the individual or the individual's authorized representative.

"(IV) BUDGET PROCESS.—With respect to individualized budgets de-

scribed in subclause (III)(ff), the State plan amendment—

"(aa) describes the method for calculating the dollar values in such budgets based on reliable costs and service utilization;

"(bb) defines a process for making adjustments in such dollar values to reflect changes in individual assessments and service plans; and

"(cc) provides a procedure to evaluate expenditures under such budgets.

"(H) QUALITY ASSURANCE; CONFLICT OF INTEREST STANDARDS.—

"(i) QUALITY ASSURANCE.—The State ensures that the provision of long-term care services and supports meets Federal and State guidelines for quality assurance.

"(ii) CONFLICT OF INTEREST STANDARDS.—The State establishes standards for the conduct of the independent evalua-

1 tion and the independent assessment to
2 safeguard against conflicts of interest.
3 "(I) REDETERMINATIONS AND APPEALS.—
4 The State allows for at least annual redeter-
5 minations of eligibility, and appeals in accord-
6 ance with the frequency of, and manner in
7 which, redeterminations and appeals of eligi-
8 bility are made under the State plan.
9 "(J) PRESUMPTIVE ELIGIBILITY FOR AS-
10 SESSMENT.—The State, at its option, elects to
11 provide for a period of presumptive eligibility
12 (not to exceed a period of 60 days) only for
13 those individuals that the State has reason to
14 believe may be eligible for long-term care serv-
15 ices and supports. Such presumptive eligibility
16 shall be limited to medical assistance for car-
17 rying out the independent evaluation and as-
18 sessment under subparagraph (E) to determine
19 an individual's eligibility for such services and
20 if the individual is so eligible, the specific long-
21 term care services and supports that the indi-
22 vidual will receive.
23 "(2) DEFINITION OF INDIVIDUAL'S REP-
24 RESENTATIVE.—In this section, the term 'individ-
25 ual's representative' means, with respect to an indi-

vidual, a parent, a family member, or a guardian of the individual, an advocate for the individual, or any other individual who is authorized to represent the individual.

''(b) SELF-DIRECTED PERSONAL ASSISTANCE SERVICES.—If a State includes personal care or personal assistance services in the long-term care services and supports available under the State plan, the State shall comply with the requirements of old section 1915(j) in the case of an individual who elects to self-direct the receipt of such care or services.

''SEC. 1918. TREATMENT OF INCOME AND RESOURCES FOR CERTAIN INSTITUTIONALIZED SPOUSES.

''Old section 1924 (relating to treatment of income and resources for certain institutionalized spouses), other than paragraphs (2) and (4)(A) of subsection (a) of such section, shall apply under this part.

''SEC. 1919. ANNUAL REPORTS.

''(a) IN GENERAL.—Each State that receives payments under this part shall submit an annual report to the Secretary, in such form and manner as the Secretary shall specify.

''(b) REQUIREMENTS.—The report shall include the following with respect to the most recent fiscal year ended:

"(1) The number of individuals served under the plan.

"(2) The number of individuals served by tier (preventive, emergency, low, medium, and high needs).

"(3) The number of individuals known to the State on waiting list for services (if any) and type of disability (physical, developmental, mental health) or aged.

"(4) Expenditures by service category.

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

"SEC. 1931. AUTHORIZATION OF APPROPRIATIONS.

"For the purpose of carrying our Federal activities and providing grants to States for expenses necessary to carry out this part, there is authorized to be appropriated—

"(1) for fiscal year 2011, $300,000,000; and

"(2) for each succeeding fiscal year, the amount authorized under this section for the preceding fiscal year, increased by 5 percent.

"SEC. 1932. APPLICATION OF CERTAIN REQUIREMENTS UNDER PRE-MODERNIZED MEDICAID.

''The following old provisions shall apply under this part:

''(1) Old section 1902(a)(9) (relating to health standards and applicable requirements for laboratory services).

''(2) Old section 1902(a)(28) (relating to nursing facilities and nursing facility services).

''(3) Old sections 1902(a)(29) and 1908 (relating to a State program for the licensing of administrators of nursing homes).

''(4) Old section 1902(a)(33)(B) (relating to licensing health institutions).

''(5) Old section 1902(d) (relating to medical or utilization review functions).

''(6) Old section 1902(i) (relating to intermediate care facilities for the mentally retarded).

''(7) Old section 1902(y) (relating to psychiatric hospitals).

''(8) Paragraphs (2) and (6) of old section 1903(g) (relating to the Secretarial requirement to conduct sample onsite surveys of private and public institutions and recertifications for the need for certain services).

"(9) Old section 1903(q)(4)(B) (relating to the definition of a board and care facility).

"(10) Old section 1910 (relating to certification and approval of rural health clinics and intermediate care facilities for the mentally retarded).

"(11) Old section 1911 (relating to Indian Health Service facilities).

"(12) Old section 1913 (relating to hospital providers of nursing facility services).

"(13) Old section 1919 (relating to requirements for nursing facilities).

"PART D—GRANTS TO STATES FOR PROGRAM INTEGRITY

"SEC. 1941. AUTHORIZATION OF APPROPRIATIONS.

"(a) IN GENERAL.—For the purpose of carrying out Federal activities under this part and providing grants to States for expenses necessary to carry out this part, there is authorized to be appropriated—

"(1) for fiscal year 2011, $100,000,000; and

"(2) for each succeeding fiscal year, the amount authorized under this section for the preceding fiscal year, increased by 5 percent.

"(b) AVAILABILITY; AUTHORITY FOR USE OF FUNDS.—

"(1) AVAILABILITY.—Amounts appropriated pursuant to subsection (a) shall remain available until expended.

"(2) AUTHORITY FOR USE OF FUNDS FOR TRANSPORTATION AND TRAVEL EXPENSES FOR ATTENDEES AT EDUCATION, TRAINING, OR CONSULTATIVE ACTIVITIES.—

"(A) IN GENERAL.—The Secretary may use amounts appropriated pursuant to subsection (a) to pay for transportation and the travel expenses, including per diem in lieu of subsistence, at rates authorized for employees of agencies under subchapter I of chapter 57 of title 5, United States Code, while away from their homes or regular places of business, of individuals described in subsection (b)(4) who attend education, training, or consultative activities conducted under the authority of that subsection.

"(B) PUBLIC DISCLOSURE.—The Secretary shall make available on a website of the Centers for Medicare & Medicaid Services that is accessible to the public—

"(i) the total amount of funds expended for each conference conducted

under the authority of subsection (b)(4); and

"(ii) the amount of funds expended for each such conference that were for transportation and for travel expenses.

"(c) ANNUAL REPORT.—Not later than 180 days after the end of each fiscal year, the Secretary shall submit a report to Congress which identifies—

"(1) the use of funds appropriated pursuant to subsection (a); and

"(2) the effectiveness of the use of such funds.

"SEC. 1942. APPLICATION OF CERTAIN REQUIREMENTS UNDER PRE-MODERNIZED MEDICAID.

"The following old provisions shall apply under this part:

"(1) Old subsections (a)(25) (other than subparagraph (E)) and (g) of section 1902 and section 1903(o) (relating to third party liability).

"(2) Old section 1902(a)(30)(B) (relating to hospital, intermediate care facility for the mentally retarded, or hospital for mental diseases admission screening and review requirements).

"(3) Old section 1902(a)(32) (relating to certain payment requirements).

1 "(4) Old section 1902(a)(35) (relating to dis-
2 closing entities under section 1124).
3 "(5) Old section 1902(a)(37) and the fifth sen-
4 tence (relating to claims payment procedures).
5 "(6) Old section 1902(a)(44) (relating to pay-
6 ment for inpatient hospital services, services in an
7 intermediate care facility for the mentally retarded,
8 or inpatient mental hospital services).
9 "(7) Old sections 1902(a)(45) and 1912 (relat-
10 ing to assignment of rights of payment).
11 "(8) Old sections 1902(a)(49) and 1921 (relat-
12 ing to information and access to information con-
13 cerning sanctions taken by State licensing authori-
14 ties against health care practitioners and providers).
15 "(9) Old sections 1902(a)(61) and 1903(q) (re-
16 lating to requirements for a medicaid fraud and
17 abuse control unit).
18 "(10) Old section 1902(a)(64) (relating to re-
19 ports from beneficiaries and others and data com-
20 pilation requirements concerning alleged instances of
21 waste, fraud, and abuse).
22 "(11) Old section 1902(a)(65) (relating to pro-
23 vider number and surety bond requirement for sup-
24 pliers of durable medical equipment).

1 "(12) Old section 1902(a)(68) (relating to re-
2 quirements for certain entities).
3 "(13) Old sections 1902(a)(69) and 1936 (re-
4 lating to the Medicaid Integrity Program) other
5 than paragraphs (1), (2)(A), and (3) of old section
6 1936(e).
7 "(14) Old section 1902(a)(70)(B)(iv) (relating
8 to prohibitions on referrals and conflict of interest
9 for certain brokers of non-emergency medical trans-
10 portation).
11 "(15) Old sections 1902(a)(71) and 1940 (re-
12 lating to a required asset verification program).
13 "(16) Old section 1902(p) (relating to exclusion
14 of certain individuals or entities).
15 "(17) Old section 1902(x) (relating to unique
16 identifiers for physicians).
17 "(18) Old section 1903(p) (relating to inter-
18 state collection of rights of support).
19 "(19) Old section 1903(r)(2) (relating to re-
20 quirements for mechanized claims processing and in-
21 formation retrieval systems).
22 "(20) Old section 1903(u) (relating to erro-
23 neous excess payments), other than clause (v) of
24 paragraph (1)(D).

"(21) Old section 1903(v) and the seventh sentence of old section 1902(a) (relating to limitations on payments for services furnished to aliens), other than subparagraphs (A) and (B) of paragraph (4).

"(22) Old section 1903(x) (relating to citizenship documentation).

"(23) Old section 1909 (relating to State false claims act requirements for increased State share of recoveries).

"(24) Old section 1914 (relating to withholding of Federal share of payments for certain Medicare providers).

"(25) Old section 1917 (relating to liens, adjustments and recoveries, and transfers of assets).

"(26) Old section 1922 (relating to correction and reduction plans for intermediate care facilities for the mentally retarded).

"PART E—GRANTS TO STATES FOR ADMINISTRATION

"SEC. 1951. AUTHORIZATION OF APPROPRIATIONS; PAYMENTS TO STATES.

"(a) IN GENERAL.—For the purpose of providing grants to States for administrative expenses necessary to carry out parts A and B, there is authorized to be appropriated—

"(1) for fiscal year 2011, $7,000,000,000; and

"(2) for each succeeding fiscal year, the amount authorized under this subsection for the preceding fiscal year, increased by 3 percent.

"(b) PAYMENTS TO STATES.—

"(1) IN GENERAL.—From the amount appropriated pursuant to subsection (a) for a fiscal year, the Secretary shall pay each State with approved plans under parts A and B for the fiscal year an amount equal to the product of the amount appropriated for the fiscal year and the ratio of the total amount of payments made to the State under paragraphs (2) through (7) of section 1903(a) for fiscal year 2008 (as such section was in effect for that fiscal year) to the total amount of such payments made to all States for such fiscal year.

"(2) PRO RATA ADJUSTMENT.—The Secretary shall make pro rata adjustments to the amounts determined under paragraph (1) for a fiscal year as necessary so as to not exceed the amount appropriated pursuant to subsection (a) for the fiscal year.

"SEC. 1952. COST-SHARING PROTECTIONS.

"(a) IN GENERAL.—A State may impose cost-sharing for individuals provided acute care medical assistance

1 under a State plan under part A or long-term care services
2 and supports under a State plan under part B consistent
3 with the following:

4 "(1) The State may (in a uniform manner) re-
5 quire payment of monthly premiums or other cost-
6 sharing set on a sliding scale based on family in-
7 come.

8 "(2) A premium or other cost-sharing require-
9 ment imposed under paragraph (1) may only apply
10 to the extent that, in the case of an individual whose
11 family income—

12 "(A) exceeds 150 percent of the poverty
13 line, the aggregate annual amount of such pre-
14 mium and other cost-sharing charges imposed
15 under the plan does not exceed 5 percent of the
16 individual's annual income; and

17 "(B) exceeds 250 percent of the poverty
18 line, the aggregate annual amount of such pre-
19 mium and other cost-sharing charges do not ex-
20 ceed 7.5 percent of the individual's annual in-
21 come.

22 "(3) A State shall not require prepayment of
23 any premium or cost-sharing imposed pursuant to
24 paragraph (1) and shall not terminate eligibility of
25 an individual under the State plan on the basis of

1 failure to pay any such premium or cost-sharing
2 until such failure continues for a period of at least
3 60 days from the date on which the premium or
4 cost-sharing became past due. The State may waive
5 payment of any such premium or cost-sharing in any
6 case where the State determines that requiring such
7 payment would create an undue hardship.

8 "(b) APPLICATION TO INSTITUTIONALIZED INDIVID-
9 UALS.—A State may impose cost-sharing consistent with
10 subsection (a) to individuals who are patients in, or resi-
11 dents of, a medical institution or nursing facility except
12 that rules relating to the post-eligibility treatment of in-
13 come (including a minium monthly personal needs allow-
14 ance) applicable to institutionalized individuals under old
15 title XIX shall apply in the same manner to individuals
16 eligible for long-term care services and supports under a
17 State plan under part B.

18 "(c) POVERTY LINE DEFINED.—In this section, the
19 term 'poverty line' has the meaning given such term in
20 section 673(2) of the Community Services Block Grant
21 Act (42 U.S.C. 9902(2)), including any revision required
22 by such section.

"SEC. 1953. APPLICATION OF CERTAIN REQUIREMENTS UNDER PRE-MODERNIZED MEDICAID.

''The following old provisions shall apply to the State plans under this title:

''(1) OLD STATE PLAN REQUIREMENTS.—

''(A) Old section 1902(a)(1) (relating to the requirement for plans to be in effect in all political subdivisions of the State).

''(B) Old section 1902(a)(2) (relating to State financial participation).

''(C) Old section 1902(a)(3) (relating to opportunity for a fair hearing).

''(D) Old section 1902(a)(4) (relating to administration).

''(E) Old section 1902(a)(5) (relating to designation of a single State agency).

''(F) Old section 1902(a)(6) (relating to reporting requirements).

''(G) Old section 1902(a)(7) (relating to restrictions on the use or disclosure of information).

''(H) Old section 1902(a)(8) (relating to applications for assistance).

''(I) Old section 1902(a)(11) (relating to cooperative agreements with other State agencies).

"(J) Old section 1902(a)(12) (relating to determinations of blindness).

"(K) Old section 1902(a)(13) (relating to determination of rates of payment for certain services), other than clause (iv) of subparagraph (A).

"(L) Subsections (a)(15) and (bb) of old section 1902(a) (relating to payment for services provided by rural health clinics and federally qualified health centers).

"(M) Old section 1902(a)(16) (relating to furnishing services to individuals when absent from the State).

"(N) Old section 1902(a)(22) (relating to certain administrative provisions).

"(O) Paragraphs (23) and (25)(D) of old section 1902(a) (relating to any willing provider requirements).

"(P) Old section 1902(a)(24) (relating to consultative services by other agencies).

"(Q) Old section 1902(a)(26) (relating to review of need for inpatient mental hospital services and written plan of care requirements).

"(R) Old section 1902(a)(27) (relating to provider record keeping requirements).

"(S) Old section 1902(a)(30)(A) (relating to utilization review).

"(T) Old section 1902(a)(31) (relating to written plan of care for services and review for intermediate care facility for the mentally retarded services).

"(U) Old section 1902(a)(33)(A) (relating to quality review requirements).

"(V) Old section 1902(a)(36) (relating to public availability of facility surveys).

"(W) Old section 1902(a)(38) (relating to the provision of information described in section 1128(b)(9) by certain entities).

"(X) Old section 1902(a)(39) (relating to the exclusion of certain entities).

"(Y) Old section 1902(a)(40) (relating to requirement for uniform reporting systems).

"(Z) Old section 1902(a)(41) (relating to notice to State medical licensing boards).

"(AA) Old section 1902(a)(42) (relating to certain audit requirements).

"(BB) Old section 1902(a)(48) (relating to eligibility cards).

"(CC) Old section 1902(a)(55) (relating to the receipt and initial processing of applica-

1 tions, but only to the extent such section is con-
2 sistent with the policy embodied in the State
3 plans under parts A and B).
4 "(DD) Subsections (a)(56) and (s) of old
5 section 1902 (relating to adjusted payments for
6 certain inpatient hospital services).
7 "(EE) Old section 1902(a)(59) (relating to
8 maintenance of list of participating physicians).
9 "(FF) The second sentence of old section
10 1902 (relating to designation of certain State
11 agencies).
12 "(GG) Old section 1902(b) (relating to
13 limitations on approval of plans).
14 "(HH) Old section 1902(j) (relating to ap-
15 plication of requirements to American Samoa
16 and the Northern Mariana Islands).
17 "(2) OTHER OLD TITLE XIX REQUIREMENTS.—
18 "(A) Old section 1903(b)(4) (relating to
19 limitations on payments to enrollment brokers).
20 "(B) Old section 1903(c) (relating to fur-
21 nishing of services included in a program or
22 plan under part B or C of the Individuals with
23 Disabilities Education Act).
24 "(C) Old section 1903(d) (relating to pay-
25 ments).

"(D) Old section 1903(e) (relating to costs with respect to certain hospital services).

"(E) Old section 1903(i) (relating to limitations on payments).

"(F) Old section 1903(r) (relating to requirements for mechanized claims processing and information retrieval systems).

"(G) Subsections (b)(5) and (w) of old section 1903 (relating to limitations on payments related to provider taxes).

"(H) Old section 1904 (relating to operation of State plans).

"(I) Old sections 1902(a)(60) and 1908A (relating to medical child support).

"(J) Paragraphs (32)(D) and (62) of old section 1902(a) and section 1928 (relating to program for distribution of pediatric vaccines).

"PART F—OTHER PROVISIONS

"SEC. 1961. APPLICATION OF CERTAIN REQUIREMENTS UNDER PRE-MODERNIZED MEDICAID.

"The following old provisions shall apply under this part:

"(1) The third sentence of old section 1902 (relating to nonapplication of certain old provisions to a religious nonmedical health care institution).

"(2) Old section 1918 (relating to application of provisions of title II relating to subpoenas).

"(3) Old section 1939 (relating to references to laws directly affecting the Medicaid program.".

(b) REPEAL OF TITLE XXI.—Effective January 1, 2011, title XXI of the Social Security Act (42 U.S.C. 1397aa et seq.) is repealed.

SEC. 202. OUTREACH.

(a) AUTHORIZATION OF APPROPRIATIONS.—The following amounts are authorized to be appropriated to the Secretary of Health and Human Services:

(1) For fiscal year 2010, $100,000,000 for the design and implementation of a public outreach campaign to inform the public about the changes to the programs under such titles that take effect on January 1, 2011, as a result of the amendment made by section 201.

(2) For each of fiscal years 2011and 2012, $200,000,000 to carry out such public outreach campaign.

(3) For fiscal year 2013, $50,000,000 to carry out such public outreach campaign.

(b) AVAILABILITY.—Funds appropriated under subsection (a) shall remain available for expenditure through September 30, 2012.

(c) AUTHORITY FOR USE OF FUNDS.—The Secretary may use funds made available under paragraphs (2) and (3) of subsection (a) to award grants to, or enter into contracts with, public or private entities, including States, local governments, schools, churches, and community groups.

SEC. 203. TRANSITION RULES; MISCELLANEOUS PROVISIONS.

(a) IN GENERAL.—

(1) Not later than June 30, 2011, a State that is one of the 50 States or the District of Columbia shall inform all individuals enrolled in a State plan under title XIX or XXI of the Social Security Act on such date (and any new enrollees after such date) of the changes to the programs under such titles that take effect on January 1, 2012, as a result of the amendment made by section 201.

(2) No State that is one of the 50 States or the District of Columbia shall approve any applications for medical assistance or child health assistance under a State plan under title XIX or XXI (as in effect for fiscal year 2011) after December 31, 2011.

(b) SUBMISSION OF LEGISLATIVE PROPOSAL FOR TECHNICAL AND CONFORMING AMENDMENTS.—Not later

than 6 months after the date of enactment of this Act, the Secretary of Health and Human Services shall submit to Congress a legislative proposal for such technical and conforming amendments as are necessary to carry out the amendments made by this Act.

Subtitle B—Supplemental Health Care Assistance for Low-Income Families

SEC. 211. SUPPLEMENTAL HEALTH CARE ASSISTANCE FOR LOW-INCOME FAMILIES.

Part D of title III of the Public Health Service Act (42 U.S.C. 254b et seq.) is amended by adding at the end the following:

"Subpart XI—Health Care Assistance to Low-income Families

"SEC. 340A–1. FINANCIAL ASSISTANCE TO LOW-INCOME FAMILIES.

''(a) IN GENERAL.—The Secretary shall supplement the costs of private health insurance for eligible low-income families through the distribution of supplemental debit cards to eligible families, which may be used to pay for costs associated with health care for the members of such eligible families and provide direct support to such families in accessing health care.

''(b) ELIGIBILITY.—

1 "(1) ELIGIBLE FAMILIES.—To be eligible for fi-
2 nancial assistance under this section—
3 "(A) a family shall—
4 "(i) consist of 2 or more individuals
5 living together who are related by mar-
6 riage, birth, adoption, or guardianship;
7 "(ii) have a gross income that does
8 not exceed 200 percent of the poverty line,
9 as applicable to a family of the size in-
10 volved; and
11 "(iii) include at least 1 individual who
12 is a dependent under the age of 19; and
13 "(B) no member of the family shall be cov-
14 ered by private health insurance.
15 "(2) DETERMINATION OF GROSS INCOME.—The
16 gross income of a family shall be determined by tak-
17 ing the sum of the income of each family member
18 who is at least age 21 but not older than age 65,
19 except that the income of any member of the family
20 who qualifies for coverage under Medicaid Part A or
21 B shall not be counted.
22 "(3) LIMITATION ON INDIVIDUAL ELIGIBILITY;
23 ASSISTANCE.—
24 "(A) IN GENERAL.—No individual who is a
25 member of an eligible family under paragraph

1 (1) is eligible to qualify separately for financial
2 assistance under this section.
3 "(B) ALIENS.—The Secretary shall ensure
4 that financial assistance under this section is
5 not provided for costs associated with health
6 care for any member of an eligible family who
7 is an alien individual who is not a lawful per-
8 manent resident of the United States.
9 "(c) SUPPLEMENTAL DEBIT CARD FOR HEALTH
10 CARE EXPENDITURES.—
11 "(1) IN GENERAL.—The Secretary shall issue
12 to each eligible family that enrolls in the program in
13 accordance with subsection (f) a supplemental debit
14 card with a dollar-amount value, in accordance with
15 subsection (d), that may be used to pay for quali-
16 fying health care expenses.
17 "(2) USE OF THE DEBIT CARD.—
18 "(A) QUALIFYING HEALTH CARE EX-
19 PENSES.—A supplemental debit card issued
20 under this section may be used by members of
21 the eligible family to pay for—
22 "(i) the purchase of health care insur-
23 ance for any member of the family;
24 "(ii) cost sharing expenses related to
25 health care, including deductibles, copay-

1 ments, and coinsurance, for any member of
2 the family; and
3 "(iii) the direct purchase of health
4 care services and supplies for any member
5 of the family.
6 "(B) GEOGRAPHIC RANGE.—Each supple-
7 mental debit card may be used to pay for quali-
8 fying health care expenses incurred anywhere in
9 the 50 States or the District of Columbia.
10 "(C) LIMITATIONS.—No supplemental
11 debit card shall be used to make a payment for
12 any cost—
13 "(i) incurred prior to the determina-
14 tion of the family's eligibility for assistance
15 under this section; or
16 "(ii) that is not a health-related ex-
17 pense.
18 "(3) ROLLOVER OF UNUSED AMOUNTS.—Not
19 more than one-quarter of the annual dollar amount
20 of a supplemental debit card that is unexpended at
21 the end of each 12-month period may rollover—
22 "(A) to the family's supplemental debit
23 card for expenditure during the subsequent 12-
24 month period, provided that the family to which
25 the supplemental debit card was issued in the

previous 12-month period is eligible to receive a supplemental debit card in the subsequent 12-month period; or

"(B) to the family's health savings account (as defined in section 223(g)(2) of the Internal Revenue Code of 1986).

"(4) MONTHLY STATEMENTS.—The Secretary shall issue a monthly statement to each family to which a supplemental debit card has been issued under this section, which shall state each payment made with the family's supplemental debit card during the month covered by the statement, the dollar amount of each such payment, and the provider to which each such payment was made.

"(d) AMOUNT OF FINANCIAL ASSISTANCE.—

"(1) AMOUNTS FOR CALENDAR YEAR 2011.—Subject to paragraph (5), the amount of financial assistance available to each eligible family during the calendar year 2011 shall be determined as follows:

"(A) Each family whose annual income does not exceed 100 percent of the poverty level, as applicable to a family of the size involved, shall receive $5,000.

"(B) Each family whose annual income exceeds 100 percent, but does not exceed 200 per-

cent, of the poverty level, as applicable to a family of the size involved, shall receive an amount as follows:

"(i) For families whose annual income exceeds 100 percent but does not exceed 120 percent, of the poverty level, $4,000.

"(ii) For families whose annual income exceeds 120 percent but does not exceed 140 percent, of the poverty level, $3,500.

"(iii) For families whose annual income exceeds 140 percent but does not exceed 160 percent, of the poverty level, $3,000.

"(iv) For families whose annual income exceeds 160 percent but does not exceed 180 percent, of the poverty level, $2,500.

"(v) For families whose annual income exceeds 180 percent but does not exceed 200 percent, of the poverty level, $2,000.

"(2) ADDITIONAL AMOUNTS.—In addition to the amounts under paragraph (1), subject to para-

graph (5), the following amounts shall be added to the supplemental debit cards of qualifying families:

"(A) For each pregnancy during which a pregnant woman's family is eligible for assistance under this section, an additional amount of $1,000 shall be added to the family's supplemental debit card, except that no family shall receive such additional $1,000 for any pregnancy for which the family received such amount in the previous 12-month period.

"(B) For each member of an eligible family who is less than 1 year old on any day within the calendar year in which the family is eligible for assistance, an additional amount of $500 shall be added to the family's supplemental debit card.

"(3) COST OF LIVING ADJUSTMENTS.—In the case of any taxable year beginning in a calendar year after 2011, each dollar amount contained in paragraphs (1) and (2) shall be increased in the same manner as the dollar amounts specified in section 25E(b)(3) of the Internal Revenue Code of 1986 are increased by the blended cost-of-living adjustment determined under subsection (k)(2) of sec-

1 tion 25E of the Internal Revenue Code for the tax-
2 able year involved.
3 "(4) STATE OPTION TO INCREASE AMOUNTS.—
4 At the option of each State, amounts in excess of
5 the annual dollar amounts under paragraphs (1) and
6 (2) may be provided through the supplemental debit
7 card to eligible families in that State, but no Federal
8 funds shall be paid to any State for any amount pro-
9 vided in excess of such annual dollar amount.
10 "(5) RISK ADJUSTMENT.—The Secretary may
11 adjust the amount of financial assistance available to
12 an eligible family for a calendar year under this sec-
13 tion based on age, health indicators, and other fac-
14 tors that represent distinct patterns of health care
15 services utilization and costs.
16 "(e) CONTRIBUTIONS OF STATES.—
17 "(1) IN GENERAL.—As a condition for receiving
18 Federal funds under Part A or Part B of Medicaid,
19 each State shall contribute 50 percent of the total
20 amount expended under the supplemental debit card
21 program by the participating families that reside
22 within the State during the time that the family re-
23 sides in that State. For purposes of this section, the
24 residency of a family is determined by the residency
25 the legally responsible head of the household.

1 "(2) PAYMENTS FROM STATES.—

2 "(A) BILLING NOTIFICATION.—

3 "(i) TIMING.—On June 30th and De-
4 cember 31st of each year, the Secretary
5 shall send written notification to each
6 State of that State's 50 percent share of
7 expenses, as described in paragraph (1),
8 for the 6-month period ending on the last
9 day of the month previous to such notifica-
10 tion.

11 "(ii) CONTENTS.—Each such notifica-
12 tion to a State shall clearly state—

13 "(I) the payment amount due
14 from the State;

15 "(II) the name of each individual
16 for whom payment was made through
17 the supplemental debit card program;

18 "(III) the health care provider to
19 whom each payment was made;

20 "(IV) the amount of each pay-
21 ment; and

22 "(V) any other information, as
23 the Secretary requires.

24 "(B) PAYMENTS.—Each State shall make
25 a payment to the Secretary, in the amount

1 billed, not later than 30 days after the billing
2 notification date, in accordance with subpara-
3 graph (A)(i).
4 "(C) PENALTIES.—If a State fails to pay
5 to the Secretary an amount required under sub-
6 paragraph (B), interest shall accrue on such
7 amount at the rate provided under old section
8 1903(d)(5) of the Social Security Act. The
9 amount so owed and applicable interest shall be
10 immediately offset against amounts otherwise
11 payable to the State under this section, in ac-
12 cordance with the Federal Claims Collection Act
13 of 1996 and applicable regulations.
14 "(f) ENROLLMENT.—
15 "(1) IN GENERAL.—The Secretary shall estab-
16 lish procedures and times for enrollment in the sup-
17 plemental debit card program. Open enrollment shall
18 be available not less than 4 times per calendar year.
19 "(2) TRANSITION OF INDIVIDUALS ENROLLED
20 IN MEDICAID OR THE STATE CHILDREN'S HEALTH
21 INSURANCE PROGRAM.—
22 "(A) INFORMATION FROM THE STATES.—
23 Each State shall—
24 "(i) not later than June 30, 2011, in-
25 form all individuals then enrolled in Med-

1 icaid or the State Children's Health Insur-
2 ance Program (SCHIP), of the changes in
3 effect beginning on January 1, 2012; and
4 "(ii) not later than October 31, 2011,
5 redetermine the eligibility of each indi-
6 vidual enrolled in Medicaid or SCHIP,
7 other than those individuals who qualify
8 for Medicaid or SCHIP as disabled, elder-
9 ly, or a special population, for the supple-
10 mental debit card program, according to
11 the eligibility criteria under subsection (b).
12 "(B) AUTOMATIC ENROLLMENT.—The
13 Secretary shall provide for the automatic enroll-
14 ment in the supplemental debit card program of
15 all individuals who are enrolled in Medicaid or
16 SCHIP and who have been redetermined by a
17 State under subparagraph (A) to be eligible for
18 Medicaid or SCHIP. Any individual who is de-
19 termined by a State not to qualify for the sup-
20 plemental debit card program may retain cov-
21 erage under Medicaid or SCHIP until June 30,
22 2012.
23 "(3) ASSISTANCE WITH QUALIFIED HEALTH IN-
24 SURANCE CREDIT.—Each State shall, to the extent
25 practicable, provide individuals residing within the

State with information regarding the qualified health insurance credit described in section 25E of the Internal Revenue Code of 1986, including information regarding eligibility for, and how to claim, such credit.

"(g) ADMINISTRATION.—

"(1) NATIONAL SYSTEM.—The Secretary may enter into contracts or agreements with a State, a consortium of States, or a private entity, including a bank, enrollment broker, or similar entity, to establish and maintain a unified national system to support the processes and transactions necessary to administer this section.

"(2) AUTOMATED SYSTEM.—The Secretary shall establish an automated means, such as an electronic benefit transfer system, by which the benefits under this section shall be transferred to eligible families.

"(3) VERIFICATION OF APPLICANT INFORMATION.—The Secretary may verify information provided by applicants with the appropriate Federal, State, and local agencies, including the Internal Revenue Service, the Social Security Administration, the Department of Labor, and child support enforcement agencies.

"(4) CHOICE COUNSELING.—The Secretary may enter into contracts or agreements with a State, a consortium of a State, or a private entity, including an enrollment broker or community organization or other organization, to educate eligible families about their options and to assist in their enrollment in the supplemental debit card plan.

"(5) APPEALS.—The Secretary shall establish an independent appeals process, to be administered by an entity separate from the entity that makes initial eligibility determinations, which shall be available to individuals who are denied benefits under the supplemental debit card program.

"(6) RESOLUTION OF ERRORS.—The Secretary shall provide for a reconciliation process with the States to resolve any errors and adjudicate disputes due to incomplete or false information in a family's application or in the billing process described in subsection (e).

"(7) PENALTIES FOR FALSE INFORMATION.—Any person who provides false information to qualify for the supplemental debit card program shall pay a penalty in the amount of 110 percent of the amount of assistance paid on behalf of such person and all members of such person's family.

1 "(h) IMPLEMENTATION PLAN.—Not later than 6
2 months after the date of enactment of this section, the
3 Secretary shall submit to Congress a plan for imple-
4 menting this program.

5 "(i) AUTHORIZATION OF APPROPRIATIONS.—

6 "(1) ADMINISTRATION OF THE SUPPLEMENTAL
7 DEBIT CARD PROGRAM.—To administer the program
8 under this section, there are authorized to be appro-
9 priated—

10 "(A) for fiscal year 2009, $300,000,000,
11 for the design of a unified, national system of
12 conducting the supplemental debit card pro-
13 gram;

14 "(B) for fiscal year 2010, $1,000,000,000
15 for start-up costs, including, contracting, hiring
16 and training employees, and testing the pro-
17 gram; and

18 "(C) for fiscal year 2011 and each subse-
19 quent fiscal year, $3,000,000,000.

20 "(2) AUTHORIZATION OF BENEFITS UNDER
21 THE SUPPLEMENTAL DEBIT CARD PROGRAM.—To
22 provide the supplemental debit card benefits de-
23 scribed in this section, there are authorized to be ap-
24 propriated—

"(A) for fiscal year 2011, $24,020,000,000;

"(B) for fiscal year 2012, $25,220,000,000;

"(C) for fiscal year 2013, $26,480,000,000;

"(D) for fiscal year 2014, $27,810,000,000; and

"(E) for fiscal year 2015, $29,200,000,000.".

TITLE III—MEDICARE REFORM

Subtitle A—New Medicare Program

SEC. 301. BENEFIT CHANGES.

Title XVIII of the Social Security Act is amended by inserting after section 1808 the following new section:

"PROGRAM FOR NEW MEDICARE BENEFICIARIES BEGINNING IN 2021

"SEC. 1810. (a) APPLICATION.—

"(1) IN GENERAL.—Notwithstanding any other provision of law (including sections 226 and 226A), the provisions of this section shall apply to individuals (other than individuals entitled to benefits only because of the application of section 1881(d)) who first become entitled to benefits under part A, or whose coverage period under part B begins, on or after January 1, 2021.

"(2) NO IMPACT ON FICA/SECA TAX REVENUES.—Nothing in this section shall be construed as affecting revenues through the payment of hospital insurance taxes under sections 1401(b), 3101(b), and 3111(b) of the Internal Revenue Code of 1986.

"(3) NO IMPACT ON OTHER BENEFICIARIES.—

"(A) IN GENERAL.—This section shall not apply to individuals not described in paragraph (1).

"(B) NO IMPACT ON COMPUTATION OF MEDICARE PREMIUMS FOR OLDER MEDICARE BENEFICIARIES.—Premiums under parts A, B, and D shall be computed for individuals not described in paragraph (1) based on the average costs that the Secretary estimates would have been applicable if this section did not apply.

"(b) ALTERNATIVE BENEFITS.—

"(1) IN GENERAL.—An individual described in subsection (a)(1) is only entitled to benefits under this title in accordance with this section. In the case of such an individual who has qualified health insurance coverage, the individual is entitled under this section—

"(A) to an income-related payment under subsection (c); and

"(B) in the case of a low-income individual (as defined in paragraph (3) of subsection (d)), to a contribution to a medical savings account of the individual in the amount specified in such subsection.

"(2) ALTERNATIVE PREMIUM OBLIGATIONS.—An individual described in subsection (a)(1)—

"(A) is not responsible for payment of any premium otherwise applicable under part B or D; but

"(B) is responsible for payment of the premium for qualified health insurance coverage referred to in paragraph (1) and may apply the income-related payment under subsection (c) toward such premium.

"(3) QUALIFIED HEALTH INSURANCE COVERAGE.—

"(A) PUBLICATION OF LIST.—The Secretary of Health and Human Services shall publish an annual list of health insurance plans that meet the definition of qualified health insurance coverage, as described in subparagraph (B) below, at least one of such plans must address the special needs of Medicare's highest-cost seniors, as determined by the Secretary.

"(B) QUALIFIED HEALTH INSURANCE COVERAGE DEFINED.—In this subsection, the term 'qualified health insurance coverage' means health benefits coverage, whether under a group health plan, health insurance coverage or otherwise, but does not include coverage under a health plan if substantially all of its coverage is coverage described in section 223(c)(1)(B) of the Internal Revenue Code of 1986.

"(c) INCOME-RELATED PAYMENT.—

"(1) IN GENERAL.—The amount of the income-related payment under this subsection for an individual for a year is equal to—

"(A) the annual amount specified for the year in paragraph (2);

"(B) subject to reduction under paragraph (3) (relating to higher income individuals);

"(C) further subject to adjustment under paragraph (4); and

"(D) subject to pro-ration under paragraph (5).

"(2) ANNUAL AMOUNT.—

"(A) IN GENERAL.—The annual amount specified in this paragraph—

1 "(i) for 2011 is the average nominal
2 dollar value of the Medicare benefit; and
3 "(ii) for any subsequent year is the
4 annual amount specified in this paragraph
5 for the preceding year increased by the an-
6 nual inflation adjustment described in sub-
7 paragraph (B) for such subsequent year.
8 Any amount computed under clause (ii) that is
9 not a multiple of $12 shall be rounded to the
10 nearest multiple of $12.
11 "(B) ANNUAL INFLATION ADJUSTMENT.—
12 The annual inflation adjustment under this
13 subparagraph for a year is equal to the average
14 of—
15 "(i) the annual rate of increase in the
16 consumer price index for urban consumers
17 (all items; U.S. city average) for the year,
18 as projected by the Secretary in consulta-
19 tion with the Bureau of Labor Statistics
20 before the beginning of the year; and
21 "(ii) the annual rate of increase in the
22 medical care component of the consumer
23 price index for all urban consumers (U.S.
24 city average) for the year, as projected by
25 the Secretary in consultation with the Bu-

reau of Labor Statistics before the beginning of the year.

"(3) REDUCTION FOR HIGHER-INCOME INDIVIDUALS.—

"(A) IN GENERAL.—In the case of an individual whose modified adjusted gross income exceeds the threshold amount specified in paragraph (2) of section 1839(i), as adjusted under paragraph (5) of such section, the annual amount under paragraph (2) shall be reduced by the adjustment percentage specified in subparagraph (B).

"(B) ADJUSTMENT PERCENTAGE.—In the case of an individual for whom the applicable percentage specified in section 1839(i)(3)(C)—

"(i) is less than 80 percent, the adjustment percentage under this subparagraph shall be 50 percent; or

"(ii) is equal to 80 percent, the adjustment percentage under this subparagraph shall be 70 percent.

"(C) APPLICATION OF CERTAIN PROVISIONS.—The provisions of paragraphs (4) through (6) of section 1839(i) shall apply under

this paragraph in the same manner as they apply for purposes of such section.

"(4) RISK, GEOGRAPHIC AREA, AND OTHER ADJUSTMENTS.—

"(A) RISK ADJUSTMENT.—The payment amount under this subsection for an individual shall be adjusted, using a methodology specified by the Secretary, in a manner that takes into account the relative risk factors (such as those described in section 1853(a)(1)(C)(i)) associated with such individual. Such adjustment shall be made in such a manner as not to change the total amount of payments made under this subsection as a result of such adjustment.

"(B) PARTIAL GEOGRAPHIC AREA ADJUSTMENT.—Such payment amount for an individual also shall be adjusted, using a methodology specified by the Secretary, in a manner that takes into account the relative differences in area health care costs for the area in which the individual resides compared to other areas. Such adjustment shall be made in such a manner as not to change the total amount of payments made under this subsection as a result of

such adjustment. The Secretary shall provide for a decrease over time in the adjustment made under this subparagraph.

"(C) CERTAIN PART A BUY-IN INDIVIDUALS.—Such payment amount for an individual who is not eligible for benefits under part A pursuant to section 226 or 226A shall be adjusted by such proportion or amount as the Secretary determines appropriate to take into account premiums that would otherwise be payable under section 1818 or 1818A for benefits under part A.

"(5) PRO-RATIO FOR PARTIAL YEAR OF ELIGIBILITY.—In the case of an individual whose entitlement under this section is for less than an entire year, the payment amount under this subsection shall be pro-rated to reflect the portion of the year included in such entitlement.

"(6) PAYMENT ON PERIODIC BASIS.—The Secretary shall provide for the payment under this subsection on an appropriate monthly or other periodic basis.

"(d) CONTRIBUTION TO A MEDICAL SAVINGS ACCOUNT (MSA) FOR LOW-INCOME INDIVIDUALS.—

"(1) IN GENERAL.—The amount of the contribution under subsection (b)(1)(B) to a medical savings account of a low-income individual is equal—

"(A) in the case of an individual described in clause (i) or (ii) of paragraph (4)(A), to the full MSA contribution amount (as defined in paragraph (2)); or

"(B) in the case of any other individual, to 75 percent of the full MSA contribution amount.

"(2) FULL MSA CONTRIBUTION AMOUNT.—For purposes of this subsection, the term 'full MSA contribution amount' means, for a year for an individual, an amount to be equivalent to the full amount of the average deductible of a high-deductible health plan (as defined in section 223(c)(2) of the Internal Revenue Code of 1986) as determined by the Secretary.

"(3) NO MEDICAID COVERAGE FOR MEDICARE-COVERED SERVICES.—

"(A) IN GENERAL.—In the case of an individual who is eligible to be provided a contribution to a medical savings account under this subsection, the individual is not entitled to any

payment under a State plan under title XIX with respect to any benefits relating to items and services for which coverage is provided under this title.

"(B) CONSTRUCTION.—Subparagraph (A) shall not affect the continued provision of medical assistance under title XIX for items and services, such as dental, vision, or long-term care facility services, for which benefits are not provided under this title regardless of medical necessity.

"(4) PERIODIC PAYMENT.—The Secretary shall provide for the contribution into medical savings accounts of amounts under this subsection on an appropriate monthly or other periodic basis.

"(5) LOW-INCOME INDIVIDUAL DEFINED.—

"(A) IN GENERAL.—For purposes of this section, the term 'low-income individual' means an individual described in subsection (a)(1)—

"(i) who meets the requirement of section 1936(c)(6)(A)(ii) (relating to a full-benefit dual eligible individual);

"(ii) whose income (as determined under section 1612 for purposes of the supplemental security income program, ex-

cept as provided in subparagraph (B)) does not exceed 100 percent of the official income poverty line (referred to in section 1905(p)(1)) applicable to a family of the size involved; or

"(iii) whose income (as so determined) exceeds 100 percent, but does not exceed 150 percent, of such official income poverty line applicable to a family of the size involved.

"(B) APPLICATION OF SPECIAL RULE REGARDING APPLICATION OF SOCIAL SECURITY INCREASES.—The provisions of subparagraph (D) of section 1905(p)(2) shall apply to determinations of income under subparagraph (A) in the same manner they apply under such section.

"(C) DETERMINATION PROCESS.—The Secretary shall specify a process for the determination of whether individuals are low-income individuals.".

SEC. 302. INCREASE IN MEDICARE ELIGIBILITY AGE.

Section 226 of the Social Security Act (42 U.S.C. 426) is amended by adding at the end the following new subsection:

"(k) INCREASING MEDICARE QUALIFYING AGE.—

"(1) IN GENERAL.—Notwithstanding any other provision of law, any reference in this section or title XVIII (or title XIX insofar as it refers to title XVIII) to 'age 65' shall be deemed a reference to the medicare qualifying age specified in paragraph (2).

"(2) MEDICARE QUALIFYING AGE SPECIFIED.—The medicare qualifying age specified in this paragraph is determined as follows:

"(A) In the case of an individual who attains 65 years of age before January 1, 2021, the medicare qualifying age is 65 years of age.

"(B) In the case of an individual who attains 65 years of age in a year after 2018 and before 2027, the medicare qualifying age is the medicare qualifying age specified in this paragraph for the previous year increased by 2 months.

"(C) In the case of an individual who attains 65 years of age—

"(i) in the 2-year period beginning on January 1, 2027, the medicare qualifying age is 67 years and 1 month; or

"(ii) in a subsequent 2-year period beginning before 2087, the medicare quali-

fying age is the medicare qualifying age specified in this paragraph for the previous 2-year period (or, in the case of the first 2-year period, specified for 2026) increased by 1 month.

''(D) In the case of an individual who attains 65 years of age on or after January 1, 2086, the medicare qualifying age is the medicare qualifying age specified in this paragraph is 69 years and 6 months.''.

SEC. 303. UNIFIED MEDICARE TRUST FUND.

(a) IN GENERAL.—The Federal Hospital Insurance Trust Fund (established under section 1817 of the Social Security Act) and the Federal Supplementary Medical Insurance Trust Fund (established under section 1841 of such Act) are hereby consolidated into a unified Medicare trust fund. Such trust fund shall have separate accounts for parts A, B, and D of such title and shall be administered by the same board of trustees that administers the current Trust Funds.

(b) CONSTRUCTION.—Nothing in this section shall be construed as affecting the actual transfer of funds or computations of amounts of premiums under any part of the Medicare program.

(c) SOLVENCY.—The Medicare trustee shall establish a measure of program solvency for the Medicare program of total outlays as a measure of gross domestic product.

Subtitle B—Changes in Current Medicare Program

SEC. 311. INCOME-RELATED REDUCTION IN PART D PREMIUM SUBSIDY.

(a) INCOME-RELATED REDUCTION IN PART D PREMIUM SUBSIDY.—

(1) IN GENERAL.—Section 1860D–13(a) of the Social Security Act (42 U.S.C. 1395w–113(a)) is amended by adding at the end the following new paragraph:

"(7) REDUCTION IN PREMIUM SUBSIDY BASED ON INCOME.—

"(A) IN GENERAL.—In the case of an individual whose modified adjusted gross income exceeds the threshold amount applicable under paragraph (2) of section 1839(i) (including application of paragraph (5) of such section) for the calendar year, the monthly amount of the premium subsidy applicable to the premium under this section for a month after December 2010 shall be reduced (and the monthly beneficiary premium shall be increased) by the

monthly adjustment amount specified in subparagraph (B).

"(B) MONTHLY ADJUSTMENT AMOUNT.—The monthly adjustment amount specified in this subparagraph for an individual for a month in a year is equal to the product of—

"(i) the quotient obtained by dividing—

"(I) the applicable percentage determined under paragraph (3)(C) of section 1839(i) (including application of paragraph (5) of such section) for the individual for the calendar year reduced by 25.5 percent; by

"(II) 25.5 percent; and

"(ii) the base beneficiary premium (as computed under paragraph (2)).

"(C) MODIFIED ADJUSTED GROSS INCOME.—For purposes of this paragraph, the term 'modified adjusted gross income' has the meaning given such term in subparagraph (A) of section 1839(i)(4), determined for the taxable year applicable under subparagraphs (B) and (C) of such section.

"(D) DETERMINATION BY COMMISSIONER OF SOCIAL SECURITY.—The Commissioner of Social Security shall make any determination necessary to carry out the income-related reduction in premium subsidy under this paragraph.

"(E) PROCEDURES TO ASSURE CORRECT INCOME-RELATED REDUCTION IN PREMIUM SUBSIDY.—

"(i) DISCLOSURE OF BASE BENEFICIARY PREMIUM.—Not later than September 15 of each year beginning with 2011, the Secretary shall disclose to the Commissioner of Social Security the amount of the base beneficiary premium (as computed under paragraph (2)) for the purpose of carrying out the income-related reduction in premium subsidy under this paragraph with respect to the following year.

"(ii) ADDITIONAL DISCLOSURE.—Not later than October 15 of each year beginning with 2010, the Secretary shall disclose to the Commissioner of Social Security the following information for the purpose of carrying out the income-related re-

1 duction in premium subsidy under this
2 paragraph with respect to the following
3 year:
4 "(I) The modified adjusted gross
5 income threshold applicable under
6 paragraph (2) of section 1839(i) (in-
7 cluding application of paragraph (5)
8 of such section).
9 "(II) The applicable percentage
10 determined under paragraph (3)(C) of
11 section 1839(i) (including application
12 of paragraph (5) of such section).
13 "(III) The monthly adjustment
14 amount specified in subparagraph
15 (B).
16 "(IV) Any other information the
17 Commissioner of Social Security de-
18 termines necessary to carry out the
19 income-related reduction in premium
20 subsidy under this paragraph.
21 "(F) RULE OF CONSTRUCTION.—The for-
22 mula used to determine the monthly adjustment
23 amount specified under subparagraph (B) shall
24 only be used for the purpose of determining

such monthly adjustment amount under such subparagraph.''.

(2) COLLECTION OF MONTHLY ADJUSTMENT AMOUNT.—Section 1860D–13(c) of the Social Security Act (42 U.S.C. 1395w–113(c)) is amended—

(A) in paragraph (1), by striking ''(2) and (3)'' and inserting ''(2), (3), and (4)''; and

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

''(4) COLLECTION OF MONTHLY ADJUSTMENT AMOUNT.—

''(A) IN GENERAL.—Notwithstanding any other provision of this subsection or section 1854(d)(2), subject to subparagraph (B), the amount of the income-related reduction in premium subsidy for an individual for a month (as determined under subsection (a)(7)) shall be paid through withholding from benefit payments in the manner provided under section 1840.

''(B) AGREEMENTS.—In the case where the monthly benefit payments of an individual that are withheld under subparagraph (A) are insufficient to pay the amount described in such subparagraph, the Commissioner of Social Se-

curity shall enter into agreements with the Secretary, the Director of the Office of Personnel Management, and the Railroad Retirement Board as necessary in order to allow other agencies to collect the amount described in subparagraph (A) that was not withheld under such subparagraph.''.

(b) CONFORMING AMENDMENTS.—

(1) MEDICARE.—Part D of title XVIII of the Social Security Act (42 U.S.C. 1395w–101 et seq.) is amended—

(A) in section 1860D–13(a)(1)—

(i) by redesignating subparagraph (F) as subparagraph (G);

(ii) in subparagraph (G), as redesignated by clause (i), by striking ''(D) and (E)'' and inserting ''(D), (E), and (F)''; and

(iii) by inserting after subparagraph (E) the following new subparagraph:

''(F) INCREASE BASED ON INCOME.—The monthly beneficiary premium shall be increased pursuant to paragraph (7).''; and

(B) in section 1860D–15(a)(1)(B), by striking "paragraph (1)(B)" and inserting "paragraphs (1)(B) and (1)(F)".

(2) INTERNAL REVENUE CODE.—Section 6103(l)(20) of the Internal Revenue Code of 1986 (relating to disclosure of return information to carry out Medicare part B premium subsidy adjustment) is amended—

(A) in the heading, by striking "PART B PREMIUM SUBSIDY ADJUSTMENT" and inserting "PARTS B AND D PREMIUM SUBSIDY ADJUSTMENTS";

(B) in subparagraph (A)—

(i) in the matter preceding clause (i), by inserting "or 1860D–13(a)(7)" after "1839(i)"; and

(ii) in clause (vii), by inserting after "subsection (i) of such section" the following: "or under section 1860D–13(a)(7) of such Act"; and

(C) in subparagraph (B)—

(i) by inserting "or such section 1860D–13(a)(7)" before the period at the end;

(ii) as amended by clause (i), by inserting ''or for the purpose of resolving tax payer appeals with respect to any such premium adjustment'' before the period at the end; and

(iii) by adding at the end the following new sentence: ''Officers, employees, and contractors of the Social Security Administration may disclose such return information to officers, employees, and contractors of the Department of Health and Human Services, the Office of Personnel Management, the Railroad Retirement Board, the Department of Justice, and the courts of the United States to the extent necessary to carry out the purposes described in the preceding sentence.''; and

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

''(C) TIMING OF DISCLOSURE.—Return information shall be disclosed to officers, employees, and contractors of the Social Security Administration under subparagraph (A) not later than the date that is 90 days prior to the date on which the taxpayer first becomes entitled to

benefits under part A of title XVIII of the Social Security Act or eligible to enroll for benefits under part B of such title.''.

SEC. 312. REDUCTION IN HOSPITAL MARKETBASKET INCREASES.

Notwithstanding any other provision of law:

(1) OUTPATIENT HOSPITAL SERVICES.—For 2010 and each succeeding year, the OPD fee schedule increase factor otherwise computed under section 1833(t)(3)(C)(iv) of the Social Security Act (42 U.S.C. 1395l(t)(3)(C)(iv)) shall be reduced by .4 percentage points.

(2) INPATIENT HOSPITAL SERVICES.—For fiscal year 2010 and each succeeding fiscal year, the applicable percentage increase otherwise computed under clauses (i) and (ii) of section 1886(b)(3)(B) of such Act (42 U.S.C. 1395ww(b)(3)(B)) shall be reduced by .4 percentage points.

SEC. 313. ELIMINATION OF INDEXING OF INCOME THRESHOLDS FOR PART B INCOME-RELATED PREMIUMS.

(a) IN GENERAL.—Section 1839(i) of the Social Security Act (42 U.S.C. 1395r(i)) is amended by striking paragraph (5).

(b) EFFECTIVE DATE.—The amendment made by subsection (a) shall apply to premiums for years beginning with 2010.

SEC. 314. REINSTATEMENT OF THE MEDICARE TRIGGER.

(a) REINSTATEMENT OF THE MEDICARE TRIGGER.—

(1) DETERMINATIONS OF EXCESS GENERAL REVENUE MEDICARE FUNDING.—

(A) IN GENERAL.—The Board of Trustees of each medicare trust fund shall include in the annual reports submitted under subsection (b)(2) of sections 1817 and 1841 of the Social Security Act (42 U.S.C. 1395i and 1395t)—

(i) the information described in paragraph (2); and

(ii) a determination as to whether there is projected to be excess general revenue medicare funding (as defined in paragraph (3)) for the fiscal year in which the report is submitted or for the previous fiscal year.

(B) MEDICARE FUNDING WARNING.—For purposes of section 1105(h) of title 31, United States Code, and this subsection, an affirmative determination under subparagraph (A)(i) in 2 consecutive annual reports shall be treated as a

medicare funding warning in the year in which the second such report is made.

(2) INFORMATION.—The information described in this subsection for an annual report in a year is as follows:

(A) PROJECTIONS OF GROWTH OF GENERAL REVENUE SPENDING.—A statement of the general revenue medicare funding as a percentage of the total medicare outlays for each of the following:

(i) The previous fiscal year.

(ii) Previous fiscal years and as of 10, 50, and 75 years after such year.

(B) COMPARISON WITH OTHER GROWTH TRENDS.—A comparison of the trend of such percentages with the annual growth rate in the following:

(i) The gross domestic product.

(ii) Private health costs.

(iii) National health expenditures.

(iv) Other appropriate measures.

(C) PART D SPENDING.—Expenditures, including trends in expenditures, under part D of title XVIII of the Social Security Act, as added by section 101 of the Medicare Prescription

1 Drug, Improvement, and Modernization Act of
2 2003 (Public Law 108–173).
3 (D) COMBINED MEDICARE TRUST FUND
4 ANALYSIS.—A financial analysis of the com-
5 bined medicare trust funds if general revenue
6 medicare funding were limited to the percentage
7 specified in paragraph (3)(A)(ii) of total medi-
8 care outlays.
9 (3) DEFINITIONS.—For purposes of this sec-
10 tion:
11 (A) EXCESS GENERAL REVENUE MEDI-
12 CARE FUNDING.—The term ''excess general rev-
13 enue medicare funding'' means, with respect to
14 a fiscal year, that—
15 (i) general revenue medicare funding
16 (as defined in subparagraph (B)), ex-
17 pressed as a percentage of total medicare
18 outlays (as defined in subparagraph (D))
19 for the fiscal year; exceeds
20 (ii) 45 percent.
21 (B) GENERAL REVENUE MEDICARE FUND-
22 ING.—The term ''general revenue medicare
23 funding'' means for a year—

(i) the total medicare outlays (as defined in subparagraph (D)) for the year; minus

(ii) the dedicated medicare financing sources (as defined in subparagraph (C)) for the year.

(C) DEDICATED MEDICARE FINANCING SOURCES.—The term ''dedicated medicare financing sources'' means the following:

(i) HOSPITAL INSURANCE TAX.—Amounts appropriated to the Hospital Insurance Trust Fund under the third sentence of section 1817(a) of the Social Security Act (42 U.S.C. 1395i(a)) and amounts transferred to such Trust Fund under section 7(c)(2) of the Railroad Retirement Act of 1974 (45 U.S.C. 231f(c)(2)).

(ii) TAXATION OF CERTAIN OASDI BENEFITS.—Amounts appropriated to the Hospital Insurance Trust Fund under section 121(e)(1)(B) of the Social Security Amendments of 1983 (Public Law 98–21), as inserted by section 13215(c) of the Om-

1 nibus Budget Reconciliation Act of 1993
2 (Public Law 103–66).
3 (iii) STATE TRANSFERS.—The State
4 share of amounts paid to the Federal Gov-
5 ernment by a State under section 1843 of
6 the Social Security Act (42 U.S.C. 1395v)
7 or pursuant to section 1935(c) of such Act.
8 (iv) PREMIUMS.—The following pre-
9 miums:
10 (I) PART A.—Premiums paid by
11 non-Federal sources under sections
12 1818 and section 1818A (42 U.S.C.
13 1395i–2 and 1395i–2a) of such Act.
14 (II) PART B.—Premiums paid by
15 non-Federal sources under section
16 1839 of such Act (42 U.S.C. 1395r),
17 including any adjustments in pre-
18 miums under such section.
19 (III) PART D.—Monthly bene-
20 ficiary premiums paid under part D of
21 title XVIII of such Act, as added by
22 section 101 of the Medicare Prescrip-
23 tion Drug, Improvement, and Mod-
24 ernization Act of 2003 (Public Law
25 108–173), and MA monthly prescrip-

1 tion drug beneficiary premiums paid
2 under part C of such title insofar as
3 they are attributable to basic prescrip-
4 tion drug coverage.
5 (IV) DESCRIPTION.—Premiums
6 under subclauses (II) and (III) shall
7 be determined without regard to any
8 reduction in such premiums attrib-
9 utable to a beneficiary rebate under
10 section 1854(b)(1)(C) of such title, as
11 amended by section 222(b)(1) of the
12 Medicare Prescription Drug, Improve-
13 ment, and Modernization Act of 2003
14 (Public Law 108–173), and premiums
15 under clause (iii) are deemed to in-
16 clude any amounts paid under section
17 1860D–13(b) of such title, as added
18 by section 101 of the Medicare Pre-
19 scription Drug, Improvement, and
20 Modernization Act of 2003 (Public
21 Law 108–173).
22 (v) GIFTS.—Amounts received by the
23 medicare trust funds under section 201(i)
24 of the Social Security Act (42 U.S.C.
25 401(i)).

(D) TOTAL MEDICARE OUTLAYS.—The term "total medicare outlays" means total outlays from the medicare trust funds and shall—

(i) include payments made to plans under part C of title XVIII of the Social Security Act that are attributable to any rebates under section 1854(b)(1)(C) of such Act (42 U.S.C. 1395w–24(b)(1)(C)), as amended by section 222(b)(1) of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (Public Law 108–173);

(ii) include administrative expenditures made in carrying out title XVIII of the Social Security Act and Federal outlays under section 1935(b) of such Act, as added by section 103(a)(2) of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (Public Law 108–173); and

(iii) offset outlays by the amount of fraud and abuse collections insofar as they are applied or deposited into a medicare trust fund.

(E) MEDICARE TRUST FUND.—The term "medicare trust fund" means—

(i) the Federal Hospital Insurance Trust Fund established under section 1817 of the Social Security Act (42 U.S.C. 1395i); and

(ii) the Federal Supplementary Medical Insurance Trust Fund established under section 1841 of such Act (42 U.S.C. 1395t), including the Medicare Prescription Drug Account under such Trust Fund.

(4) CONFORMING AMENDMENTS.—

(A) FEDERAL HOSPITAL INSURANCE TRUST FUND.—The last sentence of section 1817(b)(2) (42 U.S.C. 1395i(b)(2)) is amended to read as follows: "Each report provided under paragraph (2) beginning with the report in 2010 shall include the information specified in section 314 of the Roadmap for America's Future Act of 2010.".

(B) FEDERAL SUPPLEMENTARY MEDICAL INSURANCE TRUST FUND.—The last sentence of section 1841(b)(2) (42 U.S.C. 1395t(b)(2)) is amended to read as follows: "Each report pro-

1 vided under paragraph (2) beginning with the
2 report in 2010 shall include the information
3 specified in section 314 of the Roadmap for
4 America's Future Act of 2010.''.

5 (5) NOTICE OF MEDICARE FUNDING WARN-
6 ING.—Whenever any report described in subsection
7 (a) contains a determination that for the previous
8 fiscal year reporting period there will be excess gen-
9 eral revenue medicare funding, Congress and the
10 President should address the matter under existing
11 rules and procedures.

12 (b) PRESIDENTIAL SUBMISSION OF LEGISLATION.—

13 (1) IN GENERAL.—Section 1105(h) of title 31,
14 United States Code, is amended to read as follows:

15 ''(h)(1) If there is a medicare funding warning under
16 section 314 of the Roadmap for America's Future Act of
17 2010 made in a year, the President shall submit to Con-
18 gress, within the 15-day period beginning on the date of
19 the budget submission to Congress under subsection (a)
20 for the succeeding year, proposed legislation to respond
21 to such warning.

22 ''(2) Paragraph (1) does not apply if, during the year
23 in which the warning is made, legislation is enacted which
24 eliminates excess general revenue medicare funding (as de-
25 fined in section 314 of the Roadmap for America's Future

1 Act of 2010) for the previous fiscal year, as certified by
2 the Board of Trustees of each medicare trust fund (as de-
3 fined in section 314 of such Act) not later than 30 days
4 after the date of the enactment of such legislation.''.

5 (2) SENSE OF CONGRESS.—It is the sense of
6 Congress that legislation submitted pursuant to sec-
7 tion 1105(h) of title 31, United States Code, in a
8 year should be designed to reduce payments by 1
9 percent for services furnished in Medicare's fee-for-
10 service sector for the fiscal year that begins in such
11 year.

12 (c) PROCEDURES IN THE HOUSE OF REPRESENTA-
13 TIVES.—

14 (1) INTRODUCTION AND REFERRAL OF PRESI-
15 DENT'S LEGISLATIVE PROPOSAL.—

16 (A) INTRODUCTION.—In the case of a leg-
17 islative proposal submitted by the President
18 pursuant to section 1105(h) of title 31, United
19 States Code, within the 15-day period specified
20 in paragraph (1) of such section, the majority
21 leader of the House of Representatives (or his
22 designee) and the minority leader of the House
23 of Representatives (or his designee) shall intro-
24 duce such proposal (by request), the title of
25 which is as follows: ''A bill to respond to a

medicare funding warning.''. Such bill shall be introduced within 3 legislative days after Congress receives such proposal.

(B) REFERRAL.—Any legislation introduced pursuant to paragraph (1) shall be referred to the appropriate committees of the House of Representatives.

(2) DIRECTION TO THE APPROPRIATE HOUSE COMMITTEES.—

(A) IN GENERAL.—In the House, in any year during which the President is required to submit proposed legislation to Congress under section 1105(h) of title 31, United States Code, the appropriate committees shall report medicare funding legislation by not later than June 30 of such year.

(B) MEDICARE FUNDING LEGISLATION.—For purposes of this section, the term ''medicare funding legislation'' means—

(i) legislation introduced pursuant to subsection (c)(1), but only if the legislative proposal upon which the legislation is based was submitted within the 15-day period referred to in such subsection; or

(ii) any bill the title of which is as follows: "A bill to respond to a medicare funding warning.".

(C) CERTIFICATION.—With respect to any medicare funding legislation or any amendment to such legislation to respond to a medicare funding warning, the chairman of the Committee on the Budget of the House shall certify—

(i) whether or not such legislation eliminates excess general revenue medicare funding (as defined in subsection (a)(3)) for the previous fiscal year; and

(ii) with respect to such an amendment, whether the legislation, as amended, would reduce payments by 1 percent for services furnished in Medicare's fee-for-service sector for the fiscal year that begins in such year.

(3) FALLBACK PROCEDURE FOR FLOOR CONSIDERATION IF THE HOUSE FAILS TO VOTE ON FINAL PASSAGE BY JULY 30.—

(A) After July 30 of any year during which the President is required to submit proposed legislation to Congress under section

1105(h) of title 31, United States Code, unless the House of Representatives has voted on final passage of any medicare funding legislation for which there is an affirmative certification under paragraph (2)(C)(i), then, after the expiration of not less than 30 calendar days (and concurrently 5 legislative days), it is in order to move to discharge any committee to which medicare funding legislation which has such a certification and which has been referred to such committee for 30 calendar days from further consideration of the legislation.

(B) A motion to discharge may be made only by an individual favoring the legislation, may be made only if supported by one-fifth of the total membership of the House (a quorum being present), and is highly privileged in the House. Debate thereon shall be limited to not more than one hour, the time to be divided in the House equally between those favoring and those opposing the motion. An amendment to the motion is not in order, and it is not in order to move to reconsider the vote by which the motion is agreed to or disagreed to.

(C) Only one motion to discharge a particular committee may be adopted under this subsection in any session of a Congress.

(D) Notwithstanding subparagraph (A), it shall not be in order to move to discharge a committee from further consideration of medicare funding legislation pursuant to this subsection during a session of a Congress if, during the previous session of the Congress, the House passed medicare funding legislation for which there is an affirmative certification under paragraph (2)(C)(i).

(4) FLOOR CONSIDERATION IN THE HOUSE OF DISCHARGED LEGISLATION.—

(A) In the House, not later than 3 legislative days after any committee has been discharged from further consideration of legislation under paragraph (3), the Speaker shall resolve the House into the Committee of the Whole for consideration of the legislation.

(B) The first reading of the legislation shall be dispensed with. All points of order against consideration of the legislation are waived. General debate shall be confined to the legislation and shall not exceed five hours,

which shall be divided equally between those favoring and those opposing the legislation. After general debate the legislation shall be considered for amendment under the five-minute rule. During consideration of the legislation, no amendments shall be in order in the House or in the Committee of the Whole except those for which there has been an affirmative certification under paragraph (2)(C)(ii). All points of order against consideration of any such amendment in the Committee of the Whole are waived. The legislation, together with any amendments which shall be in order, shall be considered as read. During the consideration of the bill for amendment, the Chairman of the Committee of the Whole may accord priority in recognition on the basis of whether the Member offering an amendment has caused it to be printed in the portion of the Congressional Record designated for that purpose in clause 8 of Rule XVIII of the Rules of the House of Representatives. Debate on any amendment shall not exceed one hour, which shall be divided equally between those favoring and those opposing the amendment, and no pro forma

amendments shall be offered during the debate. The total time for debate on all amendments shall not exceed 10 hours. At the conclusion of consideration of the legislation for amendment, the Committee shall rise and report the legislation to the House with such amendments as may have been adopted. The previous question shall be considered as ordered on the legislation and amendments thereto to final passage without intervening motion except one motion to recommit with or without instructions. If the Committee of the Whole rises and reports that it has come to no resolution on the bill, then on the next legislative day the House shall, immediately after the third daily order of business under clause 1 of Rule XIV of the Rules of the House of Representatives, resolve into the Committee of the Whole for further consideration of the bill.

(C) All appeals from the decisions of the Chair relating to the application of the Rules of the House of Representatives to the procedure relating to any such legislation shall be decided without debate.

(D) Except to the extent specifically provided in the preceding provisions of this subsection, consideration of any such legislation and amendments thereto (or any conference report thereon) shall be governed by the Rules of the House of Representatives applicable to other bills and resolutions, amendments, and conference reports in similar circumstances.

(5) LEGISLATIVE DAY DEFINED.—As used in this section, the term ''legislative day'' means a day on which the House of Representatives is in session.

(6) RESTRICTION ON WAIVER.—In the House, the provisions of this section may be waived only by a rule or order proposing only to waive such provisions.

(7) RULEMAKING POWER.—The provisions of this section are enacted by the Congress—

(A) as an exercise of the rulemaking power of the House of Representatives and, as such, shall be considered as part of the rules of that House and shall supersede other rules only to the extent that they are inconsistent therewith; and

(B) with full recognition of the constitutional right of that House to change the rules

(so far as they relate to the procedures of that House) at any time, in the same manner, and to the same extent as in the case of any other rule of that House.

(d) PROCEDURES IN THE SENATE.—

(1) INTRODUCTION AND REFERRAL OF PRESIDENT'S LEGISLATIVE PROPOSAL.—

(A) INTRODUCTION.—In the case of a legislative proposal submitted by the President pursuant to section 1105(h) of title 31, United States Code, within the 15-day period specified in paragraph (1) of such section, the majority leader and minority leader of the Senate (or their designees) shall introduce such proposal (by request), the title of which is as follows: ''A bill to respond to a medicare funding warning.''. Such bill shall be introduced within 3 days of session after Congress receives such proposal.

(B) REFERRAL.—Any legislation introduced pursuant to paragraph (1) shall be referred to the Committee on Finance.

(2) MEDICARE FUNDING LEGISLATION.—For purposes of this section, the term ''medicare funding legislation'' means—

(A) legislation introduced pursuant to subsection (d)(1), but only if the legislative proposal upon which the legislation is based was submitted within the 15-day period referred to in such subsection; or

(B) any bill the title of which is as follows: ''A bill to respond to a medicare funding warning.''.

(3) QUALIFICATION FOR SPECIAL PROCEDURES.—

(A) IN GENERAL.—The special procedures set forth in paragraphs (4) and (5) shall apply to medicare funding legislation, as described in paragraph (2), only if the legislation—

(i) is medicare funding legislation that is passed by the House of Representatives; or

(ii) contains matter within the jurisdiction of the Committee on Finance in the Senate.

(B) FAILURE TO QUALIFY FOR SPECIAL PROCEDURES.—If the medicare funding legislation does not satisfy subparagraph (A), then the legislation shall be considered under the or-

dinary procedures of the Standing Rules of the Senate.

(4) DISCHARGE.—

(A) IN GENERAL.—If the Committee on Finance has not reported medicare funding legislation described in subparagraph (3)(A) by June 30 of a year in which the President is required to submit medicare funding legislation to Congress under section 1105(h) of title 31, United States Code, then any Senator may move to discharge the Committee of any single medicare funding legislation measure. Only one such motion shall be in order in any session of Congress.

(B) DEBATE LIMITS.—Debate in the Senate on any such motion to discharge, and all appeals in connection therewith, shall be limited to not more than 2 hours. The time shall be equally divided between, and controlled by, the maker of the motion and the majority leader, or their designees, except that in the event the majority leader is in favor of such motion, the time in opposition thereto shall be controlled by the minority leader or the minority leader's designee. A point of order under this subsection

may be made at any time. It is not in order to move to proceed to another measure or matter while such motion (or the motion to reconsider such motion) is pending.

(C) AMENDMENTS.—No amendment to the motion to discharge shall be in order.

(D) EXCEPTION IF CERTIFIED LEGISLATION ENACTED.—Notwithstanding subparagraph (A), it shall not be in order to discharge the Committee from further consideration of medicare funding legislation pursuant to this subsection during a session of a Congress if the chairman of the Committee on the Budget of the Senate certifies that medicare funding legislation has been enacted that reduce payments by 1 percent for services furnished in Medicare's fee-for-service sector for the next fiscal year.

(5) CONSIDERATION.—After the date on which the Committee on Finance has reported medicare funding legislation described in paragraph (3)(A), or has been discharged (under paragraph (4)) from further consideration of, such legislation, it is in order (even though a previous motion to the same effect has been disagreed to) for any Member of the Sen-

ate to move to proceed to the consideration of such legislation.

(6) RULES OF THE SENATE.—This section is enacted by the Senate—

(A) as an exercise of the rulemaking power of the Senate and as such it is deemed a part of the rules of the Senate, but applicable only with respect to the procedure to be followed in the Senate in the case of a bill described in this paragraph, and it supersedes other rules only to the extent that it is inconsistent with such rules; and

(B) with full recognition of the constitutional right of the Senate to change the rules (so far as relating to the procedure of the Senate) at any time, in the same manner, and to the same extent as in the case of any other rule of the Senate.

SEC. 315. ELIMINATING INEFFICIENCIES AND INCREASING CHOICE IN MEDICARE ADVANTAGE.

(a) REIMBURSEMENT BENCHMARKS.—In implementing section 1853 of the Social Security Act (42 U.S.C. 1395w–23)—

(1) in calculating the benchmark amounts under subsection (k), the Secretary shall use the average amount of local plan bids; and

(2) in addition to the amounts under subsection (k), the Secretary may provide bonus payments to local plans that implement care coordination programs, as defined by the Secretary.

Subtitle C—Medical Liability Reform

PART 1—ENACTING REAL MEDICAL LIABILITY REFORM

SEC. 321. ENCOURAGING SPEEDY RESOLUTION OF CLAIMS.

(a) TIMING OF LAWSUIT.—The time for the 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.

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

(b) ACTIONS BY MINORS.—Actions by a minor shall be commenced within 3 years from the date of the alleged manifestation of injury except that actions by a minor under the full age of 6 years shall be commenced within 3 years of manifestation of injury or prior to the minor's 8th birthday, whichever provides a longer period. Such time limitation shall be tolled for minors for any period during which a parent or guardian and a health care provider or health care organization have committed fraud or collusion in the failure to bring an action on behalf of the injured minor.

SEC. 322. COMPENSATING PATIENT INJURY.

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

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

1 (c) NO DISCOUNT OF AWARD FOR NONECONOMIC
2 DAMAGES.—For purposes of applying the limitation in
3 subsection (b), future noneconomic damages shall not be
4 discounted to present value. The jury shall not be in-
5 formed about the maximum award for noneconomic dam-
6 ages. An award for noneconomic damages in excess of
7 $250,000 shall be reduced either before the entry of judg-
8 ment, or by amendment of the judgment after entry of
9 judgment, and such reduction shall be made before ac-
10 counting for any other reduction in damages required by
11 law. If separate awards are rendered for past and future
12 noneconomic damages and the combined awards exceed
13 $250,000, the future noneconomic damages shall be re-
14 duced first.

15 (d) FAIR SHARE RULE.—In any health care lawsuit,
16 each party shall be liable for that party's several share
17 of any damages only and not for the share of any other
18 person. Each party shall be liable only for the amount of
19 damages allocated to such party in direct proportion to
20 such party's percentage of responsibility. Whenever a
21 judgment of liability is rendered as to any party, a sepa-
22 rate judgment shall be rendered against each such party
23 for the amount allocated to such party. For purposes of
24 this section, the trier of fact shall determine the propor-

1 tion of responsibility of each party for the claimant's
2 harm.

3 **SEC. 323. MAXIMIZING PATIENT RECOVERY.**

4 (a) COURT SUPERVISION OF SHARE OF DAMAGES
5 ACTUALLY PAID TO CLAIMANTS.—In any health care law-
6 suit, the court shall supervise the arrangements for pay-
7 ment of damages to protect against conflicts of interest
8 that may have the effect of reducing the amount of dam-
9 ages awarded that are actually paid to claimants. In par-
10 ticular, in any health care lawsuit in which the attorney
11 for a party claims a financial stake in the outcome by vir-
12 tue of a contingent fee, the court shall have the power
13 to restrict the payment of a claimant's damage recovery
14 to such attorney, and to redirect such damages to the
15 claimant based upon the interests of justice and principles
16 of equity. In no event shall the total of all contingent fees
17 for representing all claimants in a health care lawsuit ex-
18 ceed the following limits:

19 (1) 40 percent of the first $50,000 recovered by
20 the claimant(s).

21 (2) 33⅓ percent of the next $50,000 recovered
22 by the claimant(s).

23 (3) 25 percent of the next $500,000 recovered
24 by the claimant(s).

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

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

SEC. 324. ADDITIONAL HEALTH BENEFITS.

In any health care lawsuit involving injury or wrongful death, any party may introduce evidence of collateral source benefits. If a party elects to introduce such evidence, any opposing party may introduce evidence of any amount paid or contributed or reasonably likely to be paid or contributed in the future by or on behalf of the opposing party to secure the right to such collateral source benefits. No provider of collateral source benefits shall recover any amount against the claimant or receive any lien or credit against the claimant's recovery or be equitably or legally subrogated to the right of the claimant in a health care lawsuit involving injury or wrongful death. This section shall apply to any health care lawsuit that is settled

as well as a health care lawsuit that is resolved by a fact finder. This section shall not apply to section 1862(b) (42 U.S.C. 1395y(b)) or section 1902(a)(25) (42 U.S.C. 1396a(a)(25)) of the Social Security Act.

SEC. 325. 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 substantially 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 re-

1 quest of any party in a health care lawsuit, the trier of
2 fact shall consider in a separate proceeding—
3 (1) whether punitive damages are to be award-
4 ed and the amount of such award; and
5 (2) the amount of punitive damages following a
6 determination of punitive liability.
7 (b) SEPARATE PROCEEDING.—If a separate pro-
8 ceeding is requested, evidence relevant only to the claim
9 for punitive damages, as determined by applicable State
10 law, shall be inadmissible in any proceeding to determine
11 whether compensatory damages are to be awarded.
12 (c) DETERMINING AMOUNT OF PUNITIVE DAM-
13 AGES.—
14 (1) FACTORS CONSIDERED.—In determining
15 the amount of punitive damages, if awarded, in a
16 health care lawsuit, the trier of fact shall consider
17 only the following—
18 (A) the severity of the harm caused by the
19 conduct of such party;
20 (B) the duration of the conduct or any
21 concealment of it by such party;
22 (C) the profitability of the conduct to such
23 party;
24 (D) the number of products sold or med-
25 ical 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, whichever is greater. The jury shall not be informed of this limitation.

SEC. 326. 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 part.

SEC. 327. DEFINITIONS.

In this part:

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

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

(3) COLLATERAL SOURCE BENEFITS.—The term ''collateral source benefits'' means any amount

1 paid or reasonably likely to be paid in the future to
2 or on behalf of the claimant, or any service, product,
3 or other benefit provided or reasonably likely to be
4 provided in the future to or on behalf of the claim-
5 ant, as a result of the injury or wrongful death, pur-
6 suant to—
7 (A) any State or Federal health, sickness,
8 income-disability, accident, or workers' com-
9 pensation law;
10 (B) any health, sickness, income-disability,
11 or accident insurance that provides health bene-
12 fits or income-disability coverage;
13 (C) any contract or agreement of any
14 group, organization, partnership, or corporation
15 to provide, pay for, or reimburse the cost of
16 medical, hospital, dental, or income-disability
17 benefits; and
18 (D) any other publicly or privately funded
19 program.
20 (4) COMPENSATORY DAMAGES.—The term
21 ''compensatory damages'' means objectively
22 verifiable monetary losses incurred as a result of the
23 provision of, use of, or payment for (or failure to
24 provide, use, or pay for) health care services or med-
25 ical products, such as past and future medical ex-

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

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

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

1 loss of employment, and loss of business or employ-
2 ment opportunities.

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

24 (8) HEALTH CARE LIABILITY ACTION.—The
25 term ''health care liability action'' means a civil ac-

1 tion brought in a State or Federal court or pursuant
2 to an alternative dispute resolution system, against
3 a health care provider, a health care organization, or
4 the manufacturer, distributor, supplier, marketer,
5 promoter, or seller of a medical product, regardless
6 of the theory of liability on which the claim is based,
7 or the number of plaintiffs, defendants, or other par-
8 ties, or the number of causes of action, in which the
9 claimant alleges a health care liability claim.

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

24 (10) HEALTH CARE ORGANIZATION.—The term
25 ''health care organization'' means any person or en-

1 tity which is obligated to provide or pay for health
2 benefits under any health plan, including any person
3 or entity acting under a contract or arrangement
4 with a health care organization to provide or admin-
5 ister any health benefit.

6 (11) HEALTH CARE PROVIDER.—The term
7 ''health care provider'' means any person or entity
8 required by State or Federal laws or regulations to
9 be licensed, registered, or certified to provide health
10 care services, and being either so licensed, reg-
11 istered, or certified, or exempted from such require-
12 ment by other statute or regulation.

13 (12) HEALTH CARE GOODS OR SERVICES.—The
14 term ''health care goods or services'' means any
15 goods or services provided by a health care organiza-
16 tion, provider, or by any individual working under
17 the supervision of a health care provider, that relates
18 to the diagnosis, prevention, or treatment of any
19 human disease or impairment, or the assessment or
20 care of the health of human beings.

21 (13) MALICIOUS INTENT TO INJURE.—The
22 term ''malicious intent to injure'' means inten-
23 tionally causing or attempting to cause physical in-
24 jury other than providing health care goods or serv-
25 ices.

1 (14) MEDICAL PRODUCT.—The term ''medical
2 product'' means a drug, device, or biological product
3 intended for humans, and the terms ''drug'', ''de-
4 vice'', and ''biological product'' have the meanings
5 given such terms in sections 201(g)(1) and 201(h)
6 of the Federal Food, Drug and Cosmetic Act (21
7 U.S.C. 321(g)(1) and (h)) and section 351(a) of the
8 Public Health Service Act (42 U.S.C. 262(a)), re-
9 spectively, including any component or raw material
10 used therein, but excluding health care services.
11 (15) NONECONOMIC DAMAGES.—The term
12 ''noneconomic damages'' means damages for phys-
13 ical and emotional pain, suffering, inconvenience,
14 physical impairment, mental anguish, disfigurement,
15 loss of enjoyment of life, loss of society and compan-
16 ionship, loss of consortium (other than loss of do-
17 mestic service), hedonic damages, injury to reputa-
18 tion, and all other nonpecuniary losses of any kind
19 or nature.
20 (16) PUNITIVE DAMAGES.—The term ''punitive
21 damages'' means damages awarded, for the purpose
22 of punishment or deterrence, and not solely for com-
23 pensatory purposes, against a health care provider,
24 health care organization, or a manufacturer, dis-
25 tributor, or supplier of a medical product. Punitive

damages are neither economic nor noneconomic damages.

(17) RECOVERY.—The term ''recovery'' means the net sum recovered after deducting any disbursements or costs incurred in connection with prosecution or settlement of the claim, including all costs paid or advanced by any person. Costs of health care incurred by the plaintiff and the attorneys' office overhead costs or charges for legal services are not deductible disbursements or costs for such purpose.

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

SEC. 328. EFFECT ON OTHER LAWS.

(a) VACCINE INJURY.—

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

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

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

(2) APPLICATION.—If there is an aspect of a civil action brought for a vaccine-related injury or death to which a Federal rule of law under title XXI of the Public Health Service Act does not apply, then this part or otherwise applicable law (as determined under this part) will apply to such aspect of such action.

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

SEC. 329. STATE FLEXIBILITY AND PROTECTION OF STATES' RIGHTS.

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

1 (1) provides for a greater amount of damages
2 or contingent fees, a longer period in which a health
3 care lawsuit may be commenced, or a reduced appli-
4 cability or scope of periodic payment of future dam-
5 ages, than provided in this part; or
6 (2) prohibits the introduction of evidence re-
7 garding collateral source benefits, or mandates or
8 permits subrogation or a lien on collateral source
9 benefits.
10 (b) PROTECTION OF STATES' RIGHTS AND OTHER
11 LAWS.—
12 (1) IN GENERAL.—Any issue that is not gov-
13 erned by any provision of law established by or
14 under this part (including State standards of neg-
15 ligence) shall be governed by otherwise applicable
16 State or Federal law.
17 (2) PREEMPTION.—This part shall not preempt
18 or supersede any State or Federal law that imposes
19 greater procedural or substantive protections for
20 health care providers and health care organizations
21 from liability, loss, or damages than those provided
22 by this part or create a cause of action.
23 (c) STATE FLEXIBILITY.—No provision of this part
24 shall be construed to preempt—

(1) any State law (whether effective before, on, or after the date of the enactment of this Act) that specifies a particular monetary amount of compensatory or punitive damages (or the total amount of damages) that may be awarded in a health care lawsuit, regardless of whether such monetary amount is greater or lesser than is provided for under this part, notwithstanding section 323(a); or

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

SEC. 330. APPLICABILITY; EFFECTIVE DATE.

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

PART 2—ENDING LAWSUIT ABUSE

SEC. 331. STATE GRANTS TO CREATE HEALTH COURT SOLUTIONS.

Part P of title III of the Public Health Service Act (42 U.S.C. 280g et seq.) is amended by adding at the end the following:

"SEC. 399R. STATE GRANTS TO CREATE HEALTH COURT SOLUTIONS.

"(a) IN GENERAL.—The Secretary may award grants to States for the development, implementation, and evaluation of alternatives to current tort litigation that comply with this section, for the resolution of disputes concerning injuries allegedly caused by health care providers or health care organizations.

"(b) CONDITIONS FOR DEMONSTRATION GRANTS.—

"(1) APPLICATION.—To be eligible to receive a grant under this section, a State shall submit to the Secretary an application at such time, in such manner, and containing such information as may be required by the Secretary. A grant shall be awarded under this section on such terms and conditions as the Secretary determines appropriate.

"(2) STATE REQUIREMENTS.—To be eligible to receive a grant under this section, a State shall—

"(A) develop and implement an alternative to current tort litigation for resolving disputes

over injuries allegedly caused by health care providers or health care organizations based on one or more of the models described in subsection (d); and

"(B) implement policies that provide for a reduction in health care errors through the collection and analysis by organizations that engage in voluntary efforts to improve patient safety and the quality of health care delivery, of patient safety data related to disputes resolved under the alternatives under subparagraph (A).

"(3) DEMONSTRATION OF EFFECTIVENESS.—To be eligible to receive a grant under subsection (a), a State shall demonstrate how the proposed alternative to be implemented under paragraph (2)(A) will—

"(A) make the medical liability system of the State more reliable through the prompt and fair resolution of disputes;

"(B) encourage the early disclosure of health care errors;

"(C) enhance patient safety; and

"(D) maintain access to medical liability insurance.

"(4) SOURCES OF COMPENSATION.—To be eligible to receive a grant under subsection (a), a State shall identify the sources from, and methods by which, compensation would be paid for medical liability claims resolved under the proposed alternative to current tort litigation implemented under paragraph (2)(A). Funding methods shall, to the extent practicable, provide financial incentives for activities that improve patient safety.

"(5) SCOPE.—

"(A) IN GENERAL.—To be eligible to receive a grant under subsection (a), a State shall utilize the proposed alternative identified under paragraph (2)(A) for the resolution of all types of disputes concerning injuries allegedly caused by health care providers or health care organizations.

"(B) CURRENT STATE EFFORTS TO ESTABLISH ALTERNATIVE TO TORT LITIGATION.—

"(i) IN GENERAL.—Nothing in this section shall be construed to limit the efforts that any State has made prior to the date of enactment of this section to establish any alternative to tort litigation.

1 "(ii) ALTERNATIVE FOR PRACTICE
2 AREAS OR INJURIES.—In the case of a
3 State that has established an alternative to
4 tort litigation for a certain area of health
5 care practice or a category of injuries, the
6 alternative selected as provided for in this
7 section shall supplement not replace or in-
8 validate such established alternative unless
9 the State intends otherwise.
10 "(6) NOTIFICATION OF PATIENTS.—To be eligi-
11 ble to receive a grant under subsection (a), the State
12 shall demonstrate how patients will be notified when
13 they are receiving health care services that fall with-
14 in the scope of the alternative selected under this
15 section by the State to current tort litigation.
16 "(c) REPRESENTATION BY COUNSEL.—A State that
17 receives a grant under this section may not preclude any
18 party to a dispute that falls within the jurisdiction of the
19 alternative to current tort litigation that is implemented
20 under the grant from obtaining legal representation at any
21 point during the consideration of the claim under such al-
22 ternative.
23 "(d) MODELS.—
24 "(1) IN GENERAL.—The models in this section
25 are the following:

1 "(2) EXPERT PANEL REVIEW AND EARLY
2 OFFER GUIDELINES.—
3 "(A) IN GENERAL.—A State may use
4 amounts received under a grant under this sec-
5 tion to develop and implement an expert panel
6 and early offer review system that meets the re-
7 quirements of this paragraph.
8 "(B) ESTABLISHMENT OF PANEL.—Under
9 the system under this paragraph, the State
10 shall establish an expert panel to review any
11 disputes concerning injuries allegedly caused by
12 health care providers or health care organiza-
13 tions according to the guidelines described in
14 this paragraph.
15 "(C) COMPOSITION.—
16 "(i) IN GENERAL.—An expert panel
17 under this paragraph shall be composed of
18 3 medical experts (either physicians or
19 health care professionals) and 3 attorneys
20 to be appointed by the head of the State
21 agency responsible for health.
22 "(ii) LICENSURE AND EXPERTISE.—
23 Each physician or health care professional
24 appointed to an expert panel under clause
25 (i) shall—

1 "(I) be appropriately credentialed
2 or licensed in the State in which the
3 dispute takes place to deliver health
4 care services; and
5 "(II) typically treat the condi-
6 tion, make the diagnosis, or provide
7 the type of treatment that is under re-
8 view.
9 "(iii) INDEPENDENCE.—
10 "(I) IN GENERAL.—Subject to
11 subclause (II), each individual ap-
12 pointed to an expert panel under this
13 paragraph shall—
14 "(aa) not have a material
15 familial, financial, or professional
16 relationship with a party involved
17 in the dispute reviewed by the
18 panel; and
19 "(bb) not otherwise have a
20 conflict of interest with such a
21 party.
22 "(II) EXCEPTION.—Nothing in
23 subclause (I) shall be construed to
24 prohibit an individual who has staff
25 privileges at an institution where the

1 treatment involved in the dispute was
2 provided from serving as a member of
3 an expert panel merely on the basis of
4 such affiliation, if the affiliation is
5 disclosed to the parties and neither
6 party objects.
7 ''(iv) PRACTICING HEALTH CARE PRO-
8 FESSIONAL IN SAME FIELD.—
9 ''(I) IN GENERAL.—In a dispute
10 before an expert panel that involves
11 treatment, or the provision of items or
12 services—
13 ''(aa) by a physician, the
14 medical experts on the expert
15 panel shall be practicing physi-
16 cians (allopathic or osteopathic)
17 of the same or similar specialty
18 as a physician who typically
19 treats the condition, makes the
20 diagnosis, or provides the type of
21 treatment under review; or
22 ''(bb) by a health care pro-
23 fessional other than a physician,
24 at least two medical experts on
25 the expert panel shall be prac-

1 ticing physicians (allopathic or
2 osteopathic) of the same or simi-
3 lar specialty as the health care
4 professional who typically treats
5 the condition, makes the diag-
6 nosis, or provides the type of
7 treatment under review, and, if
8 determined appropriate by the
9 State agency, the third medical
10 expert shall be a practicing
11 health care professional (other
12 than such a physician) of such a
13 same or similar specialty.
14 ''(II) PRACTICING DEFINED.—In
15 this paragraph, the term 'practicing'
16 means, with respect to an individual
17 who is a physician or other health
18 care professional, that the individual
19 provides health care services to indi-
20 vidual patients on average at least 2
21 days a week.
22 ''(v) PEDIATRIC EXPERTISE.—In the
23 case of dispute relating to a child, at least
24 1 medical expert on the expert panel shall

have expertise described in clause (iv)(I) in pediatrics.

"(D) DETERMINATION.—After a review, an expert panel shall make a determination as to the liability of the parties involved and compensation based on a schedule of compensation that is developed by the panel. Such a schedule shall at least include—

"(i) payment for the net economic loss incurred by the patient, on a periodic basis, reduced by any payments received by the patient under—

"(I) any health or accident insurance;

"(II) any wage or salary continuation plan; or

"(III) any disability income insurance;

"(ii) payment for the non-economic damages incurred by the patient, if appropriate for the injury, based on a defined payment schedule developed by the State, in consultation with relevant experts and with the Secretary;

"(iii) reasonable attorney's fees; and

"(iv) regular updates of the schedule under clause (ii) as necessary.

"(E) ACCEPTANCE.—If the parties to a dispute who come before an expert panel under this paragraph accept the determination of the expert panel concerning liability and compensation, such compensation shall be paid to the claimant and the claimant shall agree to forgo any further action against the health care providers or health care organizations involved.

"(F) FAILURE TO ACCEPT.—If any party decides not to accept the expert panel's determination under this paragraph, the State may choose whether to allow the panel to review the determination de novo, with deference, or to provide an opportunity for parties to reject the determination of the panel.

"(G) REVIEW BY STATE COURT AFTER EXHAUSTION OF ADMINISTRATIVE REMEDIES.—

"(i) RIGHT TO FILE.—If the State elects not to permit the expert panel under this paragraph to conduct its own reviews of determinations, or if the State elects to permit such reviews but a party is not satisfied with the final decision of the panel

after such a review, the party shall have the right to file a claim relating to the injury involved in a State court of competent jurisdiction.

"(ii) FORFEIT OF AWARDS.—Any party filing an action in a State court under clause (i) shall forfeit any compensation award made under subparagraph (C).

"(iii) ADMISSIBILITY.—The determinations of the expert panel pursuant to a review under subparagraph (C) shall be admissible into evidence in any State court proceeding under this subparagraph.

"(3) ADMINISTRATIVE HEALTH CARE TRIBUNALS.—

"(A) IN GENERAL.—A State may use amounts received under a grant under this section to develop and implement an administrative health care tribunal system under which the parties involved shall have the right to request a hearing to review any dispute concerning injuries allegedly caused by health care providers or health care organizations before an administrative health care tribunal established by the State involved.

1 "(B) REQUIREMENTS.—In establishing an
2 administrative health care tribunal under this
3 paragraph, a State shall—
4 "(i) ensure that such tribunals are
5 presided over by special judges with health
6 care expertise who meet applicable State
7 standards for judges and who agree to pre-
8 side over such court voluntarily;
9 "(ii) provide authority to such judges
10 to make binding rulings, rendered in writ-
11 ten decisions, on standards of care, causa-
12 tion, compensation, and related issues with
13 reliance on independent expert witnesses
14 commissioned by the tribunal;
15 "(iii) establish a legal standard for
16 the tribunal that shall be the same as the
17 standard that would apply in the State
18 court of competent jurisdiction which
19 would otherwise handle the claim; and
20 "(iv) provide for an appeals process to
21 allow for review of decisions by State
22 courts.
23 "(C) DETERMINATION.—After a tribunal
24 conducts a review under this paragraph, the tri-
25 bunal shall make a determination as to the li-

ability of the parties involved and the amount of compensation that should be paid based on a schedule of compensation developed by the tribunal. Such a schedule shall at a minimum include—

"(i) payment for the net economic loss incurred by the patient, on a periodic basis, reduced by any payments received by the patient under—

"(I) any health or accident insurance;

"(II) any wage or salary continuation plan; or

"(III) any disability income insurance;

"(ii) payment for the non-economic damages incurred by the patient, if appropriate for the injury, based on a defined payment schedule developed by the State in consultation with relevant experts and with the Secretary;

"(iii) reasonable attorney's fees; and

"(iv) regular updates of the schedule under clause (ii) as necessary.

1 "(D) REVIEW BY STATE COURT AFTER EX-
2 HAUSTION OF ADMINISTRATIVE REMEDIES.—
3 "(i) RIGHT TO FILE.—Nothing in this
4 paragraph shall be construed to prohibit
5 any individual who is not satisfied with the
6 determinations of a tribunal under this
7 paragraph, from filing a claim for the in-
8 jury involved in a State court of competent
9 jurisdiction.
10 "(ii) FORFEIT OF AWARD.—Any party
11 filing an action in a State court under
12 clause (i) shall forfeit any compensation
13 award made under subparagraph (C).
14 "(iii) ADMISSIBILITY.—The deter-
15 minations of the tribunal under subpara-
16 graph (C) shall be admissible into evidence
17 in any State court proceeding under this
18 subparagraph.
19 "(4) EXPERT PANEL REVIEW AND ADMINISTRA-
20 TIVE HEALTH CARE TRIBUNAL COMBINATION
21 MODEL.—
22 "(A) IN GENERAL.—A State may use
23 amounts received under a grant under this sec-
24 tion to develop and implement an expert panel
25 review and administrative health care tribunal

combination system to review any dispute concerning injuries allegedly caused by health care providers or health care organizations. Under such system, a dispute concerning injuries allegedly caused by health care providers or health care organizations shall proceed through the procedures described in this subparagraph prior to the submission of such dispute to a State court.

"(B) GENERAL PROCEDURE.—

"(i) ESTABLISHMENT OF EXPERT PANEL.—Prior to submitting any dispute described in subparagraph (A) to an administrative health care tribunal under the system established under this paragraph, the State shall establish an expert panel (in accordance with subparagraph (C)) to review the allegations involved in such dispute.

"(ii) REFERRAL TO TRIBUNAL.—If either party to a dispute described in clause (i) fails to accept the determination of the expert panel, the dispute shall then be referred to an administrative health care tri-

1 bunal (in accordance with subparagraph
2 (D).
3 "(C) EXPERT REVIEW PANEL.—
4 "(i) IN GENERAL.—The provisions of
5 paragraph (2) shall apply with respect to
6 the establishment and operation of an ex-
7 pert review panel under this subparagraph,
8 except that the subparagraphs (F) and (G)
9 of such paragraph shall not apply.
10 "(ii) FAILURE TO ACCEPT DETER-
11 MINATION OF PANEL.—If any party to a
12 dispute before an expert panel under this
13 subparagraph refuses to accept the panel's
14 determination, the dispute shall be referred
15 to an administrative health care tribunal
16 under subparagraph (D).
17 "(D) ADMINISTRATIVE HEALTH CARE TRI-
18 BUNALS.—
19 "(i) IN GENERAL.—Upon the failure
20 of any party to accept the determination of
21 an expert panel under subparagraph (C),
22 the parties shall request a hearing con-
23 cerning the liability or compensation in-
24 volved by an administrative health care tri-

1 bunal established by the State involved
2 under this subparagraph.
3 "(ii) REQUIREMENTS.—The provisions
4 of paragraph (3) shall apply with respect
5 to the establishment and operation of an
6 administrative health care tribunal under
7 this subparagraph.
8 "(iii) FORFEIT OF AWARDS.—Any
9 party proceeding to the second step-admin-
10 istrative health care tribunal-under this
11 model shall forfeit any compensation
12 awarded by the expert panel.
13 "(iv) ADMISSIBILITY.—The deter-
14 minations of the expert panel under sub-
15 paragraph (C) shall be admissible into evi-
16 dence in any administrative health care tri-
17 bunal proceeding under this subparagraph.
18 "(E) RIGHT TO FILE.—Nothing in this
19 paragraph shall be construed to prohibit any in-
20 dividual who is not satisfied with the deter-
21 mination of the tribunal (after having proceeded
22 through both the expert panel under subpara-
23 graph (C) and the tribunal under subparagraph
24 (D)) from filing a claim for the injury involved
25 in a State court of competent jurisdiction.

"(F) ADMISSIBILITY.—The determinations of both the expert panel and the tribunal under this paragraph shall be admissible into evidence in any State court proceeding under this paragraph.

"(G) FORFEIT OF AWARDS.—Any party filing an action in State court under subparagraph (E) shall forfeit any compensation award made by both the expert panel and the administrative health care tribunal under this paragraph.

"(e) DEFINITIONS.—In this section:

"(1) CURRENT TORT LITIGATION.—The term 'current tort litigation' means the tort litigation system existing in the State on the date on which the State submits an application under subsection (b)(1), for the resolution of disputes concerning injuries allegedly caused by health care providers or health care organizations.

"(2) HEALTH CARE ORGANIZATION.—The term 'health care organization' means any individual or entity that is obligated to provide, pay for, or administer health benefits under any health plan.

"(3) NET ECONOMIC LOSS.—The term 'net economic loss' means—

"(A) reasonable expenses incurred for products, services and accommodations needed for health care, training and other remedial treatment and care of an injured individual;

"(B) reasonable and appropriate expenses for rehabilitation treatment and occupational training;

"(C) 100 percent of the loss of income from work that an injured individual would have performed if not injured, reduced by any income from substitute work actually performed; and

"(D) reasonable expenses incurred in obtaining ordinary and necessary services to replace services an injured individual would have performed for the benefit of the individual or the family of such individual if the individual had not been injured.

"(4) NON-ECONOMIC DAMAGES.—The term 'non-economic damages' means losses for physical and emotional pain, suffering, inconvenience, physical impairment, mental anguish, disfigurement, loss of enjoyment of life, loss of society and companionship, loss of consortium (other than loss of domestic service), injury to reputation, and all other non-pe-

1 cuniary losses of any kind or nature, to the extent
2 permitted under State law.
3 "(f) FUNDING.—
4 "(1) ONE-TIME INCREASE IN MEDICAID PAY-
5 MENT.—In the case of a State awarded a grant to
6 carry out this section, the total amount of the Fed-
7 eral payment determined for the State under section
8 1913 of the Social Security Act (as amended by sec-
9 tion 401) for fiscal year 2011 (in addition to the any
10 increase applicable for that fiscal year under section
11 203(b) but determined without regard to any such
12 increase) shall be increased by an amount equal to
13 1 percent of the total amount of payments made to
14 the State for fiscal year 2010 under section 1903(a)
15 of the Social Security Act (42 U.S.C. 1396b(a)) for
16 purposes of carrying out a grant awarded under this
17 section. Amounts paid to a State pursuant to this
18 subsection shall remain available until expended.
19 "(2) AUTHORIZATION OF APPROPRIATIONS.—
20 There are authorized to be appropriated for any fis-
21 cal year such sums as may be necessary for purposes
22 of making payments to States pursuant to para-
23 graph (1).".

TITLE IV—SOCIAL SECURITY REFORM

SEC. 401. SHORT TITLE.

This title may be cited as the ''Social Security Personal Savings Guarantee and Prosperity Act of 2010''.

SEC. 402. ESTABLISHMENT OF PERSONAL SOCIAL SECURITY SAVINGS PROGRAM.

(a) IN GENERAL.—Title II of the Social Security Act is amended—

(1) by inserting before section 201 the following:

"PART A—INSURANCE BENEFITS";

and

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

"PART B—PERSONAL SOCIAL SECURITY SAVINGS PROGRAM

"SEC. 251. DEFINITIONS.

''For purposes of this part—

''(1) PARTICIPATING INDIVIDUAL.—The term 'participating individual' has the meaning provided in section 253(a).

''(2) BOARD.—The term 'Board' means the Personal Social Security Savings Board established under section 260.

"(3) EXECUTIVE DIRECTOR.—The term 'Executive Director' means the Executive Director appointed under section 261.

"(4) PERSONAL SOCIAL SECURITY SAVINGS ACCOUNT.—The term 'personal social security savings account' means an account established under section 254(a).

"(5) PERSONAL SOCIAL SECURITY SAVINGS ANNUITY.—The term 'personal social security savings annuity' means an annuity approved by the Board under section 258(b)(3).

"(6) SAVINGS FUND.—The term 'Savings Fund' means the Social Security Personal Savings Fund established under section 252.

"(7) TIER I INVESTMENT FUND.—The term 'Tier I Investment Fund' means the trust fund created under section 255.

"(8) TIER II INVESTMENT FUND.—The term 'Tier II Investment Fund' means the trust fund created under section 256.

"(9) TIER III INVESTMENT OPTION.—The term 'Tier III Investment Option' means an investment option which is—

"(A) offered by an eligible entity certified by the Board under section 257(b); and

"(B) approved by the Board under section 257(c).

"SEC. 252. SOCIAL SECURITY PERSONAL SAVINGS FUND.

"(a) ESTABLISHMENT OF SAVINGS FUND.—

"(1) ESTABLISHMENT.—There is established in the Treasury of the United States a trust fund to be known as the 'Social Security Personal Savings Fund'.

"(2) AMOUNTS IN FUND.—The Savings Fund shall consist of—

"(A) all amounts transferred to or deposited into the Savings Fund under subsection (b), increased by the total net earnings from investments of sums in the Savings Fund attributable to such transferred or deposited amounts, and reduced by the total net losses from investments of such sums, and

"(B) the reserves held in the Annuity Reserves Account established under section 258(b)(3), increased by the total net earnings from investments of such reserves, and reduced by the total net losses from investments of such reserves.

"(3) TRUSTEES.—The Board shall serve as trustees of the Savings Fund.

"(4) BUDGET AUTHORITY; APPROPRIATION.—This part constitutes budget authority in advance of appropriations Acts and represents the obligation of the Board to provide for the payment of amounts provided under this part. The amounts held in the Savings Fund are appropriated and shall remain available without fiscal year limitation.

"(b) DEPOSITS INTO FUND.—

"(1) IN GENERAL.—During each calendar year, the Secretary of the Treasury shall deposit into the Savings Fund, from amounts held in the Federal Old-Age and Survivors Insurance Trust Fund, a total amount equal, in the aggregate, to 100 percent of the redirected Social Security contribution for such calendar year of each individual who is a participating individual for such calendar year.

"(2) TRANSFERS BASED ON ESTIMATES.—

"(A) IN GENERAL.—The amounts deposited pursuant to paragraph (1) shall be transferred in at least weekly payments from the Federal Old-Age and Survivors Insurance Trust Fund to the Savings Fund.

"(B) DETERMINATION OF AMOUNTS.—The amounts transferred under subparagraph (A) shall be determined on the basis of estimates,

made by the Commissioner of Social Security and certified to the Secretary of the Treasury, of the wages paid to, and self-employment income derived by, participating individuals. Proper adjustments shall be made in amounts subsequently transferred to the extent prior estimates were in excess of or were less than actual amounts transferred.

"(3) REDIRECTED SOCIAL SECURITY CONTRIBUTIONS.—For purposes of paragraph (1)—

"(A) IN GENERAL.—The term 'redirected social security contributions' means, with respect to an individual for a calendar year, the sum of—

"(i) the product derived by multiplying—

"(I) the sum of the total wages paid to, and self-employment income derived by, such individual during such calendar year, to the extent such total wages and self-employment income do not exceed the base amount for such calendar year; by

"(II) the applicable base percentage for the calendar year; and

"(ii) the product derived by multiplying—

"(I) the sum of the total wages paid to, and self-employment income derived by, such individual during such calendar year, to the extent such total wages and self-employment income exceed the base amount (taking into account the limits imposed by the contribution and benefit base under section 230); by

"(II) the applicable supplemental percentage for the calendar year.

"(B) BASE AMOUNT.—For purposes of subparagraph (A)—

"(i) INITIAL BASE AMOUNT.—The base amount for calendar year 2012 is $10,000.

"(ii) ADJUSTMENTS TO BASE AMOUNT.—The base amount for any calendar year after 2011 is the product derived by multiplying $10,000 by a fraction—

"(I) the numerator of which is the national average wage index (as

defined in section 209(k)) for the first of the 2 preceding calendar years; and

"(II) the denominator of which is the national average wage index (as so defined) for 2010.

"(C) APPLICABLE BASE PERCENTAGE.—For purposes of subparagraph (A), the applicable base percentage for a calendar year is—

"(i) for calendar years after 2011 and before 2022, 2 percent;

"(ii) for calendar years after 2021 and before 2032, 4 percent;

"(iii) for calendar years after 2031 and before 2042, 6 percent; and

"(iv) for calendar years after 2041, 8 percent.

"(D) APPLICABLE SUPPLEMENTAL PERCENTAGE.—For purposes of subparagraph (A), the applicable supplemental percentage for a calendar year is—

"(i) for calendar years after 2011 and before 2022, 1 percent;

"(ii) for calendar years after 2021 and before 2032, 2 percent;

"(iii) for calendar years after 2031 and before 2042, 3 percent; and

"(iv) for calendar years after 2041, 4 percent.

"(c) AVAILABILITY.—The sums in the Savings Fund are appropriated and shall remain available without fiscal year limitation—

"(1) to invest funds in the Tier I Investment Fund of the Savings Fund and the Tier II Investment Fund of the Savings Fund under sections 255 and 256, respectively;

"(2) to transfer into Tier III Investment Options under section 257;

"(3) to make distributions in accordance with section 258; and

"(4) to pay the administrative expenses of the Board in accordance with subsection (e).

"(d) LIMITATIONS ON USE OF FUNDS.—

"(1) IN GENERAL.—Sums in the Savings Fund credited to a participating individual's personal social security savings account may not be used for, or diverted to, purposes other than for the exclusive benefit of the participating individual or the participating individual's beneficiaries under this part.

"(2) ASSIGNMENTS.—Sums in the Savings Fund may not be assigned or alienated and are not subject to execution, levy, attachment, garnishment, or other legal process.

"(e) PAYMENT OF ADMINISTRATIVE EXPENSES.—Administrative expenses incurred to carry out this part shall be paid out of net earnings in the Savings Fund in conjunction with the allocation of investment earnings and losses under section 254(c).

"(f) LIMITATION.—The sums in the Savings Fund shall not be appropriated for any purpose other than the purposes specified in this part and may not be used for any other purpose.

"SEC. 253. PARTICIPATION IN PROGRAM.

"(a) PARTICIPATING INDIVIDUAL.—For purposes of this part, the term 'participating individual' means any individual—

"(1)(A) who receives wages in any calendar year after December 31, 2011, on which there is imposed a tax under section 3101(a) of the Internal Revenue Code of 1986, or

"(B) who derives self-employment income for a taxable year beginning after December 31, 2011, on which there is imposed a tax under section 1401(a) of the Internal Revenue Code of 1986,

"(2) who is born on or after January 1, 1956, and

"(3) who has filed an election to be treated as a participating individual under subsection (b) and has not subsequently filed an election to renounce such individual's status as a participating individual under subsection (c).

"(b) ELECTION OF PARTICIPATION.—

"(1) IN GENERAL.—An individual who has not become entitled to old-age insurance benefits under section 202(a) may elect, subject to paragraph (2) and in such form and manner as shall be prescribed in regulations of the Board, to be treated as a 'participating individual' for purposes of this part. Such regulations shall provide for regular, periodic opportunities for the filing of such an election. The Board shall provide for immediate notification to the Commissioner of Social Security, the Secretary of the Treasury, and the Executive Director of such election.

"(2) DEADLINE FOR ELECTION.—An election under paragraph (1) may be made by an individual not later than the later of—

"(A) the date on which such individual attains age 25, or

1 "(B) December 31, 2012.

2 "(3) EFFECTIVENESS OF ELECTION.—An elec-
3 tion under this subsection shall be effective with re-
4 spect to wages earned, and self-employment income
5 derived, on the earliest date on which the Board de-
6 termines is practicable to make such election effec-
7 tive following the date of the filing of the election.
8 "(c) REVOCATION OF ELECTION.—

9 "(1) IN GENERAL.—An individual may, in such
10 form and manner as shall be prescribed in regula-
11 tions of the Board, revoke an election made by such
12 individual under subsection (b) within 1 year after
13 the date of a qualifying event described in paragraph
14 (2). Upon completion of the procedures provided for
15 under paragraph (3), any such individual who has
16 made such an election shall not be treated as a par-
17 ticipating individual under this part, effective as if
18 such individual had never been a participating indi-
19 vidual. The Board shall provide for immediate notifi-
20 cation of such election to the Commissioner of Social
21 Security, the Secretary of the Treasury, and the Ex-
22 ecutive Director.

23 "(2) QUALIFYING EVENTS.—For purposes of
24 paragraph (1), the term 'qualifying event' means, in

connection with an individual, any of the following events:

"(A) The death of the individual's spouse.

"(B) The entry into marriage by the individual.

"(C) The divorce or legal separation of the individual from the individual's spouse.

"(D) A dependent child of the individual ceasing to be a dependent child of the individual under section 202(d)(3).

"(3) PROCEDURE.—The Board shall prescribe by regulation procedures governing the termination of an individual's status as 'participating individual' pursuant to a revocation under this subsection. Such procedures shall include—

"(A) prompt closing of the individual's personal social security savings account established under section 254, and

"(B) prompt transfer to the Federal Old-Age and Survivors Insurance Trust Fund as general receipts of any amount held in the Tier II Investment Fund of the Savings Fund or under a Tier III Investment Option pursuant to section 256 or 257 and credited to such individual's personal social security savings account.

"SEC. 254. PERSONAL SOCIAL SECURITY SAVINGS ACCOUNTS.

"(a) ESTABLISHMENT OF PUBLICLY ADMINISTERED SYSTEM OF PERSONAL SECURITY SAVINGS ACCOUNTS.—As soon as practicable after the later of January 1, 2011, or the date on which an individual becomes a participating individual under this part, the Executive Director shall establish a personal social security savings account for such individual. Such account shall be the means by which amounts held in the Tier I Investment Fund and the Tier II Investment Fund of the Savings Fund under sections 255 and 256 and amounts held under Tier III Investment Options under section 257 are credited to such individual, under procedures which shall be established by the Board by regulation. Each account of a participating individual shall be identified to such participating individual by means of the participating individual's Social Security account number.

"(b) ACCOUNT BALANCE.—The balance in a participating individual's account at any time is the sum of—

"(1) the balance in the Tier I Investment Fund of the Savings Fund credited to such participating individual prior to transfer of the credited amount to the Tier II Investment Fund of the Savings Fund; plus

"(2) the excess of—

"(A) all deposits in the Tier II Investment Fund of the Savings Fund credited to such participating individual's personal social security savings account, subject to such increases and reductions as may result from allocations made to and reductions made in the account pursuant to subsection (c)(1); over

"(B) amounts paid out of the Tier II Investment Fund in connection with amounts credited to such participating individual's personal social security savings account; plus

"(3) the excess of—

"(A) the deposits in the Tier III Investment Options credited to such participating individual's personal social security savings account, subject to such increases and reductions as may result from amounts credited to, and reductions made in, the account pursuant to subsection (c)(2); over

"(B) amounts paid out of the Tier III Investment Options of such participating individual.

The calculation made under paragraph (3) shall be made separately for each Tier III Investment Option of the participating individual. The Board shall also hold for the

1 participating individual any benefit credit certificate as-
2 signed to the participating individual's personal social se-
3 curity savings account under section 255.

4 "(c) ALLOCATION OF EARNINGS AND LOSSES.—Pur-
5 suant to regulations which shall be prescribed by the
6 Board, the Executive Director shall allocate to each per-
7 sonal social security savings account an amount equal to
8 the net earnings and net losses from each investment of
9 sums—

10 "(1) in the Tier I Investment Fund and the
11 Tier II Investment Fund which are attributable to
12 sums credited to such account reduced by an appro-
13 priate share of the administrative expenses paid out
14 of the net earnings, as determined by the Executive
15 Director; and

16 "(2) in the Tier III Investment Options which
17 are attributable to sums credited to such account re-
18 duced by the administrative expenses paid out of the
19 net earnings.

20 **"SEC. 255. TIER I INVESTMENT FUND.**

21 "(a) ESTABLISHMENT OF TIER I INVESTMENT
22 FUND.—

23 "(1) IN GENERAL.—The Savings Fund shall in-
24 clude a separate fund to be known as the 'Tier I In-
25 vestment Fund'.

"(2) AMOUNTS IN FUND.—The Tier I Investment Fund consists of all amounts derived from payments into the Fund under section 252(b) and remaining after investment of such amounts under subsection (b), including additional amounts derived as income from such investments.

"(3) USE OF FUNDS.—The amounts held in the Fund are appropriated and shall remain available without fiscal year limitation—

"(A) to be held for investment on behalf of participating individuals under subsection (b),

"(B) to pay the administrative expenses related to the Fund, and

"(C) to make transfers from the Fund under subsection (c)(2).

"(b) INVESTMENT OF FUND BALANCE.—For purposes of investment of the Tier I Investment Fund, the Board shall contract with appropriate professional asset managers, recordkeepers, and custodians selected for investment of amounts held in the Fund, so as to provide for investment of the balance of the Fund, in a manner providing broad diversification in accordance with regulations of the Board, in—

"(1) insurance contracts,

"(2) certificates of deposit, or

"(3) other instruments or obligations selected by such asset managers,

which return the amount invested and pay interest, at a specified rate or rates, on that amount during a specified period of time.

"(c) SEPARATE CREDITING TO PERSONAL SOCIAL SECURITY SAVINGS ACCOUNTS AND TRANSFERS TO THE TIER II INVESTMENT FUND OR TO TIER III INVESTMENT OPTIONS.—

"(1) CREDITING TO ACCOUNTS.—

"(A) IN GENERAL.—Subject to this paragraph, the Board shall provide for prompt, separate crediting, as soon as practicable, of the amounts deposited in the Tier I Investment Fund to the personal social security savings account of each participating individual with respect to the redirected social security contributions (as defined in section 252(b)(3)) of such participating individual. The Board shall include in such crediting, with respect to each such individual, any increases or decreases in such amounts so as to reflect the net returns and losses from investment of the balance of the Fund prior to such crediting. For purposes of determining such increases and decreases for

each calendar year, the amounts deposited into the Fund in connection with such individual during such calendar year shall be deemed to have been deposited on June 30 of such year.

"(B) TREATMENT OF MARRIED PARTICIPATING INDIVIDUALS.—If the participating individual is married as of the end of the calendar year in which the amounts to be credited were deposited in the Tier I Investment Fund and the spouse is also a participating individual, the personal social security savings account of the participating individual and the personal social security savings account of his or her spouse shall each be credited with 50 percent of such amounts.

"(2) TRANSFERS FROM THE TIER I INVESTMENT FUND.—In accordance with elections filed with the Board by a participating individual, any amount credited to the personal social security savings account of such participating individual under paragraph (1) shall be promptly transferred to the Tier II Investment Fund of the Savings Fund for investment in accordance with section 256 and, to the extent available under section 257, to Tier III Investment Options in accordance with section 257.

1 "(d) TREATMENT OF AMOUNTS HELD IN TIER I IN-
2 VESTMENT FUND.—Subject to this part—
3 "(1) until amounts deposited into the Tier I In-
4 vestment Fund during any calendar year are cred-
5 ited to personal social security savings accounts,
6 such amounts shall be treated as the unallocated
7 property of all participating individuals with respect
8 to whom amounts were deposited in the Fund dur-
9 ing such year, jointly held in trust for such partici-
10 pating individuals in the Savings Fund, and
11 "(2) amounts deposited into the Fund which
12 are credited to the personal social security savings
13 account of a participating individual shall be treated
14 as property of the participating individual, held in
15 trust for such participating individual in the Savings
16 Fund.
17 **"SEC. 256. TIER II INVESTMENT FUND.**
18 "(a) ESTABLISHMENT OF TIER II INVESTMENT
19 FUND.—
20 "(1) IN GENERAL.—The Savings Fund shall in-
21 clude a separate fund to be known as the 'Tier II
22 Investment Fund'.
23 "(2) AMOUNTS IN FUND.—The Tier II Invest-
24 ment Fund consists of all amounts derived from
25 payments into the Fund under section 255(c)(2) and

remaining after investment of such amounts under subsection (b), including additional amounts derived as income from such investments.

"(3) USE OF FUNDS.—The amounts held in the Fund are appropriated and shall remain available without fiscal year limitation—

"(A) to be held for investment under subsection (b),

"(B) to pay the administrative expenses related to the Fund, and

"(C) to make transfers to Tier III Investment Options under section 257 or to make payments under section 258.

"(b) PAYMENTS INTO TIER II INVESTMENT FUND.—

"(1) IN GENERAL.—Upon the crediting under section 252 to the personal social security savings account of a participating individual of any amount held in the Tier I Investment Fund for any calendar year, the Board shall transfer from the Tier I Investment Fund into the Tier II Investment Fund any amount so credited to such participating individual's account which is not transferred to a Tier III Investment Option pursuant to an election under section 257(a).

1 "(2) ONGOING SEPARATE CREDITING.—Subject
2 to this paragraph, the Board shall provide for ongo-
3 ing separate crediting to each participating individ-
4 ual's personal social security savings account of the
5 amounts deposited in the Tier II Investment Fund
6 with respect to such participating individual, to-
7 gether with any increases or decreases therein so as
8 to reflect the net returns and losses from investment
9 thereof while held in the Fund.
10 "(c) INVESTMENT ACCOUNTS.—
11 "(1) IN GENERAL.—For purposes of investment
12 of the Tier II Investment Fund, the Board shall di-
13 vide the Fund into 6 investment accounts. The
14 Board shall contract with appropriate investment
15 managers, recordkeepers, and custodians selected for
16 investment of amounts held in each investment ac-
17 count. Such accounts shall consist of—
18 "(A) a Lifecycle Investment Account,
19 "(B) a Government Securities Investment
20 Account,
21 "(C) a Fixed Income Investment Account,
22 "(D) a Common Stock Index Investment
23 Account,
24 "(E) a Small Capitalization Stock Index
25 Investment Account, and

"(F) an International Stock Index Investment Account.

"(2) ELECTION OF INVESTMENT OPTIONS.—

"(A) DEFAULT INVESTMENT ACCOUNT.—Except as provided in an election in effect under subparagraph (B), amounts held in the Tier II Investment Fund shall be credited to the Lifecycle Investment Account.

"(B) ELECTION OF TRANSFERS BETWEEN INVESTMENT ACCOUNTS.—In any case in which a participating individual who has an amount in such individual's personal social security savings account credited to any of the investment accounts in the Tier II Investment Fund files with the Secretary of the Treasury a written election under this subparagraph, not more frequently than annually and in accordance with regulations of the Board, the Secretary of the Treasury shall transfer the full amount so credited in such investment account from such investment account to any one of the other investment accounts in the Tier II Investment Fund (whichever is designated in such election).

"(d) LIFECYLE INVESTMENT ACCOUNT.—

1 "(1) IN GENERAL.—The investment manager,
2 recordkeeper, and custodian selected for investment
3 of amounts held in the Lifecyle Investment Account
4 shall invest such amounts under regulations which
5 shall be prescribed by the Board in a mix of equities
6 and fixed income instruments so as to ensure, to the
7 maximum extent practicable, that, of the total bal-
8 ance in the Fund credited to such account and avail-
9 able for investment (after allowing for administrative
10 expenses), the percentage invested in fixed income
11 instruments by individuals in designated cohorts,
12 ranging in age up to those of at least retirement
13 age, will increase in a linear progression from 0 per-
14 cent to 100 percent as the cohort approaches retire-
15 ment age.

16 "(2) INVESTMENT IN EQUITIES.—In accordance
17 with regulations which shall be prescribed by the
18 Board, the Board shall establish standards which
19 must be met by equities selected for investment in
20 the Lifecycle Investment Account. In conformity
21 with such standards, the Board shall select, for pur-
22 poses of such investment, indices which are com-
23 prised of equities the aggregate market value of
24 which is, in each case, a reasonably broad represen-
25 tation of companies whose shares are traded on the

equity markets. Amounts invested in equities under an investment option shall be held in a portfolio designed to replicate the performance of one or more of such indices.

"(3) INVESTMENT IN FIXED INCOME INSTRUMENTS.—In accordance with regulations which shall be prescribed by the Board, the Board shall establish standards which must be met by fixed income instruments selected for investment in the Lifecycle Investment Account. Such standards shall take into account the competing considerations of risk and return. Amounts invested in fixed income instruments in an investment option shall be held in a portfolio which shall consist of a diverse range of fixed income instruments, taking into full account the opposing considerations of risk and maximization of return.

"(e) GOVERNMENT SECURITIES INVESTMENT ACCOUNT.—

"(1) IN GENERAL.—Amounts in the Government Securities Investment Account shall be invested in securities of the United States Government as provided in this subsection

"(2) ISSUANCE OF SPECIAL OBLIGATIONS.—The Secretary of the Treasury is authorized to issue special interest-bearing obligations of the United

States for purchase by the Tier II Investment Fund for purposes of investment of amounts in the Government Securities Investment Account. Such obligations shall have maturities fixed with due regard to the needs of the Fund as determined by the Board, and shall bear interest at a rate equal to the average market yield (computed by the Secretary of the treasury on the basis of market quotations as of the end of the calendar month next preceding the date of issue of such obligations) on all marketable interest-bearing obligations of the United States then forming a part of the public debt which are not due or callable earlier than 4 years after the end of such calendar month. Any average market yield computed under this paragraph which is not a multiple of one-eighth of 1 percent shall be rounded to the nearest multiple of one-eighth of 1 percent.

''(f) FIXED INCOME INVESTMENT ACCOUNT.—Amounts in the Fixed Income Investment Account shall be invested in instruments or obligations which return the amount invested and pay interest, at a specified rate or rates, on that amount during a specified period of time, consisting of instruments or obligations in one or more of the following categories:

''(1) insurance contracts;

"(2) certificates of deposit; or

"(3) other instruments or obligations selected by qualified professional asset managers.

"(g) COMMON STOCK INDEX INVESTMENT ACCOUNT.—

"(1) PORTFOLIO DESIGN.—Amounts held in the Common Stock Investment Account shall be invested in a portfolio of common stock designed to replicate the performance of the index selected under paragraph (2). The portfolio shall be designed such that, to the extent practicable, the percentage of the balance in the Common Stock Index Investment Account that is invested in each stock is the same as the percentage determined by dividing the aggregate market value of all shares of that stock by the aggregate market value of all shares of all stocks included in such index.

"(2) SELECTION OF INDEX.—The Board shall select, for purposes of investment of amounts held in the Common Stock Investment Account, an index which is a commonly recognized index comprised of common stock the aggregate market value of which is a reasonably complete representation of the United States equity markets.

"(h) SMALL CAPITALIZATION STOCK INDEX INVESTMENT ACCOUNT.—

"(1) PORTFOLIO DESIGN.—Amounts held in the Small Capitalization Stock Index Investment Account shall be invested in a portfolio of common stock designed to replicate the performance of the index selected under paragraph (2). The portfolio shall be designed such that, to the extent practicable, the percentage of the balance in the Small Capitalization Stock Index Investment Account that is invested in each stock is the same as the percentage determined by dividing the aggregate market value of all shares of that stock by the aggregate market value of all shares of all stocks included in such index.

"(2) SELECTION OF INDEX.—The Board shall select, for purposes of investment of amounts held in the Small Capitalization Stock Index Investment Account, an index which is a commonly recognized index comprised of common stock the aggregate market value of which represents the United States equity markets excluding the common stocks included in the Common Stock Index Investment Account.

"(i) INTERNATIONAL STOCK INDEX INVESTMENT ACCOUNT.—

"(1) PORTFOLIO DESIGN.—Amounts held in the International Stock Index Investment Account shall be invested in a portfolio of stock designed to replicate the performance of the index selected under paragraph (2). The portfolio shall be designed such that, to the extent practicable, the percentage of the balance in the International Stock Index Investment Account that is invested in each stock is the same as the percentage determined by dividing the aggregate market value of all shares of that stock by the aggregate market value of all shares of all stocks included in such index.

"(2) SELECTION OF INDEX.—The Board shall select, for purposes of investment of amounts held in the International Stock Index Investment Account, an index which is a commonly recognized index comprised of common stock the aggregate market value of which is a reasonably complete representation of the international equity markets excluding the United States equity markets.

"(j) ADDITIONAL INVESTMENT OPTIONS.—The Board may from time to time, as determined by regulation

as appropriate to further the purposes of this section, shall—

"(1) establish investment accounts in the Tier II Investment Fund meeting the requirements of this section in addition to those established by this section, and

"(2) terminate investment accounts in the Tier II Investment Fund established pursuant to paragraph (1).

"(k) DISCLOSURE OF ADMINISTRATIVE COSTS.—The Board shall provide to each participating individual an annual disclosure of the rate of administrative costs chargeable with respect to investment in each investment account in the Tier II Investment Fund. Such disclosure shall be written in a manner calculated to be understood by the average participating individual.

"(l) TREATMENT OF AMOUNTS HELD IN TIER II INVESTMENT FUND.—Subject to this part, amounts deposited into, and held and accounted for in, the Tier II Investment Fund with respect to any participating individual shall continue to be treated as property of such participating individual, held in trust for such participating individual in the Fund.

"SEC. 257. TIER III INVESTMENT OPTIONS.

"(a) ELECTION OF TIER III INVESTMENT OPTIONS.—

"(1) IN GENERAL.—A participating individual may elect to direct transfers from amounts in the Savings Fund credited to the personal social security savings account of such individual into 1 or more Tier III Investment Options in accordance with paragraph (2).

"(2) COMMENCEMENT OF TIER III INVESTMENT OPTIONS UPON ATTAINMENT OF ELECTION THRESHOLD.—In any case in which, as of the end of any calendar year, the total balance in the Savings Fund credited to a participating individual's personal social security savings account exceeds for the first time the election threshold, the Board shall, by regulation, provide for an opportunity for such participating individual to make, at any time thereafter, such individual's first election of one or more of the Tier III Investment Options for investment of an amount in the Savings Fund credited to such account. Such election may be in lieu of or in addition to investment in the options available with respect to the Tier II Investment Fund of the Savings Fund.

"(3) ALLOCATION OF FUNDS.—In the case of an election under paragraph (1), funds credited to

the personal social security savings account of the participating individual and elected for transfer to one or more Tier III Investment Options shall be transferred to the Tier III Investment Options so elected for such calendar year, in percentages specified in the election by the participating individual for each applicable portfolio.

"(4) ELECTION THRESHOLD.—

"(A) IN GENERAL.—Subject to subparagraph (B), for purposes of this subsection the term 'election threshold' means an amount equal to $25,000.

"(B) ADJUSTMENTS.—The Board shall adjust annually (effective for annual reporting months occurring after December 2011) the dollar amount set forth in subparagraph (A) under procedures providing for adjustments in the same manner and to the same extent as adjustments are provided for under the procedures used to adjust benefit amounts under section 215(i)(2)(A), except that any amount so adjusted that is not a multiple of $1.00 shall be rounded to the nearest multiple of $1.00.

"(5) SUBSEQUENT INVESTMENT OF AMOUNTS HELD IN TIER III INVESTMENT OPTIONS.—Any

amounts held in one or more Tier III Investment Options may be—

"(A) transferred at any time to one or more other Tier III Investment Options, subject to applicable regulations of the Board and the terms governing the affected Tier III Investment Options, and

"(B) transferred, not more frequently than annually, to the Tier II Investment Fund, for deposit in the applicable investment account then selected by the participating individual under section 256.

"(b) CERTIFICATION OF ELIGIBLE ENTITIES.—

"(1) IN GENERAL.—The Board shall certify eligible entities to offer Tier III Investment Options under this part.

"(2) APPLICATION.—Any eligible entity that desires to be certified by the Board to offer a Tier III Investment Option shall submit an application to the Board at such time, in such manner, and containing such information as the Board may require.

"(3) REQUIREMENTS FOR APPROVAL.—The Board shall not certify an eligible entity unless such eligible entity agrees to the following requirements:

"(A) SEPARATE ACCOUNTING.—Each eligible entity shall, with respect to each Tier III Investment Option offered by such eligible entity to participating individuals—

"(i) establish separate accounts for the contributions of each participating individual, and any earnings properly allocable to the contributions, and

"(ii) maintain separate recordkeeping with respect to each account.

"(B) TREATMENT OF AMOUNTS HELD IN FUND.—Amounts deposited into, and held and accounted for in, a Tier III Investment Option with respect to any participating individual shall be treated as property of such participating individual, held in trust for such participating individual.

"(C) TRUST REQUIREMENTS.—Amounts held and accounted for with respect to a participating individual shall be held in a trust created or organized in the United States for the exclusive benefit of such individual or his beneficiaries.

"(D) EXEMPTION FROM THIRD PARTY CLAIMS.—Each Tier III Investment Option

shall be exempt from any and all third party claims against the eligible entity.

"(E) DISCLOSURE OF ADMINISTRATIVE COSTS.—Each eligible entity offering a Tier III Investment Option under this section shall provide to each participating individual an annual disclosure of the rate of administrative costs chargeable with respect to investment in such Option. Such disclosure shall be written in a manner calculated to be understood by the average participating individual. The Board shall provide for coordination of disclosures with respect to Tier III Investment Options under this subparagraph so as to assist participating individuals in comparing alternative Options based on administrative costs.

"(F) REPORTING TO THE EXECUTIVE DIRECTOR AND THE BOARD.—Each eligible entity shall provide reports to the Executive Director and the Board at such time, in such manner, and containing such information as the Board may require.

"(4) ELIGIBLE ENTITY DEFINED.—For purposes of this section, the term 'eligible entity' means any investment company (as defined in section 3 of

the Investment Company Act of 1940) or other person that the Board determines appropriate to offer Tier III Investment Options under this part.

"(c) APPROVAL OF TIER III INVESTMENT OPTIONS.—

"(1) IN GENERAL.—No funds may be transferred into a Tier III Investment Option unless the Board has approved an application submitted under paragraph (2) with respect to the option.

"(2) APPLICATION.—With respect to each Tier III Investment Option that an eligible entity certified under subsection (b)(1) seeks to offer, such entity shall submit an application to the Board at such time, in such manner, and containing such information as the Board may require.

"(3) QUALIFICATIONS FOR APPROVAL.—The Board may not approve an application submitted under paragraph (2) in connection with a Tier III Investment Option unless the following requirements are met:

"(A) OPTION MUST BE OFFERED BY CERTIFIED ELIGIBLE ENTITY.—The Tier III Investment Option is offered by an eligible entity certified under subsection (b).

"(B) OPTION MUST MEET QUALITY FACTORS.—

"(i) IN GENERAL.—The Tier III Investment Option meets qualifications which shall be prescribed by the Board relating to the quality factors described in clause (ii).

"(ii) QUALITY FACTORS.—The quality factors described in this clause are—

"(I) the safety and soundness of the Tier III Investment Option's proposed investment policy;

"(II) the experience and record of performance of the proposed investment option, if any;

"(III) the experience and record of performance of the entity issuing or offering such option; and

"(IV) such other factors as the Board may determine appropriate.

"(d) CONSIDERATIONS FOR CERTIFICATION AND APPROVAL.—In determining whether to certify an eligible entity under subsection (b) or to approve a Tier III Investment Option under subsection (c), the Board shall—

1 "(1) act in the best interests of the partici-
2 pating individuals;
3 "(2) base its determination solely on consider-
4 ations of balancing safety and soundness of the Tier
5 III Investment Option with the maximization of re-
6 turns of such option; and
7 "(3) not base any determination related to the
8 entity or option on political or other extraneous con-
9 siderations.
10 "(e) SPONSORSHIP OF TIER III INVESTMENT OP-
11 TIONS BY MEMBERSHIP AND LABOR ORGANIZATIONS.—
12 "(1) IN GENERAL.—A membership or labor or-
13 ganization (as defined by the Board) may sponsor
14 Tier III Investment Options under contracts with el-
15 igible entities certified under subsection (b) who
16 shall administer the investment option if such invest-
17 ment option is approved by the Board under sub-
18 section (c).
19 "(2) LIMITATION TO MEMBERSHIP.—A mem-
20 bership or labor organization (as so defined) may
21 limit to the members of such organization participa-
22 tion in a Tier III Investment Option sponsored by
23 such organization.
24 "(f) DISTRIBUTIONS IN CASE OF DEATH.—Upon the
25 death of a participating individual, the amount of any as-

sets held under a Tier III Investment Option credited to the personal social security savings account of such individual shall be distributed in accordance with section 258(e).

"SEC. 258. PERSONAL SOCIAL SECURITY SAVINGS ANNUITY AND OTHER DISTRIBUTIONS.

"(a) DATE OF INITIAL DISTRIBUTION.—Except as provided in subsection (e), distributions may be made to a participating individual from amounts credited to the personal social security savings account of such individual only on or after the earliest of—

"(1) the date the participating individual attains retirement age (as defined in section 216(l)(1)) or, if elected by the individual, early retirement age (as defined in section 216(l)(2)); or

"(2) the date on which the amount credited to the participating individual's personal social security savings account is sufficient to purchase a personal social security savings annuity with a monthly benefit that is at least equal to the minimum annuity payment amount (as defined in subsection (b)(4)(C)(iii)).

"(b) PERSONAL SOCIAL SECURITY SAVINGS ANNUITIES.—

"(1) NOTICE OF AVAILABLE ANNUITIES.—Not later than the date determined under subsection (a), the Board shall notify each participating individual of—

"(A) the most recent listing of personal social security savings annuities offered by the Annuity Issuance Authority under paragraph (2); and

"(B) the entitlement of the participating individual to purchase such an annuity.

"(2) ANNUITY ISSUANCE AUTHORITY.—There is established in the office of the Board an agency which shall be known as the 'Annuity Issuance Authority'. The Authority shall provide, in accordance with regulations of the Board, for the issuance of personal social security savings annuities for purchase from the Authority under this section and to otherwise administer the issuance of such annuities in accordance with such regulations.

"(3) ANNUITY RESERVES ACCOUNT.—There is established in the Savings Fund an Annuity Reserves Account. The Account shall consist of all amounts received by the Authority from the purchase of personal social security savings annuities under this section (plus such amounts as may be

transferred to the Account under paragraph (5)(B)), increased by the total net earnings from investments of such reserves under subparagraph (A) of paragraph (5) and reduced by the total net losses from investments of such reserves under such subparagraph.

"(4) PURCHASE OF ANNUITIES.—

"(A) SELECTION OF ANNUITY.—On a date elected by the participating individual, but no earlier than the date determined under subsection (a), a participating individual may purchase a personal social security savings annuity selected from among the annuities offered by the Authority under paragraph (2).

"(B) TRANSFER OF ASSETS.—Upon the selection of an annuity by a participating individual under subparagraph (A), the Board shall provide for the transfer of assets, credited to the personal social security savings account of the participating individual and held in the Tier II Investment Fund or under 1 or more Tier III Investment Options (or any combination thereof), in a total amount sufficient to purchase the annuity selected by the participating

individual from annuities offered by the Authority.

"(C) MINIMUM ANNUITY PAYMENT AMOUNT.—

"(i) IN GENERAL.—Subject to subparagraph (D), if, at the time a personal social security savings annuity is purchased under subparagraph (A), the assets credited to the personal social security savings account of the participating individual are sufficient to purchase a personal social security savings annuity offered by the Authority under paragraph (2) with a monthly annuity payment that is at least equal to the minimum annuity payment amount, the amount of the monthly annuity payment provided by such annuity may not be less then the minimum annuity payment amount.

"(ii) CONSTRUCTION.—Nothing in this subparagraph shall be construed to prohibit a participating individual from using personal social security savings account assets to purchase a personal social security savings annuity offered by the Au-

thority under paragraph (2) which provides for a monthly payment in excess of the minimum amount required under clause (i).

"(iii) MINIMUM ANNUITY PAYMENT AMOUNT DEFINED.—For purposes of this part, the term 'minimum annuity payment amount' means, as of any date, an amount equal to the monthly equivalent of 150 percent of the poverty line for an individual (as in effect on such date), determined under the poverty guidelines of the Department of Health and Human Services issued under sections 652 and 673(2) of the Omnibus Budget Reconciliation Act of 1981.

"(D) PURCHASE OF ANNUITIES IN THE EVENT OF INSUFFICIENT ASSETS.—If a participating individual desires, or is required under subsection (f), to purchase a personal social security savings annuity under subsection (b) on or after the date determined under subsection (a)(1) and the assets of the personal social security savings account of such individual are insufficient to purchase a personal social security

savings annuity that provides for a monthly payment that is at least equal to the minimum annuity payment amount (as defined in paragraph (4)(C)(iii)), the participating individual shall purchase a personal social security savings annuity with a monthly payment equal to the maximum amount that the participating individual's personal social security savings account can fund, as determined in accordance with regulations which shall be prescribed by the Authority, and that otherwise meets the requirements of this subsection (including the cost-of-living protection requirement of subsection (c)(1)(C)), and the Authority shall provide for appropriate certification to the Secretary of the Treasury with respect to the participating individual's eligibility for guarantee payments under section 259.

"(5) MAINTENANCE OF RESERVES FOR PAYMENT OF ANNUITIES.—

"(A) INVESTMENT OF RESERVES.—For purposes of investment of reserves held in the Annuity Reserves Account, the Authority shall contract with appropriate investment managers, recordkeepers, and custodians selected by the

Authority for investment of such reserves. Such reserves shall be invested under regulations which shall be prescribed by the Authority so as to ensure, to the maximum extent practicable, that, of the total balance of the reserves (after payment of administrative expenses to such managers, recordkeepers, and custodians)—

"(i) 65 percent is invested in equities in the same manner and under the same standards as are provided in section 256(c)(4), and

"(ii) 35 percent is invested in fixed income instruments in the same manner and under the same standards as are provided in section 256(c)(5).

"(B) PROVISION FOR FULL PAYMENT OF ANNUITIES.—Payment of personal social security savings annuities in accordance with the terms of such annuities shall be made, irrespective of the sufficiency of reserves in the Annuity Reserves Fund attributable to funds obtained from the purchase of such annuities. In the event of any impending insufficiency in the Annuity Reserves Account for the next fiscal year, the Authority shall certify to the Secretary of

the Treasury the amount of such insufficiency, and the Secretary of the Treasury shall transfer from the Federal Old-Age and Survivors Insurance Trust Fund to the Annuity Reserves Account the amount of the insufficiency, as so certified, in such installments, made prior to or during such fiscal year, as are necessary to eliminate in advance such insufficiency.

"(c) PERSONAL SOCIAL SECURITY SAVINGS ANNUITY.—

"(1) IN GENERAL.—For purposes of this part, the term 'personal social security savings annuity' means an annuity that meets the following requirements:

"(A) The annuity starting date (as defined in section 72(c)(4) of the Internal Revenue Code of 1986) commences on the first day of the month beginning after the date of the purchase of the annuity.

"(B) The terms of the annuity provide—

"(i) for a monthly payment to the participating individual during the life of the participating individual equal to at least the minimum annuity payment

amount (as defined in subsection (b)(4)(C)(iii)), or

"(ii) in the case of an annuity purchased under subparagraph (D) of subsection (b)(4), the maximum monthly payment determined under regulations prescribed under such subparagraph.

"(C) The terms of the annuity include procedures providing for adjustments in the amount of the monthly payments in the same manner and to the same extent as adjustments are provided for under the procedures used to adjust benefit amounts under section 215(i)(2)(A). Nothing in this subparagraph shall be construed to preclude the terms governing such an annuity from providing for adjustments in the amount of monthly payments resulting in a payment for any month greater than the payment for that month that would result from adjustments required under the preceding sentence (b)(4)(D).

"(D) The terms of the annuity include such other terms and conditions as the Board requires for the protection of the annuitant.

"(2) EXEMPTION FROM THIRD PARTY CLAIMS.—Each personal social security savings annuity shall be exempt from any and all third party claims against the issuer.

"(d) RIGHT TO USE EXCESS PERSONAL SOCIAL SECURITY SAVINGS ACCOUNT ASSETS.—To the extent assets credited to a participating individual's personal social security savings account remain after the purchase of an annuity under subsection (b), the remaining assets shall be payable to the participating individual at such time, in such manner, and in such amounts as the participating individual may specify, subject to subsection (f).

"(e) DISTRIBUTIONS IN CASE OF DEATH.—If the participating individual dies before all amounts which are held in the Tier I Investment Fund or the Tier II Investment Fund of the Savings Fund or held under a Tier III Investment Option and which are credited to the personal social security savings account of the individual are otherwise distributed in accordance with this section, such amounts shall be distributed, under regulations which shall be prescribed by the Board—

"(1) in any case in which one or more beneficiaries have been designated in advance, to such beneficiaries in accordance with such designation as provided in such regulations, and

"(2) in the case of any amount not distributed as described in paragraph (1), to such individual's estate.

"(f) DATE OF FINAL DISTRIBUTION.—All amounts credited to the personal social security savings account of an individual shall be distributed, by means of the purchase of annuities or otherwise in a manner consistent with the requirements of this section, not later than 5 years after the date the individual attains retirement age (as defined in section 216(l)). The Board shall provide by regulation for means of distribution necessary to ensure compliance with the requirements of this subsection.

"SEC. 259. GUARANTEE OF ACCOUNT SAVINGS.

"(a) IN GENERAL.—If, as of immediately before the month for which the first monthly payment under a participating individual's personal social security savings annuity is paid, the amount credited to such individual's personal social security savings account is less that the sum of all deposits made to the account under section 252(b), adjusted as provided in subsection (b), the Annuity Issuance Authority shall so certify to the Secretary of the Treasury and, upon receipt of such certification, such Secretary shall transfer to such individual's Tier I Investment Fund, from amounts in the Federal Old-Age and Survivors Insurance Trust Fund, an amount equal to the ex-

1 cess of such sum of such deposits, as so adjusted, over
2 such amount credited to such account.
3 "(b) ADJUSTMENTS.—
4 "(1) IN GENERAL.—For purposes of subsection
5 (a), deposits described in subsection (a) which are
6 made in any calendar year shall be deemed to be
7 equal to the product of—
8 "(A) the deposits made in such year (as
9 determined without regard to this subsection);
10 and
11 "(B) the quotient obtained by dividing—
12 "(i) the Consumer Price Index for the
13 calendar quarter beginning on July 1 and
14 ending on September 30 preceding the
15 year in which the month referred to in sub-
16 section (a) occurs; by
17 "(ii) the Consumer Price Index for
18 the calendar quarter beginning on July 1
19 and ending on September 30 preceding the
20 calendar year in which such deposits were
21 made.
22 "(2) CONSUMER PRICE INDEX.—For purposes
23 of paragraph (1), the Consumer Price Index for a
24 calendar quarter shall be the arithmetical mean of
25 the Consumer Price Index for Urban Wage Earners

and Clerical Workers (CPI–W) for the 3 months in such quarter.

"SEC. 260. PERSONAL SOCIAL SECURITY SAVINGS BOARD.

"(a) ESTABLISHMENT.—There is established in the executive branch of the Government a Personal Social Security Savings Board.

"(b) COMPOSITION.—The Board shall be composed of—

"(1) 3 members appointed by the President, of whom 1 shall be designated by the President as Chairman; and

"(2) 2 members appointed by the President, of whom—

"(A) 1 shall be appointed by the President after taking into consideration the recommendation made by the Speaker of the House of Representatives in consultation with the minority leader of the House of Representatives; and

"(B) 1 shall be appointed by the President after taking into consideration the recommendation made by the majority leader of the Senate in consultation with the minority leader of the Senate.

"(c) ADVICE AND CONSENT.—Appointments under subsection (b) shall be made by and with the advice and consent of the Senate.

"(d) MEMBERSHIP REQUIREMENTS.—Members of the Board shall have substantial experience, training, and expertise in the management of financial investments and pension benefit plans.

"(e) LENGTH OF APPOINTMENTS.—

"(1) TERMS.—A member of the Board shall be appointed for a term of 4 years, except that of the members first appointed under subsection (b)—

"(A) the Chairman shall be appointed for a term of 4 years;

"(B) the members appointed under subsection (b)(2) shall be appointed for terms of 3 years; and

"(C) the remaining members shall be appointed for terms of 2 years.

"(2) VACANCIES.—

"(A) IN GENERAL.—A vacancy on the Board shall be filled in the manner in which the original appointment was made and shall be subject to any conditions that applied with respect to the original appointment.

1 "(B) COMPLETION OF TERM.—An indi-
2 vidual chosen to fill a vacancy shall be ap-
3 pointed for the unexpired term of the member
4 replaced.
5 "(3) EXPIRATION.—The term of any member
6 shall not expire before the date on which the mem-
7 ber's successor takes office.
8 "(f) DUTIES.—The Board shall—
9 "(1) administer the program established under
10 this part;
11 "(2) establish policies for the investment and
12 management of the Savings Fund, including the
13 Tier I Investment Fund and the Tier II Investment
14 Fund, and amounts held under Tier III Investment
15 Options, including policies applicable to the asset
16 managers, recordkeepers, and custodians with re-
17 sponsibility for managing the investment of amounts
18 credited to personal social security investment ac-
19 counts, and for the management and operation of
20 personal social security savings annuities, which
21 shall provide for—
22 "(A) prudent investments suitable for ac-
23 cumulating funds for payment of retirement in-
24 come;
25 "(B) sound management practices; and

"(C) low administrative costs;

"(3) review the performance of investments made for the Tier I Investment Fund and the Tier II Investment Fund;

"(4) review the performance of investments made under Tier III Investment Options;

"(5) review the management and operation of personal social security savings annuities;

"(6) review and approve the budget of the Board; and

"(7) comply with the fiduciary requirements of part 4 of subtitle B of title I of the Employee Retirement Income Security Act of 1974 (relating to fiduciary responsibility) in connection with any exercise of discretion in connection with the assets of the Savings Fund.

"(g) ADMINISTRATIVE PROVISIONS.—

"(1) IN GENERAL.—The Board may—

"(A) adopt, alter, and use a seal;

"(B) except as provided in paragraph (4), direct the Executive Director to take such action as the Board considers appropriate to carry out the provisions of this part and the policies of the Board in accordance with delegations under this part;

"(C) upon the concurring votes of 4 members, remove the Executive Director from office for good cause shown;

"(D) provide to the Executive Director such resources as are necessary to carry out the duties of the Executive Director; and

"(E) take such other actions as may be necessary to carry out the functions of the Board.

"(2) MEETINGS.—The Board shall meet—

"(A) not less than once during each month; and

"(B) at additional times at the call of the Chairman.

"(3) EXERCISE OF POWERS.—

"(A) IN GENERAL.—Except as provided in paragraph (1)(C), the Board shall perform the functions and exercise the powers of the Board on a majority vote of a quorum of the Board. Three members of the Board shall constitute a quorum for the transaction of business.

"(B) VACANCIES.—A vacancy on the Board shall not impair the authority of a quorum of the Board to perform the functions and exercise the powers of the Board.

"(4) LIMITATIONS ON INVESTMENTS.—The Board may not direct any person to invest or to cause to be invested any sums in the Tier II Investment Fund or any personal social security investment account in a specific asset or to dispose of or cause to be disposed of any specific asset of such Fund or any such account.

"(h) COMPENSATION.—

"(1) IN GENERAL.—Each member of the Board who is not an officer or employee of the Federal Government shall be compensated at the daily rate of basic pay for level IV of the Executive Schedule for each day during which such member is engaged in performing a function of the Board.

"(2) EXPENSES.—A member of the Board shall be paid travel, per diem, and other necessary expenses under subchapter I of chapter 57 of title 5, United States Code, while traveling away from such member's home or regular place of business in the performance of the duties of the Board.

"(3) SOURCE OF FUNDS.—Payments authorized under this subsection shall be paid from the Tier I Investment Fund or the Tier II Investment Fund, as determined appropriate by the Board.

"(i) DISCHARGE OF RESPONSIBILITIES.—The members of the Board shall discharge their responsibilities solely in the interest of the participating individuals and their beneficiaries under this part.

"(j) ANNUAL INDEPENDENT AUDIT.—The Board shall annually engage an independent qualified public accountant to audit the activities of the Board.

"(k) SUBMISSION OF BUDGET TO CONGRESS.—The Board shall prepare and submit to the President, and, at the same time, to the appropriate committees of Congress, an annual budget of the expenses and other items relating to the Board which shall be included as a separate item in the budget required to be transmitted to Congress under section 1105 of title 31, United States Code.

"(l) SUBMISSION OF LEGISLATIVE RECOMMENDATIONS.—The Board may submit to the President, and, at the same time, shall submit to each House of Congress, any legislative recommendations of the Board relating to any of its functions under this part or any other provision of law.

"SEC. 261. EXECUTIVE DIRECTOR.

"(a) APPOINTMENT OF EXECUTIVE DIRECTOR.—The Board shall appoint, without regard to the provisions of law governing appointments in the competitive service, an

1 Executive Director by action agreed to by a majority of
2 the members of the Board.

3 "(b) DUTIES.—The Executive Director shall, as de-
4 termined appropriate by the Board—

5 "(1) carry out the policies established by the
6 Board;

7 "(2) invest and manage the Tier I Investment
8 Fund and the Tier II Investment Fund in accord-
9 ance with the investment policies and other policies
10 established by the Board;

11 "(3) administer the provisions of this part re-
12 lating to the Tier I Investment Fund and the Tier
13 II Investment Fund; and

14 "(4) prescribe such regulations (other than reg-
15 ulations relating to fiduciary responsibilities) as may
16 be necessary for the administration of this part re-
17 lating to the Tier I Investment Fund and the Tier
18 II Investment Fund.

19 "(c) ADMINISTRATIVE AUTHORITY.—The Executive
20 Director may, within the scope of the duties of the Execu-
21 tive Director as determined by the Board—

22 "(1) appoint such personnel as may be nec-
23 essary to carry out the provisions of this part relat-
24 ing to the Tier I Investment Fund and the Tier II
25 Investment Fund;

"(2) subject to approval by the Board, procure the services of experts and consultants under section 3109 of title 5, United States Code;

"(3) secure directly from an Executive agency, the United States Postal Service, or the Postal Rate Commission any information necessary to carry out the provisions of this part and the policies of the Board relating to the Tier I Investment Fund and the Tier II Investment Fund;

"(4) make such payments out of sums in the Tier I Investment Fund and the Tier II Investment Fund as the Executive Director determines, in accordance with regulations of the Board, are necessary to carry out the provisions of this part and the policies of the Board;

"(5) pay the compensation, per diem, and travel expenses of individuals appointed under paragraphs (1), (2), and (6) from the Tier I Investment Fund or the Tier II Investment Fund, in accordance with regulations of the Board;

"(6) accept and use the services of individuals employed intermittently in the Government service and reimburse such individuals for travel expenses, authorized by section 5703 of title 5, United States

Code, including per diem as authorized by section 5702 of such title;

"(7) except as otherwise expressly prohibited by law or the policies of the Board, delegate any of the Executive Director's functions to such employees under the Board as the Executive Director may designate and authorize such successive redelegations of such functions to such employees under the Board as the Executive Director may consider to be necessary or appropriate; and

"(8) take such other actions as are appropriate to carry out the functions of the Executive Director.".

(b) EFFECTIVE DATE.—The amendments made by this section shall apply with respect to wages paid after December 31, 2011, for pay periods ending after such date and self-employment income for taxable years beginning after such date.

SEC. 403. MONTHLY INSURANCE BENEFITS FOR PARTICIPATING INDIVIDUALS.

Section 202 of the Social Security Act (42 U.S.C. 402) is amended by adding at the end the following new subsection:

1 "Benefits for Participants Under Part B

2 "(z)(1) Notwithstanding the preceding provisions of
3 this section—

4 "(A) a participating individual under the Per-
5 sonal Social Security Savings Program under part B
6 shall not be entitled to old-age insurance benefits
7 under subsection (a); and

8 "(B) except as provided in paragraph (2), no
9 individual shall be entitled to benefits under this sec-
10 tion on the basis of the wages and self-employment
11 income of such a participating individual.

12 "(2) In the case of any such participating individual
13 who dies before such individual purchases a personal social
14 security savings annuity under section 258, paragraph
15 (1)(B) shall not apply with respect to child's insurance
16 benefits under subsection (d), widow's insurance benefits
17 under subsection (e), widower's insurance benefits under
18 subsection (f), mother's and father's insurance benefits
19 under subsection (g), and parent's insurance benefits
20 under subsection (h).".

21 **SEC. 404. TAX TREATMENT OF ACCOUNTS.**

22 (a) IN GENERAL.—

23 (1) IN GENERAL.—Subchapter F of chapter 1
24 of the Internal Revenue Code of 1986 (relating to

exempt organizations) is amended by adding at the end the following new part:

"PART IX—PERSONAL SOCIAL SECURITY SAVINGS PROGRAM

"Sec. 530A. Personal social security savings program.

"SEC. 530A. PERSONAL SOCIAL SECURITY SAVINGS PROGRAM.

"(a) GENERAL RULE.—The Social Security Personal Savings Fund and each Tier III Investment Option are exempt from taxation under this subtitle. Notwithstanding the preceding sentence, sums in a personal social security savings account which are attributable to a Tier III Option shall be subject to the taxes imposed by section 511 (relating to imposition of tax on unrelated business income of charitable, etc. organizations).

"(b) DISTRIBUTIONS.—

"(1) IN GENERAL.—Any qualified distribution from—

"(A) amounts credited to a personal social security savings account from the Social Security Personal Savings Fund or attributable to a Tier III Investment Option, or

"(B) a personal social security savings annuity,

shall not be included in the gross income of the distributee.

"(2) QUALIFIED DISTRIBUTION.—For purposes of paragraph (1), the term 'qualified distribution' means a distribution which meets the requirements of section 258 of the Social Security Act and which is not a guaranty payment (as defined by section 259 of such Act).

"(c) DEFINITIONS.—For purposes of this section—

"(1) PERSONAL SOCIAL SECURITY SAVINGS ACCOUNT.—The term 'personal social security savings account' means an account established under section 254(a) of the Social Security Act.

"(2) PERSONAL SOCIAL SECURITY SAVINGS ANNUITY.—The term 'personal social security savings annuity' means an annuity approved by the Personal Social Security Savings Board under section 258(b)(3) of the Social Security Act.

"(3) SOCIAL SECURITY PERSONAL SAVINGS FUND.—The term 'Social Security Personal Savings Fund' means the Savings Fund established under section 252 of the Social Security Act.

"(4) TIER III INVESTMENT OPTION.—The term 'Tier III Investment Option' has the meaning given

such term by section 251(9) of the Social Security Act.

"(d) ESTATE TAX TREATMENT.—No amount shall be includible in the gross estate of any individual for purposes of chapter 11 by reason of an interest in the Tier I Investment Fund or the Tier II Investment Fund of the Savings Fund or held under a Tier III Investment Option and which is credited to the personal social security savings account of the individual.".

(2) CONFORMING AMENDMENT.—Section 86(d)(1)(A) of such Code is amended by inserting "part A of" after "under".

(3) CLERICAL AMENDMENT.—The table of parts for subchapter F of chapter 1 of such Code is amended by adding after the item relating to part VIII the following new item:

"PART IX. PERSONAL SOCIAL SECURITY SAVINGS PROGRAM.".

(b) GUARANTY PAYMENTS.—Paragraph (1) of section 86(d) of the Internal Revenue Act of 1986, as amended by subsection (a)(2), is amended by striking "or" at the end of subparagraph (A), by striking the period and inserting ", or" at the end of subparagraph (B), and by adding at the end the following new subparagraph:

"(C) a guaranty payment under section 259(a), and a payment of an additional amount

under section 259(c), of the Social Security Act.''.

(c) EFFECTIVE DATE.—The amendments made by this section shall apply to taxable years beginning after December 31, 2011.

SEC. 405. SELF-LIQUIDATING SOCIAL SECURITY TRANSITION FUND.

Part B of title II of the Social Security Act (as added by section 101 of this Act) is amended by adding at the end the following new section:

''SEC. 262. SELF-LIQUIDATING SOCIAL SECURITY TRANSITION FUND.

''(a) ESTABLISHMENT.—There is hereby created on the books of the Treasury of the United States a trust fund to be known as the Self-Liquidating Social Security Transition Fund (in this section referred to as the 'Transition Fund').

''(b) BOARD OF TRUSTEES.—

''(1) ESTABLISHMENT.—With respect to the Transition Fund, there is hereby created a body to be known as the Board of Trustees of the Transition Fund (in this section referred to as the 'Board of Trustees') composed of the Commissioner of Social Security, the Secretary of the Treasury, and the

members of the Personal Social Security Savings Board.

"(2) DUTIES.—The Board of Trustees shall—

"(A) provide for the issuance of obligations by the Transition Fund pursuant to subsection (c),

"(B) provide for the receipt and management of amounts paid into the Transition Fund pursuant to subsection (d),

"(C) use all funds paid into the Transition Fund to redeem obligations issued under subsection (c) as soon as practicable,

"(D) report to Congress not later than the first day of April of each year on the operation and status of the Transition Fund during the preceding fiscal year and on its expected operation and status during the current fiscal year and the next 2 fiscal years, and

"(E) review the general policies followed in managing the Transition Fund, and recommend changes in such policies, including necessary changes in the provisions of law which govern the way in which the Transition Fund is to be managed.

1 "(3) MEETINGS.—The Board of Trustees shall
2 meet not less frequently than once each calendar
3 year.
4 "(c) ISSUANCE OF TRANSITION FUND BONDS.—
5 "(1) ISSUANCE.—
6 "(A) IN GENERAL.—The purposes for
7 which obligations of the United States may be
8 issued under chapter 31 of title 31, United
9 States Code, are hereby extended to authorize
10 the issuance at par of public-debt obligations by
11 the Transition Fund.
12 "(B) REQUIRED ISSUANCE.—Beginning on
13 January 1, 2012, whenever any obligation held
14 in the Federal Old-Age and Survivors Insurance
15 Trust Fund or the Federal Disability Insurance
16 Trust Fund is repaid from the general fund of
17 the Treasury to either of such Trust Funds, the
18 Transition Fund shall issue an obligation under
19 this subsection in an amount equal to the
20 amount of interest and principal so repaid.
21 "(C) TRANSFER OF PROCEEDS TO GEN-
22 ERAL FUND OF THE TREASURY.—Proceeds
23 from the issuance of any obligation issued
24 under this section shall be transferred to the
25 general fund of the Treasury.

"(D) ACCOUNTING.—The debt owed on any obligation issued under this section shall be considered to be debt of the Transition Fund and shall be accounted for in such manner.

"(2) MATURITIES AND INTEREST RATE.—Such obligations issued by the Transition Fund for purchase by the public shall have maturities fixed with due regard for the needs of the Transition Fund and shall bear interest at a rate equal to the average market yield (computed by the Secretary of the Treasury on the basis of market quotations as of the end of the calendar month next preceding the date of such issue) on all marketable interest-bearing obligations of the United States then forming a part of the public debt which are not due or callable until after the expiration of 4 years from the end of such calendar month, except that where such average market yield is not a multiple of one-eighth of 1 per centum, the rate of interest on such obligations shall be the multiple of one-eighth of 1 per centum nearest such market yield.

"(3) REPAYMENT OF OBLIGATIONS.—Obligations issued under this subsection may be redeemed only by funds in the Transition Fund.

"(d) DEPOSIT OF OASDI TRUST FUND SURPLUS.—

"(1) IN GENERAL.—In advance of the initial repayment from the general fund of the Treasury described in subsection (c)(1)(B), the Chief Actuary of the Social Security Administration shall certify to the Secretary of the Treasury the date of such repayment. There are appropriated to the Transition Fund for the fiscal year during which such date occurs, and for each fiscal year thereafter, out of any moneys in the Federal Old-Age and Survivors Insurance Trust Fund, amounts equivalent to the OASDI trust fund surplus (as defined in paragraph (2)) for the preceding fiscal year.

"(2) TRANSFERS BASED ON ESTIMATES.—The amounts appropriated by paragraph (1) shall be transferred from time to time from the Federal Old-Age and Survivors Insurance Trust Fund to the Transition Fund, such amounts to be determined on the basis of estimates by the Commissioner of Social Security. Proper adjustments shall be made in amounts subsequently transferred to the extent prior estimates were in excess of or were less than such surplus.

"(3) OASDI TRUST FUND SURPLUS DEFINED.—In this section, the term 'OASDI trust fund surplus' for a fiscal year means the dollar

amount by which the Federal Old-Age and Survivors Insurance Trust Fund could be reduced as of the end of such fiscal year so as to result in an OASDI trust fund ratio (as defined in section 201(p)(4)) for such fiscal year equal to 125 percent.

"(4) RULE OF CONSTRUCTION.—This section shall not be construed to require redemption of obligations of the Trust Fund for the purpose of making transfers to the Transition Fund under this section or for any other purpose other than to provide for payment of benefits under part A of title II of the Social Security Act.

"(e) REDEMPTION OF OBLIGATIONS UPON DEPOSIT OF FUNDS.—Obligations issued under subsection (c) may be redeemed only by funds in the Transition Fund. The Board of Trustees shall provide for the redemption of such obligations as soon as possible with funds deposited into the Transition Fund pursuant to subsection (d).

"(f) SUNSET.—On the first date as of which all of the obligations issued under subsection (c) have been redeemed, any balance remaining in the Transition Fund as of such date shall be deposited in the Federal Old-Age and Survivors Insurance Trust Fund, the terms of the Board of Trustees shall end, the Transition Fund shall cease to exist, and this section shall be repealed.".

SEC. 406. BUDGETARY TREATMENT OF SOCIAL SECURITY.

(a) IN GENERAL.—Section 710 of the Social Security Act (42 U.S.C. 911) is amended to read as follows:

"BUDGETARY TREATMENT OF SOCIAL SECURITY

"SEC. 710.

"Notwithstanding any other provision of law and except as provided in subsection (b), the receipts and disbursements shall be treated in the same manner as section 13301 of the Budget Enforcement Act of 1990.".

(b) EFFECTIVE DATE.—The amendments made by this section shall apply with respect to fiscal years beginning on or after October 1, 2011.

SEC. 407. ACCOUNTING FOR THE OLD-AGE, SURVIVORS, AND DISABILITY INSURANCE PROGRAM AND THE PERSONAL SOCIAL SECURITY SAVINGS PROGRAM.

Title VII of the Social Security Act is amended by inserting after section 705 (42 U.S.C. 906) the following new section:

"ACCOUNTING FOR THE OLD-AGE, SURVIVORS, AND DISABILITY INSURANCE PROGRAM AND THE PERSONAL SOCIAL SECURITY SAVINGS PROGRAM

"Social Security Lockbox Budget

"SEC. 706. (a) At the time of the transmittal to the Congress by the President of the budget of the United States Government, the President shall transmit to each

House of the Congress a separate report (to be known as the 'Social Security Lockbox Budget') detailing the performance during the preceding fiscal year of each of the accounts established under subsection (b). Such report shall set forth, as determined as of the end of the year—

"(1) the amount of the balance of each account,

"(2) the amount of the total charges and the amount of the total credits to each account for the year, and

"(3) the amount of the total for the year of each category of charges and credits itemized in subsection (b).

"Establishment of Accounts

"(b) For purposes of accounting for certain receipts and disbursement of the Treasury of the United States in connection with the Old-Age, Survivors, and Disability Insurance Program under part A of title II of the Social Security Act and the Personal Security Savings Program under part B of such title, the Secretary of the Treasury shall establish and maintain a Social Security Part A Account, a Social Security Part B Account, and a Self-Liquidating Social Security Transition Fund Account.

"Credits and Charges to the Social Security Part A Account

"(c)(1) For each fiscal year, the Social Security Part A Account shall be credited with the sum of—

"(A) all receipts during the year by the Federal Old-Age and Survivors Insurance Trust Fund and the Federal Disability Insurance Trust Fund under section 201 (including amounts received as interest on notes and obligations purchased by the Trust Funds under section 201(d) of such Act, and excluding amounts received in redemption of such notes and obligations and amounts received by either such Trust Fund as transfers from the other such Trust Fund), and

"(B) all receipts during the year by the Federal Old-Age and Survivors Insurance Trust Fund and the Federal Disability Insurance Trust Fund under section 121(e) of the Social Security Amendments of 1983 (relating to appropriation of amounts equivalent to taxes on social security benefits) (42 U.S.C. 401 note).

"(2) For each fiscal year, the Social Security Part A Account shall be charged with the sum of—

"(A) all benefits paid during the year from the Federal Old-Age and Survivors Insurance Trust

Fund and the Federal Disability Insurance Trust Fund under part A of title II of the Social Security Act,

"(B) all redirected social security contributions transferred during the year to the Social Security Personal Savings Fund under section 252(b),

"(C) all other expenditures during the year from the Trust Funds under part A of title II (excluding amounts expended as transfers by either such Trust Fund to the other such Trust Fund and amounts paid for the purchase of notes and obligations under section 201(d)), and

"(D) all transfers from the Federal Old-Age and Survivors Insurance Trust Fund to the Self-Liquidating Social Security Transition Fund under section 262(d).

"Charges and Credits to the Social Security Part B Account

"(d)(1) For each fiscal year, the Social Security Part B Account shall be credited with—

"(A) all redirected social security contributions transferred during the year to the Personal Social Security Savings Fund under section 252(b) of the Social Security Act, and

"(B) any net increase in the Tier I Investment Fund attributable to investment for the fiscal year, any net increase in the Tier II Investment Fund attributable to investment for the fiscal year, and the total amount of any net increases in Tier III Investment Options attributable to investment for the fiscal year.

"(2) For each fiscal year, the Social Security Part B Account shall be charged with—

"(A) all administrative costs incurred for the fiscal year with respect to the Tier I Investment Fund, the Tier II Investment Fund, and the Tier III Investment Options,

"(B) any net decrease in the Tier I Investment Fund attributable to investment for the fiscal year, any net decrease in the Tier II Investment Fund attributable to investment for the fiscal year, and the total amount of any net decreases in Tier III Investment Options attributable to investment for the fiscal year, and

"(C) annuity payments made during the year under section 258 from the Annuity Reserve Account in the Savings Fund.

"Charges and Credits to the Self-Liquidating Social Security Transition Fund Account

"(e)(1) For each fiscal year, the Self-Liquidating Social Security Transition Account shall be credited with—

"(A) all transfers to the Transition Fund from the Federal Old-Age and Survivors Insurance Trust Fund under section 262(b), and

"(B) all amounts expended during the fiscal year from the Trust Funds in the redemption under section 262(e) of obligations issued by the Transition fund under section 262(c).

"(2) For each fiscal year, the Self-Liquidating Social Security Transition Fund Account shall be charged with the total amount of obligations issued during the fiscal year by the Transition Fund under section 262(c)".

SEC. 408. PROGRESSIVE INDEXING OF BENEFITS FOR OLD-AGE, WIFE'S, AND HUSBAND'S INSURANCE BENEFITS.

(a) IN GENERAL.—Section 215(a) of the Social Security Act (42 U.S.C. 415(a)) is amended—

(1) by striking "The" in paragraph (1)(A) and inserting "In the case of any benefit other than an applicable benefit to which paragraph (2) applies, the", and

(2) by redesignating paragraphs (2) through (7) as paragraphs (3) through (8), respectively, and by inserting after paragraph (1) the following new paragraph:

"(2)(A) In the case of an applicable benefit with respect to any individual who initially becomes eligible for old-age insurance benefits or who dies (before becoming eligible for such benefits) in calendar year 2018 or later, the primary insurance amount of the individual shall be equal to the sum of—

"(i) 90 percent of the individual's average indexed monthly earning (determined under subsection (b)) to the extent that such earnings do not exceed the amount established for purposes of paragraph (1)(A)(i) by paragraph (1)(B);

"(ii) 32 percent of the individual's average indexed monthly earnings to the extent that such earnings exceed the amount established for purposes of paragraph (1)(A)(i) by paragraph (1)(B) but do not exceed the amount established for purposes of this clause by subparagraph (B);

"(iii) 32 percent (reduced as provided in subparagraph (C)) of the individual's average indexed monthly earnings to the extent that such earnings exceed the amount established for purposes of clause

(ii) but do not exceed the amount established for purposes of paragraph (1)(A)(ii) by paragraph (1)(B); and

"(iv) 15 percent (reduced as provided in subparagraph (C)) of the individual's average indexed monthly earnings to the extent that such earnings exceed the amount established for purposes of paragraph (1)(A)(ii) by paragraph (1)(B).

"(B)(i) For purposes of subparagraph (A)(ii), the amount established under this subparagraph for calendar year 2016 shall be the level of average indexed monthly earnings determined by the Chief Actuary of the Social Security Administration under clause (ii) as being at the 30th percentile for the period of calendar years 2007 through 2009.

"(ii) For purposes of clause (i), the average indexed monthly earnings for the period of calendar years 2007 through 2009 shall be determined by—

"(I) determining the average indexed monthly earnings for each individual who initially became eligible for old-age insurance benefits or who died (before becoming eligible for such benefits) during such period, except that in determining such average indexed monthly earnings under subsection (b), subsection (b)(3)(A)(ii)(I) shall be applied by sub-

stituting calendar year 2004 for the second calendar year described in such subsection; and

"(II) multiplying the amount determined for each individual under subclause (I) by the quotient obtained by dividing the national average wage index (as defined in section 209(k)(1)) for the calendar year 2016 by such index for the calendar year 2004.

"(iii) For purposes of subparagraph (A)(ii), the amount established under this subparagraph for any calendar year after 2018 shall be equal to the product of the amount in effect under clause (i) with respect to calendar year 2018 and the quotient obtained by dividing—

"(I) the national average wage index (as defined in section 209(k)(1)) for the second calendar year preceding the calendar year for which the determination is being made, by

"(II) the national average wage index (as so defined) for 2016.

"(iv) The amount established under this subparagraph for any calendar year shall be rounded to the nearest $1, except that any amount so established which is a multiple of $0.50 but not of $1 shall be rounded to the next higher $1.

"(C)(i) Except as provided in clause (ii), in the case of any calendar year after 2017, each of the percentages

to which this subparagraph applies by reason of clauses (iii) or (iv) of subparagraph (A) shall be a percentage equal to such percentage multiplied by the quotient obtained by dividing—

"(I) the difference of the maximum CPI-indexed benefit amount for such year over the amount determined under this paragraph for an individual whose average indexed monthly earnings are equal to the amount established for purposes of subparagraph (A)(ii) for such year, by

"(II) the difference of the maximum wage-indexed benefit amount for such year over the amount determined under this paragraph for an individual whose average indexed monthly earnings are equal to the amount established for purposes of subparagraph (A)(ii) for such year.

"(ii)(I) In the case of any calendar year which is a positive balance year, clause (i) shall not apply and each of the percentages to which this subparagraph applies by reason of clause (iii) or (iv) of subparagraph (B) shall be a percentage equal to the percentage determined under this subparagraph for the preceding year (determined after the application of this subparagraph).

"(II) In the case of any calendar year after a positive balance year which is not a positive balance year, this sub-

1 paragraph shall be applied by substituting 'the second cal-
2 endar year preceding the most recent positive balance
3 year' for '2015' each place it appears in clause (iv).

4 ''(iii) For purposes of clause (i), the maximum wage-
5 indexed benefit amount for any calendar year shall be
6 equal to the amount determined under this paragraph (de-
7 termined without regard to any reduction under this sub-
8 paragraph) for an individual with wages paid in and self-
9 employment income credited to each computation base
10 year in an amount equal to the contribution and benefit
11 base for each calendar year.

12 ''(iv) For purposes of clause (i), the maximum CPI-
13 indexed benefit amount for any calendar year shall be an
14 amount equal to the amount determined under clause (iii)
15 for such year multiplied by a fraction—

16 ''(I) the numerator of which is the ratio (round-
17 ed to the nearest one-thousandth of 1 percent) of
18 the Consumer Price Index for the second preceding
19 year to such index for 2015; and

20 ''(II) the denominator of which is the ratio
21 (rounded to the nearest one-thousandth of 1 per-
22 cent) of the national wage index (as defined in sec-
23 tion 209(k)(1)) for the second year preceding such
24 year to such index for 2015.

"(v)(I) For purposes of this subparagraph, a positive balance year is a calendar year following any calendar year after 2082 for which the Chief Actuary of the Social Security Administration certifies to the Secretary of the Treasury and the Congress that the combined balance ratio of the Federal Old-Age and Survivors Trust Fund and the Federal Disability Insurance Trust Fund is not less than 100 percent for such year.

"(II) For purposes of subclause (I), the combined balance ratio of the Federal Old-Age and Survivors Trust Fund and the Federal Disability Insurance Trust Fund for any calendar year is the ratio of the combined balance of such Trust Funds as of the last day of such calendar year (reduced by any transfer made pursuant to section 201(o) in such calendar year) to the amount estimated by the Commissioner of Social Security under section 201(l)(3)(B)(iii)(II) to be paid from such Trust Funds during the calendar year following such calendar year for all purposes authorized by section 201 (determined as if such following calendar year were a positive balance year).

"(D) For purposes of this paragraph, rules similar to the rules of subparagraphs (C) and (D) of paragraph (1) shall apply.

"(E) For purposes of this paragraph, the term 'applicable benefit' means any benefit under section 202 other than—

"(i) a child's insurance benefit under section 202(d) with respect to a child of an individual who has died;

"(ii) a widow's insurance benefit under section 202(e) with respect to a widow who has not attained age 60 and is under a disability (as defined in section 223(d)) which began before the end of the period specified in section 202(e)(4);

"(iii) a widower's insurance benefit under section 202(f) with respect to a widower who has not attained age 60 and is under a disability (as defined in section 223(d)) which began before the end of the period specified in section 202(f)(4); and

"(iv) a mother's and father's insurance benefit under section 202(g).".

(b) TREATMENT OF DISABLED BENEFICIARIES.—Section 215(a) of such Act (as amended by subsection (a)) is amended further by adding at the end the following new paragraph:

"(9)(A) Notwithstanding the preceding provisions of this subsection, in the case of an individual who has or has had a period of disability and who initially becomes

eligible for old-age insurance benefits or who dies (before becoming eligible for such benefits) in any calendar year in or after 2018, the primary insurance amount of such individual shall be the sum of—

"(i) the amount determined under subparagraph (B); and

"(ii) the product derived by multiplying—

"(I) the excess of the amount determined under subparagraph (C) over the amount determined under subparagraph (B), by

"(II) the adjustment factor for such individual determined under subparagraph (D).

"(B) The amount determined under this subparagraph is the amount of such individual's primary insurance amount as determined under this section without regard to this paragraph.

"(C) The amount determined under this subparagraph is the amount of such individual's primary insurance amount as determined under this section as in effect with respect to individuals becoming eligible for old-age or disability insurance benefits under section 202(a) on the date of the enactment of the Social Security Personal Savings Guarantee and Prosperity Act of 2010.

"(D) The adjustment factor determined under this subparagraph for any individual is the ratio (not greater than 1) of—

"(i) the total number of months during which such individual is under a disability (as defined in section 223(d)) during the period beginning on the date the individual attains age 22 and ending on the first day of such individual's first month of eligibility for old-age insurance benefits under section 202(a) (or, if earlier, the month of such individual's death), to

"(ii) the number of months during the period beginning on the date the individual attains age 22 and ending on the first day of such individual's first month of eligibility for old-age insurance benefits under section 202(a) (or, if earlier, the month of such individual's death).".

(c) CONFORMING AMENDMENTS.—

(1) Subsections (e)(2)(B)(i)(I) and (f)(2)(B)(i)(I) of section 202 of the Social Security Act are each amended by inserting "or section 215(a)(2)(B)(iii)" after "section 215(a)(1)(B)(i) and (ii)".

(2) Section 203(a)(10) of such Act is amended—

(A) in subparagraph (A)(i), by striking "215(a)(2)(B)(i)" and inserting "215(a)(3)(B)(i)";

(B) in subparagraph (A)(ii), by striking "215(a)(2)(C)" and inserting "215(a)(3)(C)"; and

(C) in subparagraph (B)(ii), by striking "215(a)(2)" and inserting "215(a)(3)".

(3) Section 209(k)(1) of such Act is amended by inserting "215(a)(2)(B), 215(a)(2)(C)," after "215(a)(1)(D),".

(4) Section 215(a) of such Act is amended—

(A) in paragraph (4)(A), as redesignated by paragraph (2), by striking "paragraph (4)" and inserting "paragraph (5)";

(B) in paragraph (4)(B), as redesignated by paragraph (2), by striking "paragraph (2)(A)" and inserting "paragraph (3)(A)";

(C) in paragraph (5), as redesignated by paragraph (2), by striking "paragraph (3)(A)" and inserting "paragraph (4)(A)";

(D) in paragraph (6)(A), as redesignated by paragraph (2), by striking "paragraph (4)(B)" and inserting "paragraph (5)(B)"; and

(E) in paragraph (8)(B)(ii)(I), as redesignated by paragraph (2), by striking ''paragraph (3)(B)'' and inserting ''paragraph (4)(B)''.

(5) Section 215(d)(3) of such Act is amended—

(A) by striking ''paragraph (4)(B)(ii)'' and inserting ''paragraph (5)(B)(ii)''; and

(B) by striking ''subsection (a)(7)(C)'' and inserting ''subsection (a)(8)(C)''.

(6) Subsection 215(f) of such Act is amended—

(A) in paragraph (2)(B), by striking ''subsection (a)(4)(B)'' and inserting ''subsection (a)(5)(B)'';

(B) in paragraph (7), by striking ''subsection (a)(4)(B)'' and inserting ''subsection (a)(5)(B)'', and by striking ''subsection (a)(6)'' and inserting ''subsection (a)(7)'';

(C) in paragraph (9)(A)—

(i) by striking ''subsection (a)(7)(A)'' and inserting ''subsection (a)(8)(A)''; and

(ii) by striking ''subsection (a)(7)(C)'' and inserting ''subsection (a)(8)(C)''; and

(D) in paragraph (9)(B), by striking ''subsection (a)(7)'' each place it appears and inserting ''subsection (a)(8)''.

SEC. 409. ADJUSTMENTS TO SCHEDULE FOR INCREASES IN NORMAL RETIREMENT AGE.

(a) COMPLETION OF PHASE-IN OF NORMAL RETIREMENT AGE TO AGE 67 BY 2021.—

(1) IN GENERAL.—Section 216(l) of the Social Security Act (42 U.S.C. 416(l)) is amended—

(A) in paragraph (1)(C), by striking ''2017'' and inserting ''2016'';

(B) in paragraph (1)(D), by striking ''2016'' and inserting ''2015'', and by striking ''2022'' and inserting ''2021'';

(C) in paragraph (1)(E), by striking ''2021'' and inserting ''2020''; and

(D) in paragraph (3)(B), by striking ''2017'' and inserting ''2016'', by striking ''2021'' and inserting ''2020'', and by striking ''2017'' and inserting ''2016''.

(2) MAINTENANCE OF CURRENT LAW FOR INDIVIDUALS BORN PRIOR TO JANUARY 1, 1956.—Section 216(l)(3) of such Act (as amended by paragraph (1)(D)) is amended—

(A) by redesignating subparagraphs (A) and (B) as clauses (i) and (ii), respectively;

(B) by inserting ''(A)'' after ''(3)''; and

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

"(B) Notwithstanding the preceding provisions of this subsection—

"(i) with respect to an individual who attains early retirement age after December 31, 2015, and before January 1, 2017, the age increase factor under subparagraph (A)(ii) shall not be applied; and

"(ii) with respect to an individual who attains early retirement age after December 31, 2016, and before January 1, 2018, the age increase factor under subparagraph (A)(ii) shall be 2 months.".

(b) ADJUSTMENTS TO NORMAL RETIREMENT AGE AFTER 2021.—Section 216(l) of such Act (as amended by subsection (a)) is amended—

(1) in paragraph (1)(E), by inserting "and before January 1, 2022," after "2020," and by striking "age." and inserting "age; and" ;

(2) in paragraph (1), by adding after subparagraph (E) the following new subparagraph:

"(F) with respect to an individual who attains early retirement age after December 31, 2121, 67 years of age plus the number of months in the age increase factor (as determined under paragraph (3)) for the calendar year in which such individual attains early retirement age."; and

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

''(C) The Commissioner of Social Security shall determine (using reasonable actuarial assumptions) and publish on or before November 1 of each calendar year after 2020 the number of months (rounded, if not a multiple of one month, to the next lower multiple of one month) by which the life expectancy as of October 1 of such calendar year of an individual attaining early retirement age on such October 1 exceeds the life expectancy as of October 1, 2020, of an individual attaining early retirement age on October 1, 2020. With respect to an individual who attains early retirement age in the calendar year following any calendar year in which a determination is made under this subparagraph, the age increase factor shall be the number of months determined under this subparagraph as of October 1 of such calendar year in which such determination is made.''.

TITLE V—SIMPLIFIED INCOME TAX

SEC. 501. SHORT TITLE.

This title may be cited as the ''Taxpayer Choice Act''.

SEC. 502. REPEAL OF ALTERNATIVE MINIMUM TAX FOR NONCORPORATE TAXPAYERS.

(a) IN GENERAL.—Section 55(a) of the Internal Revenue Code of 1986 (relating to alternative minimum tax imposed) is amended by adding at the end the following new flush sentence:

''In the case of a taxpayer other than a corporation, no tax shall be imposed by this section for any taxable year beginning after December 31, 2010, and the tentative minimum tax of any taxpayer other than a corporation for any such taxable year shall be zero for purposes of this title.''.

(b) CONFORMING AMENDMENTS.—

(1) Section 26(c) of such Code is amended by striking ''the term 'tentative minimum tax' means the amount determined under section 55(b)(1)'' and inserting ''the tentative minimum tax is zero.''.

(2) Section 911(f)(2) of such Code is amended to read as follows:

''(2) the tentative minimum tax under section 55 for the taxable year shall be zero.''.

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

SEC. 503. SIMPLIFIED INCOME TAX SYSTEM.

(a) IN GENERAL.—Part I of subchapter A of chapter 1 of the Internal Revenue Code of 1986 (relating to tax on individuals) is amended by redesignating section 5 as section 6 and by inserting after section 4 the following new section:

"SEC. 5. SIMPLIFIED INCOME TAX SYSTEM.

"(a) ELECTION.—

"(1) IN GENERAL.—A taxpayer other than a corporation may elect in accordance with this subsection to be subject to the tax imposed by this section in lieu of the tax imposed by section 1 for a taxable year and all subsequent taxable years.

"(2) EFFECT OF ELECTION.—For purposes of this title, if an election is in effect under paragraph (1) for any taxable year, the tax imposed by this section shall be treated as the tax imposed by section 1 for the taxable year and, except as provided by sections 31 and 36, no amount shall be allowed as a credit against such tax for the taxable year.

"(3) ELECTION.—

"(A) IN GENERAL.—

"(i) IN GENERAL.—Except as provided in clause (ii) of this subparagraph and clauses (ii) and (iii) of subparagraph (B), the election under paragraph (1) may

only be made with respect to any taxable year beginning before January 1, 2021, on a timely filed return for the first taxable year for which the election applies.

"(ii) NEW TAXPAYERS.—In the case of an individual with no tax liability under this title before January 1, 2021, the election under paragraph (1) may only be made for the first taxable year beginning after December 31, 2020, for which such individual has tax liability under this title.

"(B) EFFECT OF ELECTION.—

"(i) IN GENERAL.—Except as provided in clauses (ii) and (iii), the election under paragraph (1), once made, shall be irrevocable.

"(ii) ONE-TIME REVOCATION OF ELECTION.—A taxpayer may revoke an election under paragraph (1) for a taxable year and all subsequent taxable years. The preceding sentence shall not apply if the taxpayer has made a revocation under such sentence for any prior taxable year.

"(iii) FILING STATUS CHANGES DUE TO MAJOR LIFE EVENTS.—In the case of

any major life event described in clause (iv), a taxpayer may make an election under paragraph (1) or revoke such an election under clause (ii). Any such election or revocation shall apply for the taxable year for which made and all subsequent taxable years until the taxpayer makes an election under the preceding sentence for any subsequent (and all succeeding) taxable year.

"(iv) MAJOR LIFE EVENT.—For purposes of clause (iii), a major life event described in this clause is marriage, divorce, and death.

"(b) TAX IMPOSED.—

"(1) MARRIED INDIVIDUALS AND SURVIVING SPOUSES.—In the case of a taxpayer for whom an election under subsection (a) is in effect and who is a married individual (as defined in section 7703) who makes a single return jointly with his spouse under section 6013 or a surviving spouse (as defined in section 2(a)), there is hereby imposed on the alternative taxable income of such individual a tax determined in accordance with the following table:

"If taxable income is:	**The tax is:**
Not over $100,000	10% of alternative taxable income.

"If taxable income is:	The tax is:
Over $100,000	$10,000, plus 25% of the excess over $100,000.

1 "(2) UNMARRIED INDIVIDUALS (OTHER THAN
2 SURVIVING SPOUSES).—In the case of a taxpayer for
3 whom an election under subsection (a) is in effect
4 and who is not described in paragraph (1), there is
5 hereby imposed on the alternative taxable income of
6 such individual a tax determined in accordance with
7 the following table:

"If taxable income is:	The tax is:
Not over $50,000	10% of alternative taxable income.
Over $50,000	$5,000, plus 25% of the excess over $50,000.

8 "(c) ALTERNATIVE TAXABLE INCOME.—For pur-
9 poses of this section—
10 "(1) IN GENERAL.—The term 'alternative tax-
11 able income' means—
12 "(A) gross income,
13 "(B) the amount excluded from income
14 under section 139C for capital gains, dividends,
15 and interest, minus
16 "(C) the sum of—
17 "(i) the personal exemption,
18 "(ii) the dependent allowance, plus
19 "(iii) the alternative standard deduc-
20 tion.

"(2) PERSONAL EXEMPTION.—The personal exemption is—

"(A) 200 percent of the dollar amount in effect under subparagraph (B) in the case of—

"(i) a joint return, or

"(ii) a surviving spouse (as defined in section 2(a)), and

"(B) $3,500 in the case of an individual—

"(i) who is not married and is not a surviving spouse, or

"(ii) who is a married individual filing a separate return.

"(3) DEPENDENT ALLOWANCE.—The dependent allowance is $3,500 for each dependent (as defined in section 152).

"(4) ALTERNATIVE STANDARD DEDUCTION.—The alternative standard deduction means—

"(A) $25,000 in the case of—

"(i) a joint return, or

"(ii) a surviving spouse (as defined in section 2(a)), and

"(B) $12,500 in the case of an individual—

"(i) who is not married and is not a surviving spouse, or

"(ii) who is a married individual filing a separate return.

"(d) INFLATION ADJUSTMENTS.—

"(1) IN GENERAL.—In the case of any taxable year beginning in a calendar year after 2011, each of the dollar amounts for the rate brackets in subsection (b) and each of the dollar amounts in subsection (d)(2)(B), (d)(3), and (d)(4) shall be increased by an amount equal to—

"(A) such dollar amount, multiplied by

"(B) the cost-of-living adjustment determined under section 1(f)(3) for the calendar year in which the taxable year begins, by substituting 'calendar year 2010' for 'calendar year 1992' in subparagraph (B) thereof.

"(2) ROUNDING.—If any amount as adjusted under clause (i) is not a multiple of $100, such amount shall be rounded to the nearest multiple of $100.".

(b) CONFORMING AMENDMENT.—The table of sections for part I of subchapter A of chapter 1 of such Code is amended by striking the item relating to section 5 and inserting after the item relating to section 4 the following:

"Sec. 5. Simplified income tax system.
"Sec. 6. Cross references relating to tax on individuals.".

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

SEC. 504. EXCLUSION FOR CAPITAL GAINS, DIVIDENDS, AND INTEREST.

(a) IN GENERAL.—Part III of subchapter B of chapter 1 of the Internal Revenue Code of 1986 (relating to items specifically excluded from gross income) is amended by inserting after section 139C the following new section:

"SEC. 139D. CAPITAL GAINS, DIVIDENDS, AND INTEREST.

"(a) EXCLUSION.—Gross income does not include amounts received by an individual as net capital gains, qualified dividends, and interest.

"(b) QUALIFIED DIVIDENDS.—For purposes of this section—

"(1) IN GENERAL.—The term 'qualified dividends' means dividends received during the taxable year from—

"(A) domestic corporations, and

"(B) qualified foreign corporations.

"(2) QUALIFIED FOREIGN CORPORATIONS.—

"(A) IN GENERAL.—Except as otherwise provided in this paragraph, the term 'qualified foreign corporation' means any foreign corporation if—

"(i) such corporation is incorporated in a possession of the United States, or

"(ii) such corporation is eligible for benefits of a comprehensive income tax treaty with the United States which the Secretary determines is satisfactory for purposes of this paragraph and which includes an exchange of information program.

"(B) DIVIDENDS ON STOCK READILY TRADABLE ON UNITED STATES SECURITIES MARKET.—A foreign corporation not otherwise treated as a qualified foreign corporation under subparagraph (A) shall be so treated with respect to any dividend paid by such corporation if the stock with respect to which such dividend is paid is readily tradable on an established securities market in the United States.

"(C) EXCLUSION OF DIVIDENDS OF CERTAIN FOREIGN CORPORATIONS.—Such term shall not include any foreign corporation which for the taxable year of the corporation in which the dividend was paid, or the preceding taxable year, is a passive foreign investment company (as defined in section 1297).

1 "(3) SPECIAL RULE.—If a taxpayer to whom
2 this section applies receives, with respect to any
3 share of stock, qualified dividend income from 1 or
4 more dividends which are extraordinary dividends
5 (within the meaning of section 1059(c)), any loss on
6 the sale or exchange of such share shall, to the ex-
7 tent of such dividends, be treated as long-term cap-
8 ital loss.
9 "(c) INTEREST.—For purposes of this section, the
10 term 'interest' means—
11 "(1) interest on deposits with a bank (as de-
12 fined in section 581),
13 "(2) amounts (whether or not designated as in-
14 terest) paid, in respect to deposits, investment cer-
15 tificates, or withdrawable or repurchasable shares,
16 by—
17 "(A) a mutual savings bank, cooperative
18 bank, domestic building and loan association,
19 industrial loan association or bank, or credit
20 union, or
21 "(B) any other savings or thrift institu-
22 tion, which is chartered and supervised under
23 Federal or State law,

the deposits or accounts in which are insured under Federal or State law or which are protected and guaranteed under State law,

"(3) interest on—

"(A) evidences of indebtedness (including bonds, debentures, notes, and certificates) issued by a domestic corporation in registered form, and

"(B) to the extent provided in regulations prescribed by the Secretary, other evidences of indebtedness issued by a domestic corporation of a type offered by corporations to the public,

"(4) interest on obligations of the United States, a State, or a political subdivision of a State (not excluded from gross income of the taxpayer under any other provision of law), and

"(5) interest attributable to participation shares in a trust established and maintained by a corporation established pursuant to Federal law.

"(d) CERTAIN NONRESIDENT ALIENS INELIGIBLE FOR EXCLUSION.—In the case of a nonresident alien individual, subsection (a) shall apply only—

"(1) in determining the tax imposed for the taxable year pursuant to section 871(b)(1) and only in respect to dividends and interest which are effec-

tively connected with the conduct of a trade or business within the United States, or

"(2) in determining the tax imposed for the taxable year pursuant to section 877(b).".

(b) CONFORMING AMENDMENT.—Section 1 of such Code is amended by striking subsection (h).

(c) CLERICAL AMENDMENT.—The table of sections for such part III is amended by inserting after the item relating to section 139C the following new item:

"Sec. 139D. Capital gains, dividends, and interest.".

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

SEC. 505. REPEAL OF ESTATE AND GIFT TAXES.

(a) IN GENERAL.—Subtitle B of the Internal Revenue Code of 1986 is hereby repealed.

(b) EFFECTIVE DATE.—The repeal made by subsection (a) shall apply to the estates of decedents dying, and gifts made, and generation-skipping transfers after December 31, 2010.

TITLE VI—BUSINESS CONSUMPTION TAX

SEC. 601. SHORT TITLE.

This title may be cited as the "Competitive American Business Tax".

SEC. 602. REPEAL OF CORPORATE INCOME TAX; NEW TAX PAID BY CORPORATIONS AND OTHER BUSINESSES.

(a) IN GENERAL.—Chapter 2 of the Internal Revenue Code is renumbered chapter 3 and the following new chapter is inserted after chapter 1:

"CHAPTER 2—COMPETITIVE AMERICAN BUSINESS TAX

"SUBCHAPTER A. IMPOSITION OF TAX

"SUBCHAPTER B. BASIC RULES FOR BUSINESS CONSUMPTION TAX

"SUBCHAPTER C. CAPITAL CONTRIBUTIONS, MERGERS, ACQUISITIONS, AND DISTRIBUTIONS

"SUBCHAPTER D. ACCOUNTING METHOD RULES

"SUBCHAPTER E. LAND AND RENTAL PROPERTY

"SUBCHAPTER F. INSURANCE AND FINANCIAL PRODUCTS

"SUBCHAPTER G. TAX-EXEMPT ORGANIZATIONS

"SUBCHAPTER H. COOPERATIVES

"SUBCHAPTER I. SOURCING RULES

"SUBCHAPTER J. BUSINESS CONDUCTED IN A POSSESSION

"SUBCHAPTER K. IMPORT TAX

"SUBCHAPTER L. TRANSITION RULES

"SUBCHAPTER M. RULES FOR ADMINISTRATION, CONSOLIDATED RETURNS

"SUBCHAPTER N. DEFINITIONS AND RULES OF APPLICATION

"Subchapter A—Imposition of Tax

"Sec. 201. Tax imposed.

"SEC. 201. TAX IMPOSED.

"(a) TAXABLE BUSINESS ACTIVITY.—A business consumption tax is imposed on the sale of goods and services in the United States by a business entity.

"(b) BUSINESS CONSUMPTION TAX IMPOSED.—'Business consumption tax' is 8.5 percent of the gross profits of the business entity for the taxable year.

"(c) IMPORT TAX.—For rules relating to the import tax imposed by this chapter, see subchapter K (sections 281 through 283).

"Subchapter B—Basic Rules for Business Consumption Tax

"Sec. 202. Gross profits.
"Sec. 203. Taxable receipts.
"Sec. 204. Deductible amounts.
"Sec. 205. Cost of business purchases.
"Sec. 206. Business entity and business activity.
"Sec. 207. Loss carryover deduction.

"SEC. 202. GROSS PROFITS.

" 'Gross profits' means for a taxable year of a business entity the amount by which—

"(1) the taxable receipts of the business entity for the taxable year exceed,

"(2) the deductible amounts for the business entity for the taxable year.

"SEC. 203. TAXABLE RECEIPTS.

"(a) IN GENERAL.—'Taxable receipts' means all receipts from the sale of property, use of property, and performance of services in the United States.

"(b) GAMES OF CHANCE.—Amounts received for playing games of chance by business entities engaging in the activity of providing such games shall be treated as receipts from the sale of property or services.

"(c) IN-KIND RECEIPTS.—The taxable receipts attributable to the receipt of property, use of property or services in whole or partial exchange for property, use of property or services equal the fair market value of the services or property received.

"(d) TAXES.—Taxable receipts do not include any excise tax, sales tax, custom duty, or other separately stated levy imposed by a Federal, State, or local government received by a business entity in connection with the sale of property or services or the use of property.

"(e) FINANCIAL RECEIPTS.—

"(1) IN GENERAL.—Taxable receipts do not include financial receipts.

"(2) FINANCIAL RECEIPTS.—'Financial receipts' include—

"(A) interest,

"(B) dividends and other distributions by a business entity,

1 "(C) proceeds from the sale of stock, other
2 ownership interests in business entities, or
3 other financial instruments,
4 "(D) proceeds from life insurance policies,
5 "(E) proceeds from annuities,
6 "(F) proceeds from currency hedging or
7 exchanges, and
8 "(G) proceeds from other financial trans-
9 actions.
10 "(3) FINANCIAL INSTRUMENT.—'Financial in-
11 strument' means any—
12 "(A) share of stock in a corporation,
13 "(B) equity ownership in any widely held
14 or publicly traded partnership, trust, or other
15 business entity,
16 "(C) note, bond, debenture, or other evi-
17 dence of indebtedness,
18 "(D) interest rate, currency, or equity no-
19 tional principal contract,
20 "(E) evidence or interest in, or a derivative
21 financial instrument in, any financial instru-
22 ment described in subparagraph (A), (B), (C),
23 or (D), or any currency, including any option,
24 forward contract, short position, and any simi-

lar financial instrument in such a financial instrument or currency, and

"(F) a position which—

"(i) is not a financial instrument described in subparagraph (A), (B), (C), (D) or (E),

"(ii) is a hedge with respect to such a financial instrument, and

"(iii) is clearly identified in the dealer's records as being described in this subparagraph before the close of the day on which it was acquired or entered into.

"(f) CROSS REFERENCES.—

"(1) EXPORTS, SALES IN THE UNITED STATES.—See subchapter I for the exclusion from gross receipts for export sales and for rules on sales of property and services in the United States.

"(2) LAND.—See subchapter E for rules relating to certain sales of land.

"SEC. 204. DEDUCTIBLE AMOUNTS.

" 'Deductible amounts' for a business entity in a taxable year include—

"(1) the cost of business purchases in the taxable year (as determined under section 205),

"(2) the cost of employer-provided health insurance for which the employee, members of his family, or persons designated by him or members of his family are the beneficiaries,

"(3) such entity's loss carryover deduction (as determined under section 207), and

"(4) the transition basis deduction (as determined under section 290).

"SEC. 205. COST OF BUSINESS PURCHASES.

"(a) BUSINESS PURCHASES.—

"(1) IN GENERAL.—'Business purchases' means the acquisition of—

"(A) property,

"(B) the use of property, or

"(C) services

in the United States for use in a business activity.

"(2) EXAMPLES.—Business purchases include (without limitation) the—

"(A) purchase or rental of real property,

"(B) purchase or rental of capital equipment,

"(C) purchase of supplies and inventory,

"(D) purchase of services from independent contractors, and

"(E) imports for use in a business activity.

1 "(3) EXCLUSIONS.—Business purchases do not
2 include—
3 "(A) payments for use of money or capital,
4 such as interest or dividends (except to the ex-
5 tent that a portion so paid is a fee for financial
6 intermediation services),
7 "(B) premiums for life insurance,
8 "(C) the acquisition of savings assets or
9 other financial instruments (as defined in sec-
10 tion 203(e)(3)).
11 "(D) property acquired outside the United
12 States (but such property shall be taken into
13 account as an import if imported),
14 "(E) services performed outside the United
15 States (unless treated as imported into the
16 United States),
17 "(F) compensation expenses for an indi-
18 vidual (other than amounts paid to an indi-
19 vidual in his capacity as a business entity), or
20 "(G) taxes (except as provided in sub-
21 section (b)(2) relating to product taxes).
22 "(4) COMPENSATION EXPENSES.—'Compensa-
23 tion expenses' means—
24 "(A) wages, salaries or other cash payable
25 for services,

"(B) any taxes imposed on the recipient that are withheld by the business entity,

"(C) the cost of property purchased to provide employees with compensation (other than property incidental to the provision of fringe benefits that are excluded from income under the individual tax),

"(D) the cost of fringe benefits which are includible in an employee's, partner's, or proprietor's income under the business consumption tax (or are excluded solely because they constitute employee savings), including (without limitation)—

"(i) contributions to retirement and severance benefit plans,

"(ii) premiums for the cost of life, accident, disability and other insurance policies for which the employee, members of his family, or persons designated by him or members of his family are the beneficiaries,

"(iii) rental of parking spaces or parking fees (unless the parking space is used for a vehicle that is regularly used in a business activity);

1 "(iv) employer paid educational bene-
2 fits;
3 "(v) employer paid housing (other
4 than housing provided for the convenience
5 of the employer); and
6 "(vi) employer paid meals (other than
7 meals provided for the convenience of the
8 employer).
9 "(b) COST OF BUSINESS PURCHASES.—
10 "(1) IN GENERAL.—The 'cost of a business
11 purchase' is the amount paid or to be paid for the
12 business purchase.
13 "(2) TAXES.—
14 "(A) IN GENERAL.—The 'cost of business
15 purchases' includes any product taxes paid with
16 respect to the property or services purchased.
17 "(B) PRODUCT TAX.—'Product tax' means
18 any excise tax, sales or use tax, custom duty, or
19 other separately stated levy imposed by a Fed-
20 eral, State, or local government on the produc-
21 tion, severance or consumption of property or
22 on the provision of services, whether or not sep-
23 arately stated, and including any such taxes
24 that are technically imposed on the seller of
25 property or services.

1 "(C) TAXES NOT PRODUCT TAXES.—Prod-
2 uct taxes do not include—
3 "(i) the import tax,
4 "(ii) state and local property taxes,
5 "(iii) franchise or income taxes,
6 "(iv) payroll taxes and self-employ-
7 ment taxes, or
8 "(v) the business consumption tax.
9 "(3) IMPORTS.—In the case of an import by a
10 business entity, the cost of the import is the import
11 price for purposes of the import tax. The import tax
12 is not part of the cost of the import.
13 "(c) PROPERTY AND SERVICES ACQUIRED FOR
14 PROPERTY.—If a business entity receives property or serv-
15 ices from a business entity in whole or partial exchange
16 for property or services, the property or services acquired
17 shall be treated as if they were purchased for an amount
18 equal to the fair market value of the services or property
19 received. For purposes of this section, property includes
20 stock and other equity interests in business other than
21 stock or an equity interest in the business entity acquiring
22 the property or services. See section 210(b) for rules on
23 property or services received in exchange for an equity in-
24 terest in the recipient.

"(d) GAMBLING PAYMENTS.—In the case of a business involving gambling, lotteries, or other games of chance, business purchases include amounts paid to winners.

"(e) SAVINGS ASSETS.—'Savings assets' means stocks, bonds, securities, certificates of deposits, investments in partnerships and limited liability companies, shares of mutual funds, life insurance policies, annuities, and other similar savings or investment assets.

"(f) CROSS REFERENCES.—

"(1) LAND.—For special rules relating to the acquisition of land, see subchapter E.

"(2) RENTAL REAL ESTATE.—For special rules relating to the rental of real estate previously occupied by an owner of the real estate, see section 232.

"(3) OUTSIDE THE UNITED STATES.—For special rules relating to services performed outside the United States but used inside the United States and international services, see subchapter I.

"SEC. 206. BUSINESS ENTITY AND BUSINESS ACTIVITY.

"(a) BUSINESS ENTITY.—For purposes of the business consumption tax, 'business entity' means any corporation, unincorporated association, partnership, limited liability company, proprietorship, independent contractor, individual, or any other person engaging in business activ-

1 ity in the United States. An individual shall be considered
2 a business entity only with respect to the individual's busi-
3 ness activities.

4 "(b) BUSINESS ACTIVITY.—'Business activity' means
5 the sale of property or services, the leasing of property,
6 the development of property or services for subsequent
7 sale or use in producing property or services for subse-
8 quent sale. 'Business activity' does not include casual or
9 occasional sales of property used by an individual (other
10 than in a business activity), such as the sale by an indi-
11 vidual of a vehicle used by the individual.

12 "(c) EXCEPTION FOR CERTAIN EMPLOYEES.—

13 "(1) IN GENERAL.—'Business activity' does not
14 include—

15 "(A) the performance of services by an em-
16 ployee for an employer that is a business entity
17 with respect to the activity in which the em-
18 ployee is engaged, or

19 "(B) the performance of regular domestic
20 household services (including babysitting,
21 housecleaning, and lawn cutting) by an em-
22 ployee of an employer that is an individual or
23 family.

24 "(2) EMPLOYEE DEFINED.—For purposes of
25 this subsection, 'employee' includes an individual

partner who provides services to a partnership or an individual member who provides services to a limited liability company, or a proprietor with respect to compensation for services from his proprietorship.

"SEC. 207. LOSS CARRYOVER DEDUCTION.

"(a) DEDUCTION.—The 'loss carryover deduction' for a taxable year is the lesser of—

"(1) the business entity's gross profits for the taxable year (determined without the loss carryover deduction), or

"(2) the amount of the loss carryover to the taxable year.

"(b) LOSS CARRYOVER.—

"(1) GENERAL RULE.—A loss for any taxable year shall be a loss carryover to each of the 15 taxable years following the taxable year of the loss.

"(2) LOSS CARRYOVERS TO A TAXABLE YEAR.—The loss carryover to a taxable year is the sum of the loss carryovers from all prior taxable years beginning on or after January 1, 2011, that can be carried over to the taxable year.

"(3) REDUCTION OF LOSS CARRYOVERS AS A RESULT OF THE DEDUCTION.—A business entity's loss carryovers shall be reduced each year by the amount of the loss carryover deduction for the year.

1 Loss carryovers shall be reduced in the order that
2 they arose.
3 "(c) LOSS FOR TAXABLE YEAR.—A business entity's
4 loss (if any) for the taxable year equals the excess (if any)
5 of—
6 "(1) the sum of—
7 "(A) the cost of business purchases for the
8 taxable year, and
9 "(B) the transition basis adjustment for
10 the taxable year, over
11 "(2) taxable receipts for the taxable year.
12 "(d) SPECIAL RULES.—
13 "(1) CONSOLIDATED RETURNS.—In the case of
14 a consolidated return, the loss for a taxable year
15 shall be determined on a consolidated group basis.
16 In the case of a deconsolidation, the loss carryovers
17 from the consolidated group shall be allocated in ac-
18 cordance with rules to be prescribed by the Sec-
19 retary.
20 "(2) LOSS CARRYOVERS OF ACQUIRED BUSI-
21 NESS ENTITY.—
22 "(A) IN GENERAL.—If a business entity
23 acquires another business entity in a trans-
24 action that is considered the acquisition of a
25 business entity and the two entities file a con-

solidated return or if two business entities merge, the loss carryovers will survive and can be applied against the taxable receipts attributable to the business activities carried on (or in the case of a merger formerly carried on) by either entity.

"(B) ASSET ACQUISITION.—If a business entity acquires all or substantially all of the assets of another entity in a transaction that is considered an asset acquisition rather than the acquisition of a business entity, the acquirer will be treated as if it acquired the loss carryovers of the selling entity. For purposes of this rule, the assets of a business entity include ownership interests in other business entities.

"(C) SUBSTANTIALLY ALL.—For purposes of this paragraph 'substantially all' means more than 80 percent of the fair market value of a business entity's net assets. Under rules prescribed by the Secretary, the parties to a transaction may elect to treat acquisitions in excess of 70 percent of the fair market value of a business entity's net assets as acquisitions of 'substantially all' of a business entity's net assets.

"Subchapter C—Capital Contributions, Mergers, Acquisitions, and Distributions

"Sec. 210. Contributions to a business entity.
"Sec. 211. Distributions of property.
"Sec. 212. Asset acquisitions.
"Sec. 213. Mergers and stock acquisitions.
"Sec. 214. Spin-offs, split-off, etc.
"Sec. 215. Allocation of certain tax attributes.

"SEC. 210. CONTRIBUTIONS TO A BUSINESS ENTITY.

"(a) BY BUSINESS ENTITY.—

"(1) CASH.—If a business entity contributes cash to a business entity of which it is or becomes a partial or full owner, the amount contributed is not a deductible amount to the contributor or a taxable receipt to the recipient.

"(2) PROPERTY OR SERVICES.—If a business entity contributes property or services to a business entity of which it is or becomes a partial or full owner, the transaction will not result in taxable receipts to the contributor or a deduction for a business purchase for the recipient and will not constitute a sale resulting in taxable receipts to the contributor.

"(b) BY INDIVIDUAL.—

"(1) CASH.—If an individual contributes cash to a business entity, the cash received is not a taxable receipt.

"(2) NEW PROPERTY.—If an individual contributes to a business entity property that the individual purchased for the business entity but which was not used by any person after its purchase, the property shall be considered purchased by such business entity from the person from which the individual purchased the property.

"(3) PERSONAL USE PROPERTY.—

"(A) IN GENERAL.—If an individual contributes personal use property to a business entity in which the individual has an ownership interest or for which the individual receives an ownership interest, the business entity shall not be permitted to deduct the value of the property received as a business expense. The business entity will have a tax basis in the contributed property equal to the contributor's basis.

"(B) PERSONAL USE PROPERTY.—'Personal use property' means any property used by an individual at any time other than in a business activity.

"(4) SERVICES.—If an individual contributes services to a business entity in which the individual has an ownership interest or receives an ownership interest, the business entity shall not be permitted to

deduct the value of the services received (or the value of the equity interest provided to the services provider).

"SEC. 211. DISTRIBUTIONS OF PROPERTY.

"(a) DISTRIBUTIONS OTHER THAN TO CONTROLLING BUSINESS.—If a business entity distributes all or a portion of its assets to its owners (other than a controlling business entity), the business entity will be treated as if it sold the assets to its owners at fair market value. The fair market value will be determined by the distributing corporation and those determinations, unless unreasonable, will be binding on the recipients.

"(b) DISTRIBUTIONS TO A CONTROLLING BUSINESS.—If a business entity distributes all or a portion of its assets to a controlling business, the controlling business will assume the distributing entity's tax attributes with respect to the assets and neither entity will have taxable receipts or a deduction as a result of the transaction.

"(c) DISTRIBUTION OF PERSONAL USE PROPERTY.—If personal use property is distributed to the individual who contributed the personal use property to a business entity, the fair market value of the property for purposes of paragraph (a) shall equal the basis of the property plus any enhancement in value of the property attributable to business purchases with respect to the property.

"(d) CONTROLLING BUSINESS ENTITY.—A business entity is a 'controlling business entity' with respect to another business entity if it owns directly or indirectly more than 50 percent of the profits or capital interest in the other business entity.

"(e) APPLICATION OF THIS SECTION.—This section applies to both liquidating and nonliquidating distributions. Property shall be treated as distributed if the property is used for a nonbusiness purpose or used as non rental property (as defined in section 232) for more than an insubstantial period of time during a taxable year. See section 232 for rules relating to certain rental property.

"SEC. 212. ASSET ACQUISITIONS.

"(a) IN GENERAL.—If a business entity transfers some or all of its assets, the consideration received for such assets shall be allocated among the assets transferred in the same manner as was required by section 1060 of the Internal Revenue Code of 1986. If the transferee and transferor agree in writing on the allocation of any consideration, or as to the fair market value of any of the assets, such agreement shall be binding on both the transferor and transferee unless the Secretary determines that such allocation (or fair market value) is not appropriate.

"(b) TAX CONSEQUENCES.—The tax consequences of an asset acquisition shall be determined in accordance

with the rules of this chapter and shall be dependent upon allocations made under subsection (a). In general, consideration allocable to savings assets, such as stock in another business entity, would not be included in taxable receipts of the transferor and would not be a business purchase of the purchaser, but consideration allocable to the sale of tangible property and intangible property (other than savings assets) will constitute taxable receipts of the seller and a business purchase of the purchaser.

"(c) ELECTION TO TREAT ASSET ACQUISITION AS A STOCK ACQUISITION.—In the case of the sale of substantially all of the assets of a business entity or substantially all of the assets of a line of business or a separately standing business of a business entity, the transferee and transferor can jointly elect to treat the acquisition as if it were an acquisition of the stock of a business entity holding the assets so transferred. In such case, the rules of section 213 shall apply.

"(d) AUTHORITY TO REQUIRE ALLOCATION AGREEMENT AND NOTICE TO THE SECRETARY.—If the Secretary determines that certain types of asset acquisitions have significant possibilities of tax avoidance, the Secretary may require—

"(1) parties to such types of acquisitions to enter into agreements allocating consideration,

"(2) parties to acquisitions involving certain kinds of assets to enter into agreements allocating part of the consideration to those assets, or

"(3) parties to certain acquisitions to report information to the Secretary.

"(e) ASSET ACQUISITION RULES DO NOT APPLY IF CONSIDERATION INCLUDES EQUITY IN PURCHASER.—

"(1) IN GENERAL.—If a business entity issues its own equity or equity in a subsidiary or other controlled entity as part of the consideration for the transfer of assets to it, the transaction shall be treated as a business purchase and not as an asset acquisition, and the taxpayer shall not be entitled to a loss carryover for any unused deduction attributable to the equity portion of such transfer.

"(2) EQUITY.—For purposes of this subsection, equity means—

"(A) stock, in the case of a corporation,

"(B) partnership or similar interest, in the case of a partnership or limited liability company, and

"(C) an ownership interest or interest in profits in the case of any other business entity.

"SEC. 213. MERGERS AND STOCK ACQUISITIONS.

''(a) MERGERS.—A merger of one business entity into another or two businesses entities into a third business entity or any other similar transaction shall have no direct consequences under the business consumption tax. The surviving entity shall assume the tax attributes of the merged corporations, including any loss carryovers and credit carryovers.

''(b) STOCK ACQUISITION.—The acquisition of all or substantially all of the ownership interest in one business entity either for cash or in exchange for ownership in the acquiring entity or an entity controlled by the acquired entity shall have no direct consequences under the business consumption tax.

"SEC. 214. SPIN-OFFS, SPLIT-OFFS, ETC.

''A spin-off, split-off or split-up of a business entity shall have no direct tax consequences under the business consumption tax.

"SEC. 215. ALLOCATION OF CERTAIN TAX ATTRIBUTES.

''The Secretary shall prescribe rules for allocation of loss carryovers in cases of substantial shifts of assets from one business entity to another business entity. Under such rules, a portion of a business entity's carryovers may be deemed transferred when assets are transferred.

"Subchapter D—Accounting Method Rules

''Sec. 220. General accounting rules.

"Sec. 221. Use of the cash method of accounting.
"Sec. 222. Taxable year.
"Sec. 223. Long-term contracts.
"Sec. 224. Post-sale price adjustments and refunds.
"Sec. 225. Bad debts.
"Sec. 226. Transition rules.

"SEC. 220. GENERAL ACCOUNTING RULES.

"(a) IN GENERAL.—Except as provided in section 221, a business entity shall use an accrual method of accounting for purposes of determining the timing of recognition of taxable receipts and deduction of business purchases. All business purchases shall be deducted when incurred (in the case of a business entity using the accrual method of accounting) or when paid (in case of a business entity using the cash method of accounting) without regard to whether the business purchases are for or relate to—

"(1) inventory,

"(2) assets with a useful life of more than one year, or

"(3) property that will be used to produce other property.

"(b) ECONOMIC PERFORMANCE.—For purposes of determining whether an amount has been incurred, the all events test shall not be treated as met any earlier than when economic performance with respect to such item occurs.

1 "(c) CONSISTENT ACCOUNTING METHODS.—Except
2 as otherwise expressly provided in this chapter, a business
3 entity shall secure the consent of the Secretary before
4 changing the method of accounting by which it determines
5 gross profits. This provision shall not apply to changes
6 required by the adoption of the business consumption tax.

7 **"SEC. 221. USE OF THE CASH METHOD OF ACCOUNTING.**

8 "(a) IN GENERAL.—A business entity that was per-
9 mitted to use and used the cash method of accounting
10 under the Internal Revenue Code of 1986 shall be per-
11 mitted to continue to use the cash method of accounting.

12 "(b) NEW BUSINESS ENTITIES.—A new business en-
13 tity shall be permitted to use the cash method of account-
14 ing if permitted to under regulations prescribed by the
15 Secretary.

16 "(c) CHANGE OR EXPANSION OF BUSINESS.—Sub-
17 section (a) shall cease to apply to a business entity that
18 changes or expands its business such that under regula-
19 tions prescribed by the Secretary it is no longer eligible
20 to use the cash method of accounting.

21 "(d) REGULATIONS.—

22 "(1) USE OF CASH METHOD.—The Secretary
23 shall prescribe regulations defining which business
24 entities may use the cash method of accounting. In
25 general, those regulations shall be consistent with

the rules under sections 447 and 448 of the Internal Revenue Code of 1986. The regulations shall not require a business entity described in subsection (a) to convert to the accrual method prior to January 1, 2012.

"(2) CHANGE IN ACCOUNTING METHOD.—The Secretary shall prescribe regulations to prevent double counting of taxable receipts and deductible expenses in the case of a change in accounting method.

"SEC. 222. TAXABLE YEAR.

"(a) COMPUTATION OF GROSS PROFITS.—Gross profits shall be computed on the basis of a business entity's taxable year.

"(b) TAXABLE YEAR.—'Taxable year' means—

"(1) the taxpayer's annual accounting period, if it is a calendar year or a fiscal year;

"(2) the calendar year, if subsection (g) applies; or

"(3) the period for which the return is made if the return is made for a period of less than 12 months.

"(c) ANNUAL ACCOUNTING PERIOD.—'Annual accounting period' means the annual period on the basis of which the business entity regularly keeps its books.

"(d) CALENDAR YEAR.—'Calendar year' means a period of 12 months ending on December 31.

"(e) FISCAL YEAR.—'Fiscal year' means a period of 12 months ending on the last day of any month other than December. In the case of any business entity that has made the election provided by subsection (f), the term means the annual period (varying from 52 to 53 weeks) so elected.

"(f) ELECTION OF 52–53 WEEK YEAR.—

"(1) GENERAL RULE.—A business entity which, in keeping its books, regularly computes its income or profits on a basis of an annual period which varies from 52 to 53 weeks and ends always on the same day of the week and ends always—

"(A) on whatever date such same day of the week last occurs in a calendar month, or

"(B) on whatever date such same day of the week falls which is nearest to the last day of a calendar month, may elect to compute its gross profits on the basis of such annual period.

"(2) REGULATIONS.—The Secretary shall prescribe such regulations as he deems necessary for the application of this subsection, including regulations relating to the application of effective dates to taxpayers using a 52–53 week year.

1 "(g) CALENDAR YEAR REQUIRED.—

2 "(1) NO ACCOUNTING PERIOD.—A business en-
3 tity's taxable year shall be the calendar year if the
4 business entity does not have an annual accounting
5 period or has an annual accounting period that does
6 not qualify as a fiscal year.

7 "(2) NEW BUSINESS ENTITY.—The taxable
8 year of a business entity that begins business activ-
9 ity after December 31, 2010, shall be the calendar
10 year (or a 52–53 week fiscal year ending in Decem-
11 ber) unless the business entity can demonstrate a
12 business reason for selecting an accounting period
13 other than the calendar year.

14 "(h) TRANSITION RULE FOR BUSINESS ENTITIES
15 WITH A FISCAL YEAR.—

16 "(1) IN GENERAL.—A business entity with a
17 taxable year that is not the calendar year shall have
18 a short taxable year ending on December 31, 2010,
19 and a subsequent taxable year beginning on January
20 1, 2011, and ending on the day immediately pre-
21 ceding the beginning of the business entity's next
22 fiscal year.

23 "(2) BUSINESS ENTITIES WITH 52–53 WEEK
24 YEAR ENDING IN DECEMBER.—

"(A) IN GENERAL.—If a business entity has a 52–53 week taxable year (under the Internal Revenue Code of 1986) that ends in December 2010, it may elect to begin its first taxable year for the business consumption tax on the first day immediately following the last day of such taxable year.

"(B) NO ELECTION.—If a business entity that has a 52–53 week taxable year that ends in December 2010, does not make the election under subparagraph (A) or is prohibited from making such election by subparagraph (C), the business entity's taxable year under the Internal Revenue Code of 1986 that would end in December 2010 shall end on December 31, 2010.

"(C) ANTI-ABUSE RULE.—Subparagraph (A) shall not apply to any taxpayer that enters into business transactions in 2010 following the scheduled end of its fiscal year with business entities that are not subject to the business consumption tax at the time of such transactions if such transactions deviate from the normal course of business in order to achieve some tax benefit.

"SEC. 223. LONG-TERM CONTRACTS.

"(a) IN GENERAL.—In the case of a long-term contract—

"(1) CONTRACTOR EXPENSES.—The contractor shall be entitled to deduct its business purchases when paid or incurred.

"(2) CONTRACTOR RECEIPTS.—The contractor shall recognize taxable receipts—

"(A) in the case of a project in which the acquirer has no ownership interest in the project until delivery—

"(i) upon delivery of the project, in the case of an accrual basis contractor, or

"(ii) upon the later of delivery of the project or the receipt of payment, in the case of cash-basis contractor.

"(B) in the case of a project in which the acquirer obtains an ownership interest as the project is constructed—

"(i) when the contractor has the right to payments, in the case of an accrual basis contractor, or

"(ii) upon the later of when the contractor receives the cash or has the right to payments, in the case of a cash basis contractor.

1 "(3) ACQUIRER EXPENSES.—The acquirer that
2 is a business entity shall be entitled to deduct its
3 costs of the business purchase—
4 "(A) in the case of a cash-basis acquirer,
5 at such time as a cash basis contractor would
6 be required to treat the amounts paid as tax-
7 able receipts, or
8 "(B) in the case of an accrual-basis
9 acquirer, at such time as an accrual basis con-
10 tractor would be required to treat the amounts
11 paid or due as taxable receipts.
12 "(b) RIGHT TO PAYMENTS.—
13 "(1) IN GENERAL.—A contractor shall be treat-
14 ed as having a right to payments with respect to a
15 project at any time to the extent that the contractor
16 would not be required to return payments received
17 (or would be entitled to collect payments not yet re-
18 ceived) if the project were terminated at such time
19 by the contractor.
20 "(2) CONTRACTUAL PROVISIONS.—If a long-
21 term contract includes a procedure for paying the
22 contractor as work is completed (for example, by
23 reason of a draw down from a trust account), the
24 contractual provisions shall generally govern when a
25 contractor has a right to payment.

1 "(3) PERCENTAGE COMPLETION METHOD OF
2 ACCOUNTING.—If a long-term contract does not in-
3 clude a mechanism for paying the contractor as
4 work is completed, the percentage-of-completion
5 method of accounting shall be used to determine the
6 timing of taxable receipts of the contractor and busi-
7 ness purchases of the acquirer.
8 "(c) LONG-TERM CONTRACT.—
9 "(1) IN GENERAL.—'Long-term contract'
10 means—
11 "(A) any contract that covers service or
12 production through parts of two different cal-
13 endar years if the contract includes a formal
14 deposit and draw-down mechanism, and
15 "(B) any contract for the manufacture,
16 building, installation, or construction of prop-
17 erty if such contract is not completed within the
18 taxable year of the contractor in which such
19 contract is entered into.
20 "(2) EXCEPTION.—A contract for the manufac-
21 ture of property shall not be treated as a long-term
22 contract unless such contract involves the manufac-
23 ture of—

"(A) any unique item of a type which is not normally included in the finished goods inventory of the taxpayer, or

"(B) any item which normally requires more than 12 calendar months to complete.

"(d) CONSISTENCY.—The Secretary may require business entities to file statements containing such information with respect to long-term contracts as the Secretary may prescribe to ensure consistency in reporting.

"(e) FOREIGN CONTRACTS.—This section shall not be construed to permit a deduction for a business purchase for the cost of property produced outside the United States pursuant to a long-term contract at any time prior to the import of such property into the United States.

"SEC. 224. POST-SALE PRICE ADJUSTMENTS AND REFUNDS.

"(a) RECEIPT OF PRICE ADJUSTMENT.—In the case of a post-sale price adjustment attributable to a business purchase which was taken into account in computing gross profits for a prior taxable year, the amount of such adjustment shall be treated as a reduction or increase, as the case may be, in the cost of business purchases for the taxable year in which the adjustment is made or incurred.

"(b) ISSUANCE OF PRICE ADJUSTMENT.—In the case of a post-sale price adjustment attributable to a sale the receipts from which were taken into account in deter-

mining taxable receipts for a prior taxable year, the amount of such adjustment shall be treated as a reduction or increase, as the case may be, in taxable receipts for the taxable year in which the adjustment is made or incurred.

''(c) POST-SALE PRICE ADJUSTMENT.—'Post-sale price adjustment' means a refund, rebate, or other price allowance attributable to a sale of property or services or an upward adjustment in price that was not previously taken into account under the business entity's method of accounting.

"SEC. 225. BAD DEBTS.

''(a) SELLER.—If an amount owed to an accrual basis business entity for property or services sold—

''(1) was taken into account as a taxable receipt in a prior taxable year, and

''(2) becomes wholly or partially uncollectible during the taxable year, then the seller shall treat the amount as a reduction in taxable receipts for the taxable year in which it becomes wholly or partially uncollectible.

''(b) NOTICE REQUIREMENT.—No reduction shall be allowed under subsection (a) unless the seller notifies the purchaser of the amount which the seller has treated as wholly or partially uncollectible.

"(c) SUBSEQUENT COLLECTION.—If an amount which was treated as uncollectible under subsection (a) is subsequently collected, it shall be treated as a taxable receipt when collected.

"(d) PURCHASER.—If a purchaser receives notice under subsection (b) from a seller and the purchaser has treated the amount labeled uncollectible as a business purchase in a prior taxable year, then the purchaser shall treat such amount as a reduction in the cost of business purchases in the taxable year to which the notice relates. If the purchaser subsequently repays such amount, the repayment shall constitute the cost of a business purchase.

"SEC. 226. TRANSITION RULES.

"(a) NO DOUBLE DEDUCTIONS.—A business entity shall not be entitled to treat as a 'cost of business purchase' any amount that the business entity deducted in computing taxable income under the income tax in effect prior the effective date of the business consumption tax.

"(b) NO DOUBLE INCLUSION.—A business entity shall not be required to include in taxable receipts any receipt that the business entity took into account in computing taxable income under the income tax in effect prior to the effect date of the business consumption tax.

"(c) NO LOSS OF DEDUCTION.—An expense which—

"(1) a business entity would have been able to deduct as a cost of a business purchase in an accounting period before the effective date of the business consumption tax if the business consumption tax had been in effect in such period, and

"(2) the business entity would have been able to deduct as an expense in computing taxable income in a period after the business consumption tax is effective if the income tax had continued in effect,

shall be treated as a cost of a business purchase incurred or paid at the time that it would have been paid or incurred under the income tax if the income tax had continued in effect. This subsection shall not apply to any amount which is to be taken into account under subchapter L (relating to transition rules), any amounts which would have been deducted under the income tax through loss carryover deductions, or any deductions deferred by the uniform capitalization rules under section 263A of the Internal Revenue Code of 1986.

"(d) ALL TAXABLE RECEIPTS TAXED.—A receipt which—

"(1) a business entity would have been required to treat as a taxable receipt in an accounting period before the effective date of the business consumption

tax if the business consumption tax had been in effect in such period, and

"(2) the business entity would have been required to include in gross income in a period after the business consumption tax is effective if the income tax had continued in effect,

shall be treated as a taxable receipt at the time that it would have been included in income if the income tax had continued in effect.

"Subchapter E—Land and Rental Property

"Sec. 230. No deduction for land purchased for nonbusiness use.
"Sec. 231. Taxable receipts for land held for nonbusiness use.
"Sec. 232. Certain rental property.

"SEC. 230. NO DEDUCTION FOR LAND PURCHASED FOR NONBUSINESS USE.

"(a) IN GENERAL.—The acquisition of unimproved land shall not constitute a business purchase if the unimproved land is not acquired to be used in a business activity or if the land is acquired for—

"(1) speculation,

"(2) development (including subdivision), or

"(3) temporary leasing or other use not commensurate with the value of the land,

"(4) indefinite future use in a business activity, or

"(5) use in compensating employees.

1 "(b) FUTURE USE IN BUSINESS ACTIVITY.—Unim-
2 proved land will not be considered held for 'indefinite fu-
3 ture use in a business activity' if promptly upon acquisi-
4 tion, the purchaser or the lessee begins construction of im-
5 provements on the land (other than improvements, such
6 as paving or sewage lines, intended for indefinite future
7 development) that will be used in a business activity. Such
8 improvement must be commensurate with the value of the
9 land.

10 "(c) UNIMPROVED LAND.—'Unimproved land'
11 means—

12 "(1) land with no buildings on it,

13 "(2) land with improvements if the value of the
14 improvements is relatively small in comparison to
15 the value of the land and it is anticipated that the
16 improvements will be demolished and not used,

17 "(3) land in excess of the amount reasonably
18 needed for the buildings located on it.

19 "(d) CONVERSION TO BUSINESS USE.—If the acqui-
20 sition of land is not treated as a business purchase by rea-
21 son of subsection (a) and the land is subsequently used
22 in a manner for which it could have been treated as a
23 business purchase, the cost of the land will be treated as
24 a business purchase when the improvements on the land

are placed in service (or in the case of construction for sale, substantially completed and advertised for sale).

"SEC. 231. TAXABLE RECEIPTS FROM SALE OF LAND HELD FOR NONBUSINESS USE.

"(a) TAX BASIS.—A business entity shall have a tax basis in land equal to the cost of the land if such cost is not deductible by reason of section 230(a) and the land has not been converted to business use for purposes of section 230(d).

"(b) TAXABLE RECEIPTS OF A LAND SALE.—The taxable receipts from the sale of land (or portion thereof) in which a business entity has a tax basis by reason of subsection (a) shall be the amount by which the proceeds exceed the basis of such land (or portion thereof).

"SEC. 232. CERTAIN RENTAL PROPERTY.

"(a) IN GENERAL.—Except as provided in subsection (b), the activity of rental of real estate is a business activity to which the business consumption tax applies.

"(b) NOT RENTAL PROPERTY.—Subsection (a) shall not apply—

"(1) to property used on more than 14 days during the taxable year for nonbusiness purposes, or

"(2) to property rented for no more than 14 days during the taxable year and the total rental re-

ceived with respect to such property does not exceed $10,000.

"(c) RENTAL PROPERTY BECOMES NONRENTAL PROPERTY.—If property which is considered rental property for purposes of subsection (a) in one taxable year ceases to be rental property (by reason of subsection (b)) in the following taxable year, the property (and any associated debt) shall be treated as distributed by the business entity to its owners. Section 211(a) shall apply to such distribution.

"Subchapter F—Insurance and Financial Products

"Sec. 241. General rules.

"SEC. 241. GENERAL RULES.

"(a) TAXABLE RECEIPTS.—Taxable receipts do not include financial receipts (as defined in section 203(e)(2)).

"(b) BUSINESS PURCHASES.—Business purchases do not include the cost of financial instruments (as defined in section 203(e)(3)) or payments for use of money or capital.

"Subchapter G—Tax-exempt Organizations

"Sec. 251. Exemption for governmental entities.
"Sec. 252. Taxable activity of governmental entities.
"Sec. 253. Tax-exempt organizations.
"Sec. 254. Special rules for (c)(3) organizations.
"Sec. 255. Tax on unrelated business activity.
"Sec. 256. Unrelated business activity.

"SEC. 251. EXEMPTION FOR GOVERNMENTAL ENTITIES.

"(a) STATES.—Except as provided in section 252, a state, political subdivision thereof and the District of Columbia shall be exempt from taxation under this chapter on any gross profits derived from the exercise of any essential governmental function.

"(b) POSSESSIONS.—The government of any possession of the United States shall be exempt from taxation under this chapter on any gross profits earned by the possession.

"SEC. 252. TAXABLE ACTIVITY OF GOVERNMENTAL ENTITIES.

"(a) CERTAIN ACTIVITIES TAXABLE.—A governmental entity shall be considered a business and subject to tax on any business activity of a type frequently provided by business entities subject to tax under this chapter.

"(b) CERTAIN ACTIVITIES TREATED AS ESSENTIAL GOVERNMENT FUNCTIONS.—Subsection (a) shall not apply to the following activities, which shall be treated as essential government functions:

"(1) Provision of mass transportation services.

"(2) Provision of public utility services.

"SEC. 253. TAX-EXEMPT ORGANIZATIONS.

"(a) EXEMPTION FROM TAXATION.—An organization described in subsection (c) or (d) shall be exempt from taxation under this chapter.

"(b) TAX ON UNRELATED BUSINESS ACTIVITY.—An organization exempt from taxation under subsection (a) shall be subject to tax to the extent provided in sections 255 and 256, but shall be considered a tax-exempt organization for purposes of any law that refers to tax-exempt organizations.

"(c) LIST OF EXEMPT ORGANIZATIONS.—The following organizations are referred to in subsection (a):

"(1) INSTRUMENTALITY OF THE UNITED STATES.—Any corporation organized under Act of Congress which is an instrumentality of the United States but only if such corporation—

"(A) is exempt from Federal income taxes—

"(i) under such Act as amended and supplemented before July 18, 1984, or

"(ii) under this title without regard to any provision of law which is not contained in this title and which is not contained in a revenue Act, or

"(B) is described in subsection (h).

"(2) TITLE HOLDING COMPANIES.—Corporations organized for the exclusive purpose of holding title to property, collecting income therefrom, and turning over the entire amount thereof, less expenses, to an organization which itself is exempt under this section. Rules similar to the rules of subparagraph (G) of paragraph (25) shall apply for purposes of this paragraph.

"(3) CHARITABLE, EDUCATIONAL AND RELIGIOUS ORGANIZATIONS.—Corporations, and any community chest, fund, or foundation, organized and operated exclusively for religious, charitable, scientific, testing for public safety, literary, or educational purposes, or to foster national or international amateur sports competition (but only if no part of its activities involve the provision of athletic facilities or equipment), or for the prevention of cruelty to children or animals, no part of the net earnings of which inures to the benefit of any private shareholder or individual, no substantial part of the activities of which is carrying on propaganda, or otherwise attempting, to influence legislation (except as otherwise provided in subsection (g)), and which does not participate in, or intervene in (including the publishing or distributing of statements), any polit-

ical campaign on behalf of (or in opposition to) any candidate for public office.

"(4) SOCIAL WELFARE ORGANIZATIONS, ETC.—

"(A) Civic leagues or organizations not organized for profit but operated exclusively for the promotion of social welfare, or local associations of employees, the membership of which is limited to the employees of a designated person or persons in a particular municipality, and the net earnings of which are devoted exclusively to charitable, educational, or recreational purposes.

"(B) Subparagraph (A) shall not apply to an entity unless no part of the net earnings of such entity inures to the benefit of any private shareholder or individual.

"(5) LABOR AND AGRICULTURAL ORGANIZATIONS.—Labor, agricultural, or horticultural organizations.

"(6) TRADE ASSOCIATIONS.—Business leagues, chambers of commerce, real-estate boards, boards of trade, or professional football leagues (whether or not administering a pension fund for football players) not organized for profit and no part of the net

earnings of which inures to the benefit of any private shareholder or individual.

"(7) SOCIAL CLUBS.—Clubs organized for pleasure, recreation, and other nonprofitable purposes, substantially all of the activities of which are for such purposes and no part of the net earnings of which inures to the benefit of any private shareholder.

"(8) CERTAIN FRATERNAL SOCIETIES.—Fraternal beneficiary societies, orders, or associations—

"(A) operating under the lodge system or for the exclusive benefit of the members of a fraternity itself operating under the lodge system, and

"(B) providing for the payment of life, sick, accident, or other benefits to the members of such society, order, or association or their dependents.

"(9) VEBAS.—Voluntary employees' beneficiary associations providing for the payment of life, sick, accident, or other benefits to the members of such association or their dependents or designated beneficiaries, if no part of the net earnings of such association inures (other than through such payments)

to the benefit of any private shareholder or individual.

"(10) OTHER FRATERNAL ORGANIZATIONS.—Domestic fraternal societies, orders, or associations, operating under the lodge system—

"(A) the net earnings of which are devoted exclusively to religious, charitable, scientific, literary, educational, and fraternal purposes, and

"(B) which do not provide for the payment of life, sick, accident, or other benefits.

"(11) LOCAL TEACHERS' RETIREMENT FUNDS.—Teachers' retirement fund associations of a purely local character, if—

"(A) no part of their net earnings inures (other than through payment of retirement benefits) to the benefit of any private shareholder or individual, and

"(B) the income consists solely of amounts received from public taxation, amounts received from assessments on the teaching salaries of members, and income in respect of investments.

"(12) CERTAIN COOPERATIVES.—

"(A) Benevolent life insurance associations of a purely local character, mutual ditch or irrigation companies, mutual or cooperative tele-

phone companies, or like organizations; but only if 85 percent or more of the income consists of amounts collected from members for the sole purpose of meeting losses and expenses.

"(B) In the case of a mutual or cooperative telephone company, subparagraph (A) shall be applied without taking into account any income received or accrued—

"(i) from a nonmember telephone company for the performance of communication services which involve members of the mutual or cooperative telephone company,

"(ii) from qualified pole rentals,

"(iii) from the sale of display listings in a directory furnished to the members of the mutual or cooperative telephone company, or

"(iv) from the prepayment of a loan under section 306A, 306B, or 311 of the Rural Electrification Act of 1936 (as in effect on January 1, 1987).

"(C) In the case of a mutual or cooperative electric company, subparagraph (A) shall be ap-

plied without taking into account any income received or accrued—

"(i) from qualified pole rentals, or

"(ii) from the prepayment of a loan under section 306A, 306B, or 311 of the Rural Electrification Act of 1936 (as in effect on January 1, 1987).

"(D) For purposes of this paragraph, the term 'qualified pole rental' means any rental of a pole (or other structure used to support wires) if such pole (or other structure)—

"(i) is used by the telephone or electric company to support one or more wires which are used by such company in providing telephone or electric services to its members, and

"(ii) is used pursuant to the rental to support one or more wires (in addition to the wires described in clause (i)) for use in connection with the transmission by wire of electricity or of telephone or other communications.

For purposes of the preceding sentence, the term 'rental' includes any sale of the right to use the pole (or other structure).

"(13) NONPROFIT CEMETERIES.—Cemetery companies owned and operated exclusively for the benefit of their members or which are not operated for profit; and any corporation chartered solely for the purpose of the disposal of bodies by burial or cremation which is not permitted by its charter to engage in any business not necessarily incident to that purpose and no part of the net earnings of which inures to the benefit of any private shareholder or individual.

"(14) GRANDFATHERED MUTUAL FINANCIAL INSTITUTIONS.—

"(A) Credit unions without capital stock organized and operated for mutual purposes and without profit.

"(B) Certain corporations or associations organized before September 1, 1957, and described in subparagraphs (B) or (C) of section 501(c)(14) of the Internal Revenue Code of 1986.

"(15) GRANDFATHERED SMALL INSURANCE COMPANIES.—Insurance companies described in section 501(c)(15) of the Internal Revenue Code of 1986.

"(16) CROP FINANCING ASSOCIATIONS.—Corporations organized by an association subject to part IV of this subchapter or members thereof, for the purpose of financing the ordinary crop operations of such members or other producers, and operated in conjunction with such association. Exemption shall not be denied any such corporation because it has capital stock, if the dividend rate of such stock is fixed at not to exceed the legal rate of interest in the State of incorporation or 8 percent per annum, whichever is greater, on the value of the consideration for which the stock was issued, and if substantially all such stock (other than nonvoting preferred stock, the owners of which are not entitled or permitted to participate, directly or indirectly, in the profits of the corporation, on dissolution or otherwise, beyond the fixed dividends) is owned by such association, or members thereof; nor shall exemption be denied any such corporation because there is accumulated and maintained by it a reserve required by State law or a reasonable reserve for any necessary purpose.

"(17) SUPPLEMENTAL EMPLOYMENT BENEFIT TRUST.—

"(A) A trust or trusts forming part of a plan providing for the payment of supplemental unemployment compensation benefits, if—

"(i) under the plan, it is impossible, at any time prior to the satisfaction of all liabilities, with respect to employees under the plan, for any part of the corpus or income to be (within the taxable year or thereafter) used for, or diverted to, any purpose other than the providing of supplemental unemployment compensation benefits,

"(ii) such benefits are payable to employees under a classification which is set forth in the plan and which is found by the Secretary not to be discriminatory in favor of employees who are highly compensated employees (within the meaning of section 414(q)), and

"(iii) such benefits do not discriminate in favor of employees who are highly compensated employees (within the meaning of section 414(q). A plan shall not be considered discriminatory within the meaning of this clause merely because the bene-

fits received under the plan bear a uniform relationship to the total compensation, or the basic or regular rate of compensation, of the employees covered by the plan.

"(B) Rules similar to those contained in subparagraphs (B) through (E) of section 501(c)(7) of the Internal Revenue Code of 1986 shall apply to subparagraph (A).

"(18) GRANDFATHERED TRUSTS.—A trust or trusts created before June 25, 1959, and described in section 501(c)(18) of the Internal Revenue Code of 1986.

"(19) CERTAIN VETERANS' ORGANIZATIONS.—A post or organization of past or present members of the Armed Forces of the United States, or an auxiliary unit or society of, or a trust or foundation for, any such post or organization—

"(A) organized in the United States or any of its possessions,

"(B) at least 75 percent of the members of which are past or present members of the Armed Forces of the United States and substantially all of the other members of which are individuals who are cadets or are spouses, widows, or widowers of past or present members of

the Armed Forces of the United States or of cadets, and

"(C) no part of the net earnings of which inures to the benefit of any private shareholder or individual.

"(20) LEGAL SERVICE PLAN TRUSTS.—An organization or trust created or organized in the United States, the exclusive function of which is to form part of a qualified group legal services plan or plans.

"(21) BLACK LUNG ACT TRUSTS.—A trust or trusts established in writing, created or organized in the United States, and contributed to by any person (except an insurance company) if—

"(A) the purpose of such trust or trusts is exclusively—

"(i) to satisfy, in whole or in part, the liability of such person for, or with respect to, claims for compensation for disability or death due to pneumoconiosis under Black Lung Acts,

"(ii) to pay premiums for insurance exclusively covering such liability,

"(iii) to pay administrative and other incidental expenses of such trust in connec-

tion with the operation of the trust and the processing of claims against such person under Black Lung Acts, and

"(iv) to pay accident or health benefits for retired miners and their spouses and dependents (including administrative and other incidental expenses of such trust in connection therewith) or premiums for insurance exclusively covering such benefits; and

"(B) such trusts meets requirements similar to those contained in section 501(c)(21) of the Internal Revenue Code of 1986.

"(22) MULTIEMPLOYER ERISA TRUST.—A trust created or organized in the United States and established in writing by the plan sponsors of multiemployer plans if—

"(A) the purpose of such trust is exclusively—

"(i) to pay any amount described in section 4223(c) or (h) of the Employee Retirement Income Security Act of 1974, and

"(ii) to pay reasonable and necessary administrative expenses in connection with the establishment and operation of the

trust and the processing of claims against the trust,

"(B) no part of the assets of the trust may be used for, or diverted to, any purpose other than—

"(i) the purposes described in subparagraph (A), or

"(ii) prudent investment in securities, obligations, or time or demand deposits,

"(C) such trust meets the requirements of paragraphs (2), (3), and (4) of section 4223(b), 4223(h), or, if applicable, section 4223(c) of the Employee Retirement Income Security Act of 1974, and

"(D) the trust instrument provides that, on dissolution of the trust, assets of the trust may not be paid other than to plans which have participated in the plan or, in the case of a trust established under section 4223(h) of such Act, to plans with respect to which employers have participated in the fund.

"(23) GRANDFATHERED VETERANS' INSURANCE ORGANIZATION.—Any association organized before 1880 more than 75 percent of the members of which are present or past members of the Armed Forces

and a principal purpose of which is to provide insurance and other benefits to veterans or their dependents.

"(24) ERISA TRUST.—A trust described in section 4049 of the Employee Retirement Income Security Act of 1974 (as in effect on the date of the enactment of the Single-Employer Pension Plan Amendments Act of 1986).

"(25) REAL TITLE HOLDING CORPORATION OR TRUST.—

"(A) Any corporation or trust which—

"(i) has no more than 35 shareholders or beneficiaries,

"(ii) has only 1 class of stock or beneficial interest, and

"(iii) is organized for the exclusive purposes of—

"(I) acquiring real property and holding title to, and collecting income from, such property, and

"(II) remitting the entire amount of income from such property (less expenses) to 1 or more organizations described in subparagraph (C) which are

shareholders of such corporation or beneficiaries of such trust.

For purposes of clause (iii), the term 'real property' shall not include any interest as a tenant in common (or similar interest) and shall not include any indirect interest.

"(B) A corporation or trust shall be described in subparagraph (A) without regard to whether the corporation or trust is organized by 1 or more organizations described in subparagraph (C).

"(C) An organization is described in this subparagraph if such organization is—

"(i) a qualified pension, profit sharing, or stock bonus plan that meets the requirements of section 401(a),

"(ii) a governmental plan (within the meaning of section 414(d)),

"(iii) the United States, any State or political subdivision thereof, or any agency or instrumentality of any of the foregoing, or

"(iv) any organization described in paragraph (3).

"(D) A corporation or trust shall in no event be treated as described in subparagraph (A) unless such corporation or trust permits its shareholders or beneficiaries—

"(i) to dismiss the corporation's or trust's investment adviser, following reasonable notice, upon a vote of the shareholders or beneficiaries holding a majority of interest in the corporation or trust, and

"(ii) to terminate their interest in the corporation or trust by either, or both, of the following alternatives, as determined by the corporation or trust:

"(I) by selling or exchanging their stock in the corporation or interest in the trust (subject to any Federal or State securities law) to any organization described in subparagraph (C) so long as the sale or exchange does not increase the number of shareholders or beneficiaries in such corporation or trust above 35, or

"(II) by having their stock or interest redeemed by the corporation or trust after the shareholder or bene-

ficiary has provided 90 days notice to such corporation or trust.

"(E)(i) For purposes of this paragraph—

"(I) a corporation which is a qualified subsidiary shall not be treated as a separate corporation, and

"(II) all assets, liabilities, and items of income, deduction, and credit of a qualified subsidiary shall be treated as assets, liabilities, and such items (as the case may be) of the corporation or trust described in subparagraph (A).

"(ii) For purposes of this subparagraph, the term 'qualified subsidiary' means any corporation if, at all times during the period such corporation was in existence, 100 percent of the stock of such corporation is held by the corporation or trust described in subparagraph (A).

"(iii) For purposes of this subtitle, if any corporation which was a qualified subsidiary ceases to meet the requirements of clause (ii), such corporation shall be treated as a new corporation acquiring all of its assets (and assuming all of its liabilities) immediately before such

cessation from the corporation or trust described in subparagraph (A) in exchange for its stock.

"(F) For purposes of subparagraph (A), the term 'real property' includes any personal property which is leased under, or in connection with, a lease of real property, but only if the rent attributable to such personal property for the taxable year does not exceed 15 percent of the total rent for the taxable year attributable to both the real and personal property leased under, or in connection with, such lease.

"(G)(i) An organization shall not be treated as failing to be described in this paragraph merely by reason of the receipt of any otherwise disqualifying income which is incidentally derived from the holding of real property.

"(ii) Clause (i) shall not apply if the amount of gross income described in such clause exceeds 10 percent of the organization's gross income for the taxable year unless the organization establishes to the satisfaction of the Secretary that the receipt of gross income described in clause (i) in excess of such limitation was inadvertent and reasonable steps are being

1 taken to correct the circumstances giving rise to
2 such income.
3 "(26) STATE ESTABLISHED MEDICAL CARE IN-
4 SURER.—Any membership organization if—
5 "(A) such organization is established by a
6 State exclusively to provide coverage for medical
7 care on a not-for-profit basis to individuals de-
8 scribed in subparagraph (B) through—
9 "(i) insurance issued by the organiza-
10 tion, or
11 "(ii) a health maintenance organiza-
12 tion under an arrangement with the orga-
13 nization,
14 "(B) the only individuals receiving such
15 coverage through the organization are individ-
16 uals—
17 "(i) who are residents of such State,
18 and
19 "(ii) who, by reason of the existence
20 or history of a medical condition—
21 "(I) are unable to acquire med-
22 ical care coverage for such condition
23 through insurance or from a health
24 maintenance organization, or

1 "(II) are able to acquire such
2 coverage only at a rate which is sub-
3 stantially in excess of the rate for
4 such coverage through the member-
5 ship organization,
6 "(C) the composition of the membership in
7 such organization is specified by such State,
8 and
9 "(D) no part of the net earnings of the or-
10 ganization inures to the benefit of any private
11 shareholder or individual. A spouse and any
12 qualifying child) of an individual described in
13 subparagraph (B) (without regard to this sen-
14 tence) shall be treated as described in subpara-
15 graph (B).
16 "(27) GRANDFATHERED WORKERS COMPENSA-
17 TION ORGANIZATION.—Any membership organiza-
18 tion established before June 1, 1996, by a State ex-
19 clusively to reimburse its members for losses arising
20 under workmen's compensation acts, and described
21 in section 501(c)(27) of the Internal Revenue Code
22 of 1986.
23 "(d) RELIGIOUS AND APOSTOLIC ORGANIZATIONS.—
24 The following organizations are referred to in subsection
25 (a): Religious or apostolic associations or corporations, if

1 such associations or corporations have a common treasury
2 or community treasury, even if such associations or cor-
3 porations engage in business for the common benefit of
4 the members, but only if such activity is treated as unre-
5 lated business activity.

6 "(e) COOPERATIVE HOSPITAL SERVICE ORGANIZA-
7 TIONS.—For purposes of this chapter, an organization
8 shall be treated as an organization organized and operated
9 exclusively for charitable purposes, if—

10 "(1) such organization is organized and oper-
11 ated solely—

12 "(A) to perform, on a centralized basis,
13 one or more of the following services which, if
14 performed on its own behalf by a hospital which
15 is an organization described in subsection (c)(3)
16 and exempt from taxation under subsection (a),
17 would constitute activities in exercising or per-
18 forming the purpose or function constituting
19 the basis for its exemption: data processing,
20 purchasing (including the purchasing of insur-
21 ance on a group basis), warehousing, billing
22 and collection, food, clinical, industrial engi-
23 neering, laboratory, printing, communications,
24 record center, and personnel (including selec-

tion, testing, training, and education of personnel) services; and

"(B) to perform such services solely for two or more hospitals each of which is—

"(i) an organization described in subsection (c)(3) which is exempt from taxation under subsection (a),

"(ii) a constituent part of an organization described in subsection (c)(3) which is exempt from taxation under subsection (a) and which, if organized and operated as a separate entity, would constitute an organization described in subsection (c)(3), or

"(iii) owned and operated by the United States, a State, the District of Columbia, or a possession of the United States, or a political subdivision or an agency or instrumentality of any of the foregoing;

"(2) such organization is organized and operated on a cooperative basis and allocates or pays, within 8½ months after the close of its taxable year, all net earnings to patrons on the basis of services performed for them; and

1 "(3) if such organization has capital stock, all
2 of such stock outstanding is owned by its patrons.
3 For purposes of this title, any organization which, by rea-
4 son of the preceding sentence, is an organization described
5 in subsection (c)(3) and exempt from taxation under sub-
6 section (a), shall be treated as a hospital and as an organi-
7 zation the principal purpose or functions of which are the
8 providing of medical or hospital care or medical education
9 or medical research, if the organization is a hospital, or
10 if the organization is a medical research organization di-
11 rectly engaged in the continuous active conduct of medical
12 research in conjunction with a hospital.

13 "(f) COOPERATIVE SERVICE ORGANIZATIONS OF OP-
14 ERATING EDUCATIONAL ORGANIZATIONS.—For purposes
15 of this chapter—

16 "(1) If an organization is—

17 "(A) organized and operated solely to hold,
18 commingle, and collectively invest and reinvest
19 (including arranging for and supervising the
20 performance by independent contractors of in-
21 vestment services related thereto) in stocks and
22 securities, the moneys contributed thereto by
23 each of the members of such organization, and
24 to collect income therefrom and turn over the

entire amount thereof, less expenses, to such members,

"(B) organized and controlled by one or more such members, and

"(C) comprised solely of members that are organizations described in paragraph (2) or (3)—

"(i) which are exempt from taxation under subsection (a), or

"(ii) the gross profits of which are excluded from taxation under section 251(a),

then such organization shall be treated as an organization organized and operated exclusively for charitable purposes.

"(2) An organization is described in this paragraph if the organization is an educational organization which normally maintains a regular faculty and curriculum and normally has a regularly enrolled body of pupils or students in attendance at the place where its educational activities are regularly carried on.

"(3) An organization is described in this paragraph if the organization is an organization which normally receives a substantial part of its support (exclusive of income received in the exercise or per-

formance by such organization of its charitable, educational, or other purpose or function constituting the basis for its exemption under section 253(a)) from the United States or any State or political subdivision thereof or from direct or indirect contributions from the general public, and which is organized and operated exclusively to receive, hold, invest, and administer property and to make expenditures to or for the benefit of a college or university which is an organization referred to in clause (ii) of this subparagraph and which is an agency or instrumentality of a State or political subdivision thereof, or which is owned or operated by a State or political subdivision thereof or by an agency or instrumentality of one or more States or political subdivisions.

''(g) EXPENDITURES BY PUBLIC CHARITIES TO INFLUENCE LEGISLATION.—

''(1) GENERAL RULE.—In the case of an organization to which this subsection applies, exemption from taxation under subsection (a) shall be denied because a substantial part of the activities of such organization consists of carrying on propaganda, or otherwise attempting, to influence legislation, but only if such organization normally—

"(A) makes lobbying expenditures in excess of the lobbying ceiling amount for such organization for each taxable year, or

"(B) makes grass roots expenditures in excess of the grass roots ceiling amount for such organization for each taxable year.

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

"(A) LOBBYING EXPENDITURES.—'Lobbying expenditures' means expenditures for the purpose of influencing legislation (as defined in section 4911(d)).

"(B) LOBBYING CEILING AMOUNT.—The lobbying ceiling amount for any organization for any taxable year is 150 percent of the lobbying nontaxable amount for such organization for such taxable year, determined under section 4911.

"(C) GRASS ROOTS EXPENDITURES.—'Grass roots expenditures' means expenditures for the purpose of influencing legislation (as defined in section 4911(d) without regard to paragraph (1)(B) thereof).

"(D) GRASS ROOTS CEILING AMOUNT.—The grass roots ceiling amount for any organi-

zation for any taxable year is 150 percent of the grass roots nontaxable amount for such organization for such taxable year, determined under section 4911.

"(3) ORGANIZATIONS TO WHICH THIS SUBSECTION APPLIES.—This subsection shall apply to any organization which has elected (in such manner and at such time as the Secretary may prescribe) to have the provisions of this subsection apply to such organization and which, for the taxable year which includes the date the election is made, is described in subsection (c)(3) and is not described in paragraph (4) and is not a private foundation.

"(4) DISQUALIFIED ORGANIZATIONS.—This subsection does not apply to—

"(A) a church,

"(B) an integrated auxiliary of a church or of a convention or association of churches, or

"(C) a member of an affiliated group of organizations (within the meaning of section 4911(f)(2)) if one or more members of such group is described in subparagraph (A) or (B).

"(5) YEARS FOR WHICH ELECTION IS EFFECTIVE.—An election by an organization under this

subsection shall be effective for all taxable years of such organization which—

"(A) end after the date the election is made, and

"(B) begin before the date the election is revoked by such organization (under regulations prescribed by the Secretary).

"(6) NO EFFECT ON CERTAIN ORGANIZATIONS.—With respect to any organization for a taxable year for which—

"(A) such organization is described in paragraph (5), or

"(B) an election under this subsection is not in effect for such organization, nothing in this subsection or in section 4911 shall be construed to affect the interpretation of the phrase, 'no substantial part of the activities of which is carrying on propaganda, or otherwise attempting, to influence legislation,' under subsection (c)(3).

"(h) GOVERNMENT CORPORATIONS EXEMPT UNDER SUBSECTION (c)(1).—For purposes of subsection (c)(1), the following organizations are described in this subsection:

"(1) The Central Liquidity Facility established under title III of the Federal Credit Union Act (12 U.S.C. 1795 et seq.).

"(2) The Resolution Trust Corporation established under section 21A of the Federal Home Loan Bank Act.

"(3) The Resolution Funding Corporation established under section 21B of the Federal Home Loan Bank Act.

"(i) CERTAIN EDUCATIONAL ORGANIZATIONS.—An organization shall not be eligible for exemption as an educational organization under subsection (c)(3) if a substantial amount of its activities and funds are devoted to—

"(1) conducting seminars and other similar programs,

"(2) conducting research to educate Congress or the general public about public policy issues,

"(3) producing books and pamphlets, or

"(4) a combination of the foregoing.

"SEC. 254. SPECIAL RULES FOR (c)(3) ORGANIZATIONS.

"(a) NEW ORGANIZATIONS MUST NOTIFY SECRETARY.—Except as provided in subsection (c), an organization shall not be treated as an organization described in section 253(c)(3)—

"(1) unless that it has given notice to the Secretary, in such manner as the Secretary may prescribe, that it is applying for recognition of such status, or

"(2) for any period before giving of such notice, if such notice is given after the time prescribed by the Secretary by regulations for giving notice under this subsection.

"(b) PRESUMPTION THAT ORGANIZATIONS ARE PRIVATE FOUNDATIONS.—Except as provided in subsection (c), any organization described in section 253(c)(3) and which does not notify the Secretary, at such time and in such manner as the Secretary may by regulations prescribe, that it is not a private foundation shall be presumed to be a private foundation.

"(c) EXCEPTIONS.—Subsections (a) and (b) shall not apply to—

"(1) organizations organized before October 10, 1969;

"(2) organizations which obtained recognition of tax-exempt status under section 501(c)(3) of the Internal Revenue Code of 1986 (in the case of subsection (a) only);

"(3) organizations which were determined not to be private foundations under the Internal Revenue Code of 1986;

"(4) churches, their integrated auxiliaries, and conventions and associations of churches;

"(5) any organization that is not a private foundation and the gross receipts of which in each taxable year are not more than $25,000, or

"(6) such other classes of organizations which the Secretary may exempt.

"SEC. 255. TAX ON UNRELATED BUSINESS ACTIVITY.

"(a) IN GENERAL.—Each organization described in subsection (b) shall be subject to the Competitive American Business Tax for businesses under section 201 on its gross profits from its unrelated business activity.

"(b) ORGANIZATIONS SUBJECT TO TAX.—This section shall apply to—

"(1) organizations exempt from the business consumption tax under section 253(a), other than instrumentalities of the United States described in section 253(c)(1).

"(2) colleges and universities which are instrumentalities of any government and corporations owned by one or more such colleges or universities.

"SEC. 256. UNRELATED BUSINESS ACTIVITY.

"(a) IN GENERAL.—'Unrelated business activity' means any trade or business the conduct of which is not substantially related (aside from the need of such organization for income or funds or the use it makes of the profits derived) to the exercise or performance by such organization of its charitable, educational, or other purpose or function constituting the basis for its exemption under section 253, except that such term does not include any trade or business—

"(1) in which substantially all the work in carrying on such trade or business is performed for the organization without compensation; or

"(2) which is carried on, in the case of an organization described in section 253(c)(3) or in the case of a college or university described in section 255(b), by the organization primarily for the convenience of its members, students, patients, officers, or employees, which is the selling by the organization of items of work-related clothes and equipment and items normally sold through vending machines, through food dispensing facilities, or by snack bars, for the convenience of its members at their usual places of employment; or

"(3) which is the selling of merchandise, substantially all of which has been received by the organization as gifts or contributions.

"(b) ADVERTISING, ETC., ACTIVITIES.—For purposes of this section, 'trade or business' includes any activity which is carried on for the production of income from the sale of goods or the performance of services. For purposes of the preceding sentence, an activity does not lose identity as a trade or business merely because it is carried on within a larger aggregate of similar activities or within a larger complex of other endeavors which may, or may not, be related to the exempt purposes of the organization. Where an activity carried on for profit constitutes an unrelated trade or business, no part of such trade or business shall be excluded from such classification merely because it does not result in profit.

"(c) TRADE OR BUSINESS.—

"(1) CERTAIN BUSINESS ACTIVITIES.—An activity shall not be considered a 'trade or business' solely because the activity is a business activity (such as certain passive rental activity) that would be subject to the business consumption tax if conducted by a business entity other than a tax-exempt organization.

"(2) REGULATIONS.—The Secretary shall prescribe regulations defining a 'trade or business'. Such regulations shall be consistent with the provisions under sections 511 through 513 of the Internal Revenue Code of 1986, except to the extent such provisions are inconsistent with other principles of the business consumption tax. The regulations shall include exclusions from the definition of 'trade or business' similar to those contained in section 513 of the Internal Revenue Code for—

"(A) certain bingo games,

"(B) certain hospital services, and

"(C) certain public entertainment activity at fairs and expositions by an organization which regularly conducts, as one of its substantial exempt purposes, an agricultural or educational fair or exhibition.

"(3) TRADE SHOWS.—The conduct of trade shows and conventions shall not be excluded from the definition of trade or business.

"Subchapter H—Cooperatives

"Sec. 260. Patronage dividends of cooperatives.

"SEC. 260. PATRONAGE DIVIDENDS OF COOPERATIVES.

"(a) PATRONAGE DIVIDENDS PAID BY SUPPLY COOPERATIVES.—A qualified patronage dividend paid by a

1 supply cooperative to a patron shall be treated as if it is
2 a refund of a portion of the amounts paid by the patron
3 for goods, services, or use of capital. In general, if the
4 supply cooperative included the amount received from the
5 patron in taxable receipts, the dividend shall reduce tax-
6 able receipts in the year incurred. If the recipient of the
7 dividend is a business entity which deducted the cost of
8 business purchases to which the dividend related, the re-
9 cipient will reduce its cost of business purchases by the
10 amount of the dividend in the year the dividend is paid
11 or incurred.

12 ''(b) PATRONAGE DIVIDENDS PAID BY MARKETING
13 COOPERATIVES.—A qualified patronage dividend paid to
14 a patron by a marketing cooperative shall be treated as
15 an upward price adjustment in the amount received by the
16 patron for its goods marketed by the cooperative. In gen-
17 eral, the cooperative will increase its cost of business pur-
18 chases by the amount of the qualified patronage dividend
19 and the recipient will increase its taxable receipts by the
20 amount of the qualified patronage dividend.

21 ''(c) DIVIDEND TREATMENT.—Only the portion of a
22 patronage dividend that is not a qualified patronage divi-
23 dend shall be treated as a dividend under this chapter and
24 chapter 2.

25 ''(d) DEFINITIONS.—

1 "(1) QUALIFIED PATRONAGE DIVIDEND.—A
2 'qualified patronage dividend' is that part of a pa-
3 tronage dividend that is attributable to the patron's
4 allocable share of patronage earnings of a marketing
5 cooperative or a supply cooperative.
6 "(2) SUPPLY COOPERATIVE.—A 'supply cooper-
7 ative' is a cooperative that sells goods or service to
8 patrons and provided patronage dividends with re-
9 spect to the quantity of purchases of the patrons.
10 "(3) MARKETING COOPERATIVE.—A 'marketing
11 cooperative' is a cooperative that sells goods pro-
12 duced by its members and provides patronage divi-
13 dends to the members based on the quantities of
14 goods sold or provided for sale.
15 "(e) SPECIAL RULES.—
16 "(1) NOTICES OF ALLOCATION AND PER-UNIT
17 RETAIN CERTIFICATES.—Except as provided in
18 paragraph (2), a notice of allocation, per-unit retain
19 certificate, or other similar document shall not be
20 treated as a patronage dividend until it is redeemed
21 in cash or property.
22 "(2) OPPORTUNITY TO RECEIVE CASH.—If a
23 patron is given an opportunity to receive a patron-
24 age dividend in cash, but instead chooses to accept
25 a per-unit retain certificate or a qualified notice of

allocation, the patron will be treated as receiving cash and simultaneously contributing to the capital of the cooperative.

"(3) APPLICATION LIMITED TO QUALIFIED COOPERATIVES.—Under rules to be prescribed by the Secretary, this section shall apply only to cooperatives to which one of the following provisions of the Internal Revenue Code of 1986 would have applied:

"(A) Section 501(c)(12) (relating to cooperative telephone companies and similar organizations).

"(B) Section 501(c)(14) (relating to certain cooperative banks).

"(C) Section 521 (relating to farm cooperatives).

"(D) Section 1381 (relating to cooperatives generally).

"(4) REGULATIONS.—The Secretary shall prescribe regulations for the application of this section. The regulations shall generally be consistent with subchapter T of chapter 1 of the Internal Revenue Code of 1986 except to the extent that such rules are inconsistent with provisions of this chapter.

"Subchapter I—Sourcing Rules

"Sec. 265. Exports of property or services.
"Sec. 266. Imports of property or services.
"Sec. 267. Import or export of services.

"Sec. 268. International transportation services.
"Sec. 269. International communications.
"Sec. 270. Insurance.
"Sec. 271. Banking services.

"SEC. 265. EXPORTS OF PROPERTY OR SERVICES.

"(a) GENERAL RULE.—Taxable receipts do not include amounts received by the exporter thereof for property or services exported from the United States for use or consumption outside the United States.

"(b) EXPORT THROUGH NONBUSINESS ENTITY.—For purposes of subsection (a), if property or services are sold to a governmental entity or a tax-exempt organization for export and are exported other than in an activity of such entity which is subject to the business consumption tax, then the seller of such property or services is deemed to be the exporter thereof.

"(c) EXPORT OF SERVICES.—See section 267 for rules for determining whether services are exported or imported.

"SEC. 266. IMPORTS OF PROPERTY OR SERVICES.

"(a) IN GENERAL.—The import of property or services for consumption in the United States shall constitute a business purchase if such property or service is to be used in a business activity in the United States. Property being held for sale or retail by a business entity that is in the business of selling goods shall be considered held for 'use in a business activity'.

1 "(b) AMOUNT OF BUSINESS PURCHASE.—

2 "(1) IN GENERAL.—The cost of business pur-
3 chases with respect to the import of property or
4 services for use or consumption in the United States
5 is the customs value, price or other amount used for
6 purposes of determining the import tax under sec-
7 tion 281 or section 282.

8 "(2) IMPORT TAX.—The cost of business pur-
9 chases does not include any import tax paid. No de-
10 duction shall be allowed with respect to property or
11 service imported by a business entity unless the im-
12 port tax is paid with respect to such import.

13 **"SEC. 267. IMPORT OR EXPORT OF SERVICES.**

14 "(a) IN GENERAL.—Except as otherwise provided in
15 this subchapter, services shall not be treated as imported
16 or exported from the location in which they are performed.

17 "(b) IMPORT OF SERVICES.—A business entity shall
18 be treated as importing a service if—

19 "(1) the entire benefit of the service will be re-
20 alized in the United States, and

21 "(2) the benefit will be realized in connection
22 with the United States business activities of the
23 business entity.

24 "(c) EXPORT OF SERVICES.—A business will be
25 treated as exporting a service if—

"(1) the entire benefit of the service will be realized outside of the United States, and

"(2) the benefit will be realized solely in connection with the activities of the purchaser occurring outside the United States.

"(d) SERVICES ACQUIRED FROM SERVICE PROVIDER THAT PROVIDES SERVICES IN AND OUTSIDE THE UNITED STATES.—

"(1) IN GENERAL.—If a business entity acquires services from a service provider that provides services both in and outside the United States and the service provider shows on the invoice where the services are provided—

"(A) the business entity shall treat the services as provided where stated on the invoice, and

"(B) the service provider shall treat as taxable receipts any services listed as provided in the United States.

"(2) NO INVOICE.—If a business entity acquires services from a service provider that provides services both in and outside the United States and the service provider does not show on an invoice where such services are provided—

"(A) the business entity shall treat the services as if provided in the location to which payment is sent, and

"(B) the service provider shall treat as taxable receipts any payments received in the United States.

"(e) SPECIAL RULES PREVAIL.—See sections 268 and 269 for special rule relating to transportation and communication services.

"SEC. 268. INTERNATIONAL TRANSPORTATION SERVICES.

"(a) TRANSPORTATION OF PROPERTY.—

"(1) TAXABLE RECEIPTS.—

"(A) EXPORTS.—Taxable receipts do not include receipts from the transportation of property exported from the United States.

"(B) IMPORTS.—Taxable receipts include receipts from transportation of property imported into the United States only if such costs are not taken into account in determining the import tax.

"(C) PRESUMPTIONS.—The Secretary shall prescribe regulations describing situations in which a transporter of property must presume that no import tax has been paid on the cost of its services.

1 "(2) BUSINESS PURCHASES.—

2 "(A) EXPORTS.—Business purchases do
3 not include amounts paid or incurred for the
4 cost of transportation of property exported from
5 the United States.

6 "(B) IMPORTS.—Amounts paid or incurred
7 for transportation of goods imported into the
8 United States, shall constitute a cost of busi-
9 ness purchase only to the extent that they are
10 taken into account in determining the customs
11 value for purposes of section 281(a) (relating to
12 the import tax).

13 "(b) TRANSPORTATION OF PASSENGERS.—

14 "(1) TAXABLE RECEIPTS.—Taxable receipts—

15 "(A) include receipts from the transpor-
16 tation of passengers from the United States to
17 a destination outside the United States, but

18 "(B) do not include receipts from the
19 transportation of passengers from outside the
20 United States to a destination in the United
21 States.

22 "(2) BUSINESS PURCHASES.—Business pur-
23 chases—

24 "(A) include amounts paid or incurred in
25 a business activity for the transportation of

passengers from the United States to a destination outside the United States, but

"(B) do not include amounts paid or incurred for transportation of passengers from outside the United States to a destination in the United States.

"(3) SIMPLIFYING RULES.—The Secretary may provide rules that simplify this subsection, including rules under which—

"(A) half of receipts attributable to transportation to or from the United States are treated as taxable receipts,

"(B) half of the cost for business trips to and from the United States are treated as business purchases, and

"(C) all transportation expenses of a business entity that has no regular business outside the United States are treated as business purchases.

"SEC. 269. INTERNATIONAL COMMUNICATIONS.

"(a) IN GENERAL.—For purposes of section 266, communications services shall be treated as provided at the point of origin of the communications and shall not be treated as imported or exported.

1 "(b) COMMUNICATIONS SERVICES.—Communications
2 services include—
3 "(1) internet services,
4 "(2) telephone and electronic email communica-
5 tions services,
6 "(3) courier services (except in the case of
7 transportation of property that is imported or ex-
8 ported),
9 "(4) satellite transmission services,
10 "(5) telegraph services,
11 "(6) facsimile transmission services, and
12 "(7) other similar services.
13 **"SEC. 270. INSURANCE.**
14 "(a) IN GENERAL.—Insurance services will be treat-
15 ed as provided at the location of the insurance company
16 providing the services. Except as the Secretary may pre-
17 scribe by regulations, insurance companies will be treated
18 as providing services at the location to which insurance
19 payments are made.
20 "(b) INSURED RISKS IN THE UNITED STATES.—If
21 insurance services are provided outside the United States
22 and the insured risk is located in the United States—
23 "(1) the insurance service shall be treated as
24 imported,

"(2) the insurance premiums shall be subject to the import tax, and

"(3) payments of insurance benefits shall not be treated as imported.

"(c) INSURED RISK OUTSIDE THE UNITED STATES.—If insurance services are provided inside the United States and the insured risk is located outside the United States—

"(1) insurance services shall be treated as exported,

"(2) payments of insurance benefits shall be treated as payments for services outside the United States, and shall not be deducted as business purchases.

"(d) INSURANCE SERVICES.—Insurance services means the provision of insurance and services related to insurance other than insurance that is treated as a savings asset.

"SEC. 271. BANKING SERVICES.

"The Secretary shall prescribe regulations on the location of banking services and the extent to which such services are to be treated as imported or exported.

"Subchapter J—Business Conducted in a Possession

"Sec. 276. Treatment of possessions.

"SEC. 276. TREATMENT OF POSSESSIONS.

"(a) IN GENERAL.—For purposes of the business consumption tax imposed by this chapter, the U.S. possessions shall not be treated as part of the United States.

"(b) POSSESSION.—For purposes of this subchapter, 'U.S. possession' or 'possession' means a possession of the United States and includes the Commonwealth of Puerto Rico and the Virgin Islands.

"Subchapter K—Import Tax

"Sec. 281. Imposition of tax on property.
"Sec. 282. Imposition of tax on import of services.
"Sec. 283. General rules for the import tax.

"SEC. 281. IMPOSITION OF TAX ON PROPERTY.

"(a) GENERAL RULE.—There is hereby imposed a tax equal to 8.5 percent of the customs value of all property entered into the United States for consumption, use or warehousing.

"(b) LIABILITY FOR TAX.—The tax imposed on the import of property by subsection (a) shall be paid by the person entering the property into the United States for consumption, use or warehousing. Such tax shall be due and payable at the time of import.

"(c) IMPORTS OF PREVIOUSLY EXPORTED PROPERTY.—In the case of any article that is classified under a heading or subheading of subchapter I or II of chapter 98 of the Tariff Schedules of the United States, the tax under this section shall be imposed only on that portion

of the customs value of such article that is dutiable under such heading or subheading.

"(d) IMPORTS FOR PERSONAL CONSUMPTION.—The import tax imposed by this section shall not apply to any article entered into the United States duty free under subchapters I through VII of chapter 98 of the Tariff Schedules of the United States.

"(e) EXCEPTION FOR CERTAIN COMMODITIES AND PRODUCTS.—The import tax imposed by this section shall not apply to petroleum, petroleum products or such commodities or products as the President shall by Executive Order determine to be in short supply and vital to national security.

"SEC. 282. IMPOSITION OF TAX ON IMPORT OF SERVICES.

"(a) GENERAL RULE.—There is hereby imposed a tax equal to 8.5 percent of the cost of all services treated as imported into the United States during the taxable year of the service recipient.

"(b) LIABILITY FOR THE TAX.—The tax on the import of services imposed by subsection (a) shall be paid by the person who receives the imported services. The tax shall be payable as if it were an addition to the business consumption tax imposed by section 201.

"(c) IMPORTED SERVICES.—For purposes of this section, services shall be treated as imported if they are treat-

ed as imported under section 267 (general rules on import or export of services) or section 270 (related to insurance).

"(d) SPECIAL RULE FOR INSURANCE.—The seller of insurance that is treated as imported under section 270 shall be liable for the collection of the tax imposed by subsection (a) on the insurance and for paying such tax to the Secretary. The first sentence of subsection (b) (relating to the person liable for the tax) shall apply to insurance only to the extent that the seller of the insurance services does not collect such tax.

"SEC. 283. GENERAL RULES FOR THE IMPORT TAX.

" 'Import tax' means the tax imposed by section 281 on the import of property and the tax imposed by section 282 on the import of services.

"Subchapter L—Transition Rules

"Sec. 290. Amortization of transition basis.

"SEC. 290. AMORTIZATION OF TRANSITION BASIS.

"(a) TRANSITION BASIS DEDUCTION.—The 'transition basis deduction' for a taxable year is the sum of the amortization allowance determined under this section for the taxable year.

"(b) TREATMENT OF INTEREST FLOWS.—Interest flows between non-financial businesses shall be treated as under current law, phased out over 5 years.

"(c) AMORTIZATION RULES.—The amortization allowance to all property placed in service before the effective date of this section shall be the lesser of—

"(1) the amortization period under current law remaining on such date, or

"(2) a 5-year ratable period beginning on such date.

"Subchapter M—Rules for Administration, Consolidated Returns

"Sec. 301. Returns, due dates, etc.
"Sec. 302. Consolidated returns.

"SEC. 301. RETURNS, DUE DATES, ETC.

"(a) IN GENERAL.—Until subtitle F is amended to reflect the adoption of this chapter, the rules of subtitle F relating to C corporations shall apply to business entities with respect to—

"(1) returns and records;

"(2) time and place for paying tax;

"(3) assessment of taxes;

"(4) collections and liens;

"(5) abatements, credits, and refunds;

"(6) interest on underpayments and overpayments;

"(7) additions to tax and penalties;

"(8) closing agreements and compromises;

"(9) crimes;

1 "(10) judicial proceedings;

2 "(11) discovery of liability and enforcement;
3 and

4 "(12) estimated taxes.

5 "(b) INDIVIDUALS ENGAGING IN BUSINESS ACTIVI-
6 TIES.—Under rules prescribed by the Secretary, individ-
7 uals engaging in business activities on their own or with
8 their spouses shall be permitted to file their business con-
9 sumption tax returns with their individual tax returns and
10 shall be subject to estimated tax rules for individual in-
11 come tax returns. Such rules shall include rules to prevent
12 the avoidance or abuse of this chapter and chapter 1.

13 **"SEC. 302. CONSOLIDATED RETURNS.**

14 "(a) IN GENERAL.—Business entities may file con-
15 solidated returns of business consumption tax if they
16 would have been permitted to file consolidated returns
17 under section 1501 of the Internal Revenue Code and such
18 section were applied by treating each business entity as
19 a corporation and its owners or partners as shareholders.

20 "(b) FINANCIAL INSTITUTIONS.—Financial inter-
21 mediation businesses may be included in consolidated re-
22 turns.

23 "(c) INTERCOMPANY TRANSACTIONS.—In computing
24 the gross profits of a consolidated group, intercompany
25 transactions can be taken into account, or at the election

of the filer, be disregarded (except in the case of transactions with financial intermediation businesses).

"Subchapter N—Definitions and Rules of Application

"Sec. 310. Definitions.
"Sec. 311. Rules of application.

"SEC. 310. DEFINITIONS.

"When used in this chapter, where not otherwise distinctly expressed or manifestly incompatible with the intent thereof—

"(1) INTERNAL REVENUE CODE OF 1986.—'Internal Revenue Code of 1986' means the Internal Revenue Code of 1986 as in effect immediately before the enactment of the Competitive American Business Tax.

"(2) UNITED STATES.—'United States' means the States and the District of Columbia.

"SEC. 311. RULES OF APPLICATION.

"(a) DEFINITIONS.—Any definition included in this chapter shall apply for all purposes of this chapter unless—

"(1) such definition is limited to the purposes of a particular chapter, section, or subsection, or

"(2) the definition clearly would not be applicable in a particular context.

"(b) INTERPRETATIONS CONSISTENT WITH INTERNAL REVENUE CODE OF 1986.—Terms not defined in this chapter or elsewhere in this title, but defined in the Internal Revenue Code of 1986, shall be interpreted in a manner consistent with the Internal Revenue Code of 1986, except to the extent such interpretation would be inconsistent with the principles and purposes of this chapter.".

(b) The amendments made by this section shall be effective on January 1, 2011, except to the extent otherwise specifically provided in the text of such amendments.

SEC. 603. REPEAL OF CHAPTER 6.

Chapter 6 of the Code (relating to consolidated returns) is repealed as of January 1, 2011.

TITLE VII—JOB TRAINING RESULTS ACT OF 2010

SEC. 701. SHORT TITLE.

This title may be cited as the "Job Training Results Act of 2010".

SEC. 702. PURPOSE.

The purpose of this title is to ensure accountability and job training results in Federal job training programs.

SEC. 703. IMPROVEMENT OF JOB TRAINING PROGRAMS; PERFORMANCE METRICS FOR WIA JOB TRAINING PROGRAMS.

Title V of the Workforce Investment Act of 1998 (20 U.S.C. 9271 et seq.) is amended—

(1) by redesignating section 507 as section 510; and

(2) by inserting after section 506, the following:

"SEC. 507. IMPROVEMENT OF JOB TRAINING PROGRAMS.

"(a) GENERAL RULES.—

"(1) GRANT COMPETITION.—In order to encourage competition under the grant programs for providers of job training programs authorized under this Act, any grants under such grant programs shall be awarded on a competitive basis.

"(2) PRIORITY.—In awarding grants under this Act, the Secretary shall give priority to applicants that leverage private resources.

"(3) GRANT RENEWAL.—

"(A) THRESHOLD DETERMINATION.—The Secretary shall not renew a grant for a provider of a training program under this Act that fails to demonstrate, in accordance with the performance measures described section 508(b), that at least 50 percent of the participants of such program were employed for at least 1 year in an

1 occupation related to the training provided
2 under the program.
3 "(B) PRIORITY.—In renewing grants for
4 providers who meet the requirement described
5 in subparagraph (A), the Secretary shall give
6 priority to those providers that have the great-
7 est percentage of participants who—
8 "(i) were employment for at least 1
9 year in an occupation related to the train-
10 ing provided under the program; and
11 "(ii) as a result of the training pro-
12 vided under the program—
13 "(I) have the highest income lev-
14 els; and
15 "(II) the lowest percentage of
16 participants receiving Federal assist-
17 ance.
18 "(b) EXCEPTIONS.—Subsection (a) shall not apply to
19 State allotments made under sections 127 and 132.
20 "(c) ENROLLMENT PROHIBITION AND REQUIRE-
21 MENT.—
22 "(1) PROHIBITION.—A provider of a job train-
23 ing program under this Act may not in any way
24 limit recruitment for, or enrollment in, such pro-
25 gram to individuals who are more likely to be suc-

cessful in obtaining employment or earning a higher income after the completion of the program, as compared to other individuals.

"(2) REQUIREMENT.—An individual who participates in, or receives any service under, a training program shall be considered to be enrolled as a participant in the program.

"(d) DEFINITIONS.—For purposes of this section and section 508:

"(1) FEDERAL ASSISTANCE.—

"(A) IN GENERAL.—The term 'Federal assistance' includes—

"(i) supplemental nutrition assistance authorized under the Food and Nutrition Act of 2008 (7 U.S.C. 2011 et seq.);

"(ii) the case where a participant's adjusted gross income (or, if greater, earned income) for the most recently ended taxable year exceeds the amount of adjusted gross income, or earned income, as the case may be, which would cause the credit allowable to the participant for such taxable year under paragraph (1) of section 32(a) of the Internal Revenue Code of

1986 to be reduced by reason of paragraph (2) of such section;

"(iii) supplemental security income benefits under title XVI of the Social Security Act (42 U.S.C. 1382 et seq.);

"(iv) assistance under the State medicaid program under title XIX of the Social Security Act (42 U.S.C. 1396 et seq.); and

"(v) benefits under the temporary assistance for needy families program funded under part A of title IV of the Social Security Act (42 U.S.C. 601 et seq.).

"(B) DEFINED TERMS.—The terms 'adjusted gross income', 'earned income', and 'phaseout amount' shall have the respective meanings given such terms by section 32 of the Internal Revenue Code of 1986.

"(2) JOB TRAINING PROGRAM.—The term 'job training program' includes the following programs:

"(A) Programs for migrant youth authorized under section 127.

"(B) Native American Programs authorized under section 166.

"(C) Migrant and seasonal farm workers programs authorized under section 167.

"(D) Youth Opportunity Grant authorized under section 169.

"(E) Grants to States for Incarcerated Youth Offenders authorized under section 171.

"(F) Programs for the reintegration of ex-offenders authorized under section 171.

"(G) Responsible Reintegration of Youth Offenders program authorized under section 171.

"(H) Program of Competitive Grants for Worker Training and Placement in High Growth and Emerging Industry Sectors authorized under section 171.

"(I) Energy Efficiency and Renewable Worker Training Programs authorized under section 171(e).

"(J) Youthbuild Program authorized under section 173A.

"(K) Veterans' Workforce Investment Program authorized under section 168.

"(L) The program of workforce investment activities for youth authorized under chapter 4 of subtitle B of title I.

"(M) The program of workforce investment activities for adults authorized under chapter 5 of subtitle B of title I.

"(N) The program of workforce investment activities for dislocated workers under chapter 5 of subtitle B of title I.

"(O) Job Corps program authorized under subtitle C of title I.

"(P) The Adult Education and Family Literacy Act authorized under title II.

"(3) PARTICIPANT.—The term 'participant' means an individual who participated in, or received a service under, a job training program that is funded under this Act.

"(4) PROVIDER.—The term 'provider'—

"(A) has the meaning given the term 'eligible provider' in section 101(12);

"(B) has the meaning given the term 'service provider' in section 142(10); and

"(C) means any other agency, entity, or provider that is responsible for administering, or carrying out, a job training program under this Act.

"SEC. 508. PERFORMANCE MEASURES FOR JOB TRAINING PROGRAMS.

"(a) IN GENERAL.—Notwithstanding any other provision of law, each provider of a job training program under this Act shall, annually—

"(1) use the performance measures described in subsection (b) to assess the effectiveness of such job training program; and

"(2) submit the results of such assessment to the Secretary.

"(b) PERFORMANCE MEASURES.—In carrying out the assessment described in subsection (a), a provider of a job training program shall include the following performance measures in the assessment:

"(1) The type of job training each participant received under the program and the program costs (such as tuition and fees) for each participant.

"(2) The employment status of each participant—

"(A) 1 year after the participant completes the program;

"(B) 3 years after the participant completes the program; and

"(C) 5 years after the participant completes the program.

"(3) The percentage and number of participants who obtained employment after the completion of the program in an occupation related to the training provided under the program.

"(4) The income level of each participant—

"(A) 2 years prior to participating in the program; and

"(B) every year, up to 5 years, after participation in the program.

"(5) The percentage and number of participants receiving Federal assistance—

"(A) prior to participating in the program; and

"(B) every year, up to 5 years, after participation in the program.

"(c) RULE OF CONSTRUCTION.—Nothing in this section shall be construed to prohibit a provider of a job training program from assessing the program by using (in addition to the performance measures described in subsection (b)) a performance measure—

"(1) not described in subsection (b); or

"(2) that was being used by the provider on the day before the date of the enactment of this section.

"(d) AUDITS.—

"(1) IN GENERAL.—The Inspector General of the Department of Labor and the Comptroller General of the United States shall conduct periodic audits to ensure that providers of job training programs are—

"(A) accurately assessing the programs, including the outcomes of all participants of such programs, using the performance measures required under this section; and

"(B) in compliance with section 507(c).

"(2) REQUIREMENTS.—

"(A) IN GENERAL.—In carrying out any audit under this section (other than any initial audit survey or any audit investigating possible criminal or fraudulent conduct), either directly or through grant or contract, the Inspector General of the Department of Labor and the Comptroller General of the United States shall furnish to the providers of job training programs, or other entity to be audited, advance notification of the overall objectives and purposes of the audit, and any extensive recordkeeping or data requirements to be met, not later than 14 days (or as soon as practicable), prior to the commencement of the audit.

"(B) NOTIFICATION REQUIREMENT.—If the scope, objectives, or purposes of the audit change substantially during the course of the audit, the entity being audited shall be notified of the change as soon as practicable.

"(C) ADDITIONAL REQUIREMENT.—The reports on the results of such audits shall cite the law, regulation, policy, or other criteria applicable to any finding contained in the reports.

"(D) RULE OF CONSTRUCTION.—Nothing contained in this title shall be construed so as to be inconsistent with the Inspector General Act of 1978 (5 U.S.C. App.) or government auditing standards issued by the Comptroller General of the United States.".

SEC. 704. OTHER JOB TRAINING PROGRAMS.

(a) IN GENERAL.—The appropriate Secretaries shall—

(1) require that the providers of job training programs, as such term is defined by such Secretaries, under the programs described in subsection (b), conduct an annual assessment of the programs in accordance with section 508(b) of the Workforce Investment Act of 1998; and

(2) award grants under the programs described in subsection (b) on a competitive basis.

(b) JOB TRAINING PROGRAMS.—Subsection (a) shall apply to the following programs:

(1) The Disabled Veterans Outreach Program authorized under section 4103A of title 38, United States Code.

(2) The Local Veterans' Employment Representative Program authorized under section 4104 of title 38, United States Code.

(3) The Homeless Veterans' Reintegration Program authorized under section 2021 of title 38, United States Code.

(4) Vocational Rehabilitation for Disabled Veterans authorized under chapter 31 of title 38, United States Code.

(5) The National Guard Challenge Program authorized under section 509 of title 32, United States Code.

(6) The Older American Community Service Program authorized under title V of the Older Americans Act of 1965 (42 U.S.C. 3056 et seq.).

(7) The Native American Vocational and Technical Education Program authorized under section

116 of the Carl D. Perkins Career and Technical Education Act of 2006 (29 U.S.C. 741).

(8) Tribally Controlled Post-secondary Vocational and Technical Institutions programs authorized under section 117 of the Carl D. Perkins Career and Technical Education Act of 2006 (20 U.S.C. 2327).

(9) The Native Hawaiian Vocational Education Program authorized under section 116 of the Carl D. Perkins Career and Technical Education Act of 2006 (29 U.S.C. 741).

(10) Career and Technical Assistance to the States authorized under section title I of the Carl D. Perkins Career and Technical Education Act of 2006 (20 U.S.C. 2321 et seq.).

(11) Tech Prep Education Program authorized under title II of the Carl D. Perkins Career and Technical Education Act of 2006 (29 U.S.C. 2371 et seq.).

(12) Migrant and Seasonal Farmworkers Program authorized under section 304 of the Rehabilitation Act of 1973 (29 U.S.C. 774).

(13) Projects with industry authorized under section 611 of the Rehabilitation Act of 1973 (29 U.S.C. 795).

(14) Vocational Rehabilitation Services authorized under title I of the Rehabilitation Act of 1973 (29 U.S.C. 720 et seq.).

(15) American Indian Vocational Rehabilitation Services authorized under part C of title I of the Rehabilitation Act of 1973 (29 U.S.C. 741 et seq.).

(16) Coordination of Migrant Education Activities authorized under section 1308 of the Elementary and Secondary Education Act of 1965 (20 U.S.C. 6398).

(17) Programs authorized under the Community Services Block Grant Act (42 U.S.C. 9901 et seq.).

(18) The Tribal Work Grants program authorized under section 412(a)(2) of Social Security Act (42 U.S.C. 612(a)(2)).

(19) Job training grants authorized under section 414(c) of the American Competitiveness and Workforce Improvement Act of 1998 (29 U.S.C. 2916a).

(20) Indian Employment, Job Placement Assistance, and Vocational Training programs authorized under the Indian Self-Determination Act (25 U.S.C. 450 et seq.).

(21) Programs authorized under part A of title IV of the Social Security Act (42 U.S.C. 601 et seq.).

(22) Refugee assistance programs authorized under chapter 2 of title IV of the Immigration and Nationality Act (8 U.S.C. 1521 et seq.).

(23) Targeted assistance programs for refugees and entrants authorized under chapter 2 of title IV of the Immigration and Nationality Act (8 U.S.C. 1521 et seq.).

(24) Programs authorized under section 16(h) of the Food and Nutrition Act of 2008 (7 U.S.C. 2025(h)).

(25) The Federal Prisoner Reentry Initiative authorized under section 231(i) of Second Chance Act of 2007 (42 U.S.C. 17541(i)).

(26) Employment services authorized under the Wagner-Peyser Act of 1933 (29 U.S.C. 49 et seq.).

(27) Training programs under section 236 of part II of subchapter B of chapter 2 of title II of the Trade Adjustment Assistance Act of 1974 (19 U.S.C. 2296).

(c) DEFINITION.—The term ''appropriate Secretary'' means the head of the Federal agency who exercises ad-

ministrative authority over a program described in subsection (b).

SEC. 705. TRANSPARENCY.

Section 136(d)(3)(A) of the Workforce Investment Act of 1998 (29 U.S.C. 2871) is amended to read as follows:

"(A) shall make available to the general public the information contained in such reports and the results of an assessment using the performance measures described in section 508(b) with respect to the workforce investment activities authorized under this subtitle—

"(i) through publication; and

"(ii) by posting such information and results on the Internet website of the Department of Labor in a format and language understandable by the general public.".

SEC. 706. EVALUATIONS.

(a) EVALUATIONS.—Section 172 of the Workforce Investment Act of 1998 (29 U.S.C. 2917) is amended—

(1) in subsection (a)—

(A) in the matter preceding paragraph (1)—

(i) by inserting ''impact'' after ''continuing''; and

(ii) by inserting ''impact'' after ''Such''; and

(B) in paragraph (1)—

(i) by striking ''the general effectiveness'' and inserting ''outcomes measuring of the effectiveness'';

(ii) in subparagraph (A), by striking ''and'' after the semicolon;

(iii) in subparagraph (B)—

(I) by striking ''to the extent feasible,''; and

(II) by inserting ''and'' after the semicolon; and

(iv) by adding at the end the following:

''(C) increase the incomes and hourly wages of participants in comparison to similarly situated individuals who did not participate in such programs and activities.'';

(2) in subsection (b), by inserting ''impact'' after ''conduct'';

(3) in subsection (c)—

(A) by striking ''Evaluations'' and inserting ''Impact evaluations'';

(B) by inserting ''intervention and'' after '', including the use of' '

(C) by inserting ''The Secretary for each impact evaluation shall fulfill all the notification and reporting requirements under subsections (d), (e), and (f).'' after ''assignment methodologies.''; and

(D) by striking ''by the end of fiscal year 2005'' and inserting ''not later than 3 years after the date of the enactment of the Job Training Results Act of 2010'';

(4) by redesignating subsections (c) through (f), as subsections (d) through (g), respectively; and

(5) by inserting after subsection (c), the following:

''(a) NOTIFICATION OF IMPACT EVALUATION PROGRESS.—

''(1) REPORTS TO CONGRESS.—Not later than 1 year after the date of the enactment of the Job Training Results Act of 2010, and annually thereafter, the Secretary shall transmit to the Committee on Education and the Labor, and the Committee on the Budget, of the House of Representatives and the

Committee on Health, Education, Labor, and Pensions, and the Committee on Budget, of the Senate a report on the progress the Secretary is making in evaluating the programs and activities carried out under this section.

''(2) AVAILABILITY TO GENERAL PUBLIC.—Not later than 1 year after the date of the enactment of the Job Training Results Act of 2010, and annually thereafter not later than 30 days after the transmission of an annual report under paragraph (1), the Secretary shall make available the reports to the general public on the Internet website of the Department of Labor.'';

(6) by amending subsection (e) (as so redesignated), by inserting ''impact'' after ''carrying out an'';

(7) by amending subsection (f) (as so redesignated)—

(A) by striking ''Workforce'' and inserting '', Labor and the Committee on the Budget,'';

(B) by striking ''Committee on Labor and Human Resources'' and inserting ''Committee on Health, Education, Labor, and Pensions, and the Committee on Budget,'';

(C) by striking ''30 days'' and inserting ''60 days''; and

(D) by inserting the following: ''All reports transmitted under this subsection shall be made available to the general public on the Internet website of the Department of Labor.''; and

(8) by adding at the end the following:

''(h) GAO REPORT.—Not later than 3 years after the date of the enactment of the Job Training Results Act of 2010, and every 3 years thereafter, the Comptroller General of the United States shall conduct a study and submit a report to Congress that evaluates—

''(1) the effectiveness of the impact evaluations conducted under this section; and

''(2) the impact of such evaluations on the assessments conducted under section 508(b) with respect to the programs and activities carried out under this title.

''(i) DEFINITIONS.—In this section:

''(1) IMPACT EVALUATION.—The term 'impact evaluation' means an evaluative study that evaluates, in accordance with subsection (a), the outcomes of programs and activities carried out under this title, including the impact on social conditions such programs and activities are intended to improve.

1 "(2) SCIENTIFIC RANDOM ASSIGNMENT METH-
2 ODOLOGIES.—The term 'scientific random assign-
3 ment methodologies' means research designs con-
4 ducted in program settings in which intervention
5 and control groups are—
6 "(A) formed by random assignment; and
7 "(B) compared on the basis of outcome
8 measures for the purpose of determining the
9 impact of the programs and activities carried
10 out under this title on participants.
11 "(3) CONTROL GROUP.—The term 'control
12 group' means a group of individuals—
13 "(A) who did not participate in the pro-
14 grams and activities carried out under this title;
15 and
16 "(B) whose outcome measures are com-
17 pared to the outcome measures of individuals in
18 an intervention group.
19 "(4) INTERVENTION GROUP.—The term 'inter-
20 vention group' means a group of individuals—
21 "(A) who participated in the programs and
22 activities carried out under this title; and
23 "(B) whose outcome measures are com-
24 pared to the outcome measures of individuals in
25 a control group.".

SEC. 707. ENCOURAGING INNOVATION.

(a) STATE BLOCK GRANT.—Section 192 (29 U.S.C. 2942) is amended to read as follows:

"SEC. 192. JOB TRAINING IMPROVEMENT PLAN.

"(a) STATE BLOCK GRANT.—

"(1) IN GENERAL.—Not earlier than 1 year of the date of the enactment of the 'Job Training Results Act of 2010', a State may submit to the Secretary, and the Secretary (in cooperation with the appropriate Secretaries) may approve a Job Training Improvement Plan (in this section referred to as a 'Plan') submitted by a State pursuant to subsection (d) under which the State is authorized to—

"(A) integrate any of the funds that the State is eligible to receive under the job training programs described in subsection (g) to improve job training results in the State; and

"(B) waive, in accordance with the Plan and except as otherwise indicated in this subsection, any of the statutory and regulatory requirements—

"(i) applicable under this title to local areas; and

"(ii) applicable under the programs described in subsection (g), the funds of

which will be integrated under a Plan submitted under this section.

"(2) ELIGIBILITY.—In order for a State's Plan to be approved under this section, the providers of training programs in the State shall have carried out at least 1 assessment pursuant to section 508 with respect to such programs.

"(b) PERIODS.—

"(1) IN GENERAL.—The Secretary (in cooperation with other appropriate Secretaries) may—

"(A) approve a State's Plan under this section for a period of not more than 3 years; and

"(B) renew a State's Plan under this section for additional 3-year periods if the State demonstrates a significant improvement in job training results at the end of the preceding 3-year period.

"(c) DEFINITIONS.—For purposes of this section:

"(1) JOB TRAINING RESULTS.—

"(A) IN GENERAL.—The term 'job training results' means an improvement in the assessment carried out pursuant to section 508 with respect to the job training programs conducted in a State, as compared to the assessment of

1 such programs carried out in the most recent
2 preceding fiscal year.
3 "(B) IMPROVEMENTS.—An improvement
4 in an assessment described in subparagraph (A)
5 shall include—
6 "(i) an increase in the percentage of
7 participants—
8 "(I) who were employed for at
9 least 1 year in an occupation related
10 to the training provided under the
11 program;
12 "(II) who are employed at higher
13 income levels; and
14 "(ii) a decrease in the percentage of
15 participants who are receiving Federal as-
16 sistance
17 "(2) APPROPRIATE SECRETARY.—The term 'ap-
18 propriate Secretary' means the head of the Federal
19 agency who exercises administrative authority over a
20 program described in subsection (g).
21 "(d) CONTENTS OF PLAN.—To have a Plan approved
22 under this subsection, a State, after consultation with
23 State and local workforce investment boards, shall submit
24 a Plan to the Secretary at such time, in such manner,

and containing such information as the Secretary may require, including—

"(1) identification of the funds the State is eligible to receive under the job training programs described in subsection (g) that will be integrated;

"(2) a description of how the Plan, including how the integration of funds under the Plan will result in a significant improvement in job training results in the State;

"(3) a description of how the State will maintain accurate records of the performance measures for the assessments required pursuant to section 508;

"(4) assurances that in carrying out the Plan—

"(A) the State will serve populations consistent with the populations served by the funds which are being integrated, and will provide such populations universal access to work ready services as described in section 134(d)(2) of this Act;

"(B) of the funds expended under the plan each fiscal year, not more than 10 percent of such funds will be expended on the costs of administration (as defined by the Secretary); and

"(C) the State will comply with requirements under this title and the programs to be integrated relating to wage and labor standards (including nondisplacement provisions), grievance procedures and judicial review, and nondiscrimination;

"(5) identification of private resources that will be used to assist in improving job training results; and

"(6) a description of the job training awareness campaign that the State will carry out as part of such Plan.

"(e) INTEGRATION OF JOB TRAINING PROGRAMS AUTHORIZED.—

"(1) AUTHORIZATION FOR INTEGRATION.—In carrying out this subsection, the Secretary, in cooperation with the appropriate Secretaries, shall, upon the approval of the Plan submitted under subsection (d), authorize a State to integrate, as described in paragraph (2) the portion of the funds the State is eligible to receive under the programs described in subsection (g) to assist in implementing such Plan.

"(2) INTEGRATION.—The authorization shall give the State the authority to integrate, in accordance with the State's Plan, funds the State—

"(A) is eligible to receive under the programs described in subsection (g); and

"(B) has identified under the Plan as funds to be integrated.

"(f) EFFECT ON PROGRAM REQUIREMENTS.—The State may use the integrated funds used to carry out any of the activities authorized under any of the programs described in subsection (g), but shall not be required to carry out any requirements of the statutes authorizing the programs, except as otherwise specified in this section.

"(g) JOB TRAINING PROGRAMS.—Funds that shall be made available for integration under an approved Plan are funds provided under the following programs:

"(1) Programs for migrant youth authorized under section 127.

"(2) Native American Programs authorized under section 166.

"(3) Migrant and seasonal farm workers programs authorized under section 167.

"(4) Youth Opportunity Grant authorized under section 169.

1 "(5) Grants to States for Incarcerated Youth
2 Offenders authorized under section 171.
3 "(6) Programs for the reintegration of ex-of-
4 fenders authorized under section 171.
5 "(7) Responsible Reintegration of Youth Of-
6 fenders program authorized under section 171.
7 "(8) Program of Competitive Grants for Work-
8 er Training and Placement in High Growth and
9 Emerging Industry Sectors authorized under section
10 171.
11 "(9) Energy Efficiency and Renewable Worker
12 Training Programs authorized under section 171(e).
13 "(10) Youthbuild Program authorized under
14 section 173A.
15 "(11) Veterans' Workforce Investment Program
16 authorized under section 168.
17 "(12) The program of workforce investment ac-
18 tivities for youth authorized under chapter 4 of sub-
19 title B of title I.
20 "(13) The program of workforce investment ac-
21 tivities for adults authorized under chapter 5 of sub-
22 title B of title I.
23 "(14) The program of workforce investment ac-
24 tivities for dislocated workers under chapter 5 of
25 subtitle B of title I.

"(15) The Adult Education and Family Literacy Act authorized under title II.

"(16) The Disabled Veterans Outreach Program authorized under section 4103A of title 38, United States Code.

"(17) The Local Veterans' Employment Representative Program authorized under section 4104 of title 38, United States Code.

"(18) The Homeless Veterans' Reintegration Program authorized under section 2021 of title 38, United States Code.

"(19) Vocational Rehabilitation for Disabled Veterans authorized under chapter 31 of title 38, United States Code.

"(20) The National Guard Challenge Program authorized under section 509 of title 32, United States Code.

"(21) The Older American Community Service Program authorized under title V of the Older Americans Act of 1965 (42 U.S.C. 3056 et seq.).

"(22) The Native American Vocational and Technical Education Program authorized under section 116 of the Carl D. Perkins Career and Technical Education Act of 2006 (29 U.S.C. 741).

"(23) Tribally Controlled Post-secondary Vocational and Technical Institutions programs authorized under section 117 of the Carl D. Perkins Career and Technical Education Act of 2006 (20 U.S.C. 2327).

"(24) The Native Hawaiian Vocational Education Program authorized under section 116 of the Carl D. Perkins Career and Technical Education Act of 2006 (29 U.S.C. 741).

"(25) Career and Technical Assistance to the States authorized under section title I of the Carl D. Perkins Career and Technical Education Act of 2006 (20 U.S.C. 2321 et seq.).

"(26) Tech Prep Education Program authorized under title II of the Carl D. Perkins Career and Technical Education Act of 2006 (29 U.S.C. 2371 et seq.).

"(27) Migrant and Seasonal Farmworkers Program authorized under section 304 of the Rehabilitation Act of 1973 (29 U.S.C. 774).

"(28) Projects with industry authorized under section 611 of the Rehabilitation Act of 1973 (29 U.S.C. 795).

"(29) Vocational Rehabilitation Services authorized under title I of the Rehabilitation Act of 1973 (29 U.S.C. 720 et seq.).

"(30) American Indian Vocational Rehabilitation Services authorized under part C of title I of the Rehabilitation Act of 1973 (29 U.S.C. 741 et seq.).

"(31) Coordination of Migrant Education Activities authorized under section 1308 of the Elementary and Secondary Education Act of 1965 (20 U.S.C. 6398).

"(32) Programs authorized under the Community Services Block Grant Act (42 U.S.C. 9901 et seq.).

"(33) The Tribal Work Grants program authorized under section 412(a)(2) of Social Security Act (42 U.S.C. 612(a)(2)).

"(34) Job training grants authorized under section 414(c) of the American Competitiveness and Workforce Improvement Act of 1998 (29 U.S.C. 2916a).

"(35) Indian Employment, Job Placement Assistance, and Vocational Training programs authorized under the Indian Self-Determination Act (25 U.S.C. 450 et seq.).

"(36) Programs authorized under part A of title IV of the Social Security Act (42 U.S.C. 601 et seq.).

"(37) Refugee assistance programs authorized under chapter 2 of title IV of the Immigration and Nationality Act (8 U.S.C. 1521 et seq.).

"(38) Targeted assistance programs for refugees and entrants authorized under chapter 2 of title IV of the Immigration and Nationality Act (8 U.S.C. 1521 et seq.).

"(39) Programs authorized under section 16(h) of the Food and Nutrition Act of 2008 (7 U.S.C. 2025(h)).

"(40) The Federal Prisoner Reentry Initiative authorized under section 231(i) of Second Chance Act of 2007 (42 U.S.C. 17541(i)).

"(41) Employment services authorized under the Wagner-Peyser Act of 1933 (29 U.S.C. 49 et seq.).

"(42) Training programs under section 236 of part II of subchapter B of chapter 2 of title II of the Trade Adjustment Assistance Act of 1974 (19 U.S.C. 2296).

"(h) PERFORMANCE MEASURES AND REPORTING.—

"(1) PERFORMANCE MEASURES.—Each State with an approved Plan under this section shall carry out an assessment pursuant to section 508 of all the job training programs conducted in such State that receive funding under the Plan for each fiscal year the Plan is approved under this section.

"(2) REPORTING.—Each State with an approved Plan under this section shall ensure that records are maintained and reports are submitted, in such form and containing such information, as the Secretary may require regarding the performance of job training programs funded pursuant to this section.

"(i) TECHNICAL ASSISTANCE AND EVALUATION.—

"(1) TECHNICAL ASSISTANCE.—The Secretary shall provide such staff training, technical assistance, and other activities as the Secretary deems appropriate to support the implementation of this section.

"(2) EVALUATION.—The Secretary may require that States with an approved Plan under this section participate in an evaluation of job training programs funded pursuant to this subsection, including an evaluation using the techniques described in section 172(c).

1 "(j) PLAN REVIEW.—

2 "(1) IN GENERAL.—Upon receipt of a Plan
3 from the Governor, the Secretary shall consult with
4 the appropriate Secretaries in reviewing and approv-
5 ing such plan. Such plan shall be approved if it
6 meets the requirements described in subsection (d).

7 "(2) PLAN APPROVAL.—

8 "(A) 90-DAY PERIOD.—Subject to subpara-
9 graph (B), a Plan that is submitted to the Sec-
10 retary under this section shall be considered to
11 be approved by the Secretary at the end of the
12 90-day period beginning on the day the Sec-
13 retary receives the Plan, unless the Secretary
14 denies the Plan during the 90-day period.

15 "(B) 30-DAY EXTENSIONS.—If the Sec-
16 retary is in good faith negotiations with a State
17 with respect to the State's Plan—

18 "(i) at the end of the 90-day period
19 described in subparagraph (A), the Sec-
20 retary may have an additional 30 days to
21 determine whether to approve the Plan; or

22 "(ii) at the end of the 30 days de-
23 scribed in clause (i), the Secretary may
24 have an additional 30 days to determine
25 whether to approve the Plan.

"(3) PLAN DENIAL.—In the case where the Secretary denies a Plan submitted by a State under this section, the Secretary shall—

"(A) provide a written explanation to the State for the denial of the Plan; and

"(B) make such written explanation accessible to the general public.

"(k) FEDERAL RESPONSIBILITIES.—

"(1) INTERAGENCY MEMORANDUM OF UNDERSTANDING.—Within 90 days following the date of enactment of this section, the Secretary and the appropriate Secretaries shall enter into an interdepartmental memorandum of agreement providing for the implementation of the Plans with respect to the integration of funds administered by each Secretary.

"(2) INTERAGENCY FUNDS TRANSFERS AUTHORIZED.—The Secretary and the appropriate Secretaries responsible for the programs that are included in a Plan approved are authorized to take such action as may be necessary to provide for intra-agency or interagency transfers of funds otherwise available to a State in order to further the purposes of this section.".

SEC. 708. MAKING WIA TRAINING VOUCHERS MORE ACCESSIBLE AND FLEXIBLE.

(a) USE OF FUNDS FOR EMPLOYMENT AND TRAINING ACTIVITIES.—

(1) WORK READY SERVICES.—Section 134(d)(2) (29 U.S.C. 2864(c)(2)) is amended—

(A) in the heading, by striking ''CORE SERVICES'' and inserting ''WORK READY SERVICES'';

(B) by striking ''core services'' and inserting ''work ready services'';

(C) by striking ''paragraph (1)(A)'' and inserting ''paragraph (1)(A)(i)'';

(D) by striking ''who are adults or dislocated workers'';

(E) in subparagraph (A), by inserting ''and assistance in obtaining eligibility determinations under the other one-stop partner programs through such activities as assisting in the submission of applications, the provision of information on the results of such applications, the provision of intake services and information, and, where appropriate and consistent with the authorizing statute of the one-stop partner program, determinations of eligibility'' after ''subtitle'';

(F) by amending subparagraph (D) to read as follows:

"(D) labor exchange services, including—

"(i) job search and placement assistance, and where appropriate career counseling;

"(ii) appropriate recruitment services for employers, including small employers, in the local area, which may include services described in this subsection, including information and referral to specialized business services not traditionally offered through the one-stop delivery system; and

"(iii) reemployment services provided to unemployment claimants, including claimants identified as in need of such services under the worker profiling system established under section 303(j) of the Social Security Act (42 U.S.C. 503(j));";

(G) in subparagraph (I), by inserting "and the administration of the work test for the unemployment compensation system" after "compensation"; and

(H) by striking subparagraph (H) and inserting the following:

"(H) provision of accurate information, in formats that are usable and understandable to all one-stop center customers, relating to the availability of supportive services or assistance, including child care, child support, medical or child health assistance under title XIX or XXI of the Social Security Act (42 U.S.C. 1396 et seq. and 1397aa et seq.), benefits under the Food Stamp Act of 1977 (7 U.S.C. 2011 et seq.), the earned income tax credit under section 32 of the Internal Revenue Code of 1986, and assistance under a State program funded under part A of title IV of the Social Security Act (42 U.S.C. 601 et seq.) and other supportive services and transportation provided through funds made available under such part, available in the local area, and referral to such services or assistance as appropriate;"; and

(I) by amending subparagraph (J) to read as follows:

"(J) assistance in establishing eligibility for programs of financial aid assistance for training and education programs that are not funded under this Act and are available in the local area; and"; and

(J) by redesignating subparagraph (K) as subparagraph (M); and

(K) by inserting the following new subparagraphs after subparagraph (J)):

''(K) the provision of information from official publications of the Internal Revenue Service, regarding Federal tax credits available to individuals relating to education, job training and employment, including the Hope Scholarship Credit and the Lifetime Learning Credit (26 U.S.C. 25A), and the Earned Income Tax Credit (26 U.S.C. 32);

''(L) services relating to the Work Opportunity Tax Credit (26 U.S.C. 51);

''(M) comprehensive and specialized assessments of the skill levels and service needs of adults and dislocated workers, which may include—

''(i) diagnostic testing and use of other assessment tools; and

''(ii) in-depth interviewing and evaluation to identify employment barriers and appropriate employment goals;

''(N) development of an individual employment plan, to identify the employment goals,

appropriate achievement objectives, and appropriate combination of services for the participation to achieve the employment goals;

"(O) group counseling;

"(P) individual counseling and career planning;

"(Q) case management;

"(R) short-term prevocational services, including development of learning skills, communications skills, interviewing skills, punctuality, personal maintenance skills, and professional conduct, to prepare individuals for unsubsidized employment or training;

"(S) internships and work experience;

"(T) literacy activities relating to basic work readiness, information and communication technology literacy activities, and financial literacy activities, if such activities are not available to participants in the local area under programs administered under the Adult Education and Family Literacy Act (20 U.S.C. 2901 et seq.); and

"(U) out-of-area job search assistance and relocation assistance.".

(L) DELIVERY OF SERVICES.—Section 134(c)(3) (29 U.S.C. 2864(c)(3)) is amended to read as follows:

"(3) DELIVERY OF SERVICES.—The work ready services described in paragraph (M) through (U) shall be provided through the one-stop delivery system and may be provided through contracts with public, private for-profit, and private nonprofit service providers, approved by the local board.".

(M) TRAINING SERVICES.—Section 134(c)(4) is amended—

(i) by amending subparagraph (A) to read as follows:

"(A) IN GENERAL.—Funds allocated to a local area under section 133(b) shall be used to provide training services to adults who—

"(i) after an interview, evaluation, or assessment, and case management, have been determined by a one-stop operator or one-stop partner, as appropriate, to—

"(I) be in need of training services to obtain or retain suitable employment; and

"(II) have the skills and qualifications to successfully participate in

the selected program of training services;

"(ii) select programs of training services that are directly linked to the employment opportunities in the local area involved or in another area in which the adults receiving such services are willing to commute or relocate;

"(iii) who meet the requirements of subparagraph (B); and

"(iv) who are determined eligible in accordance with the priority system in effect under subparagraph (E).";

(ii) in subparagraph (B)(i), by striking "Except" and inserting "Notwithstanding section 479B of the Higher Education Act of 1965 (20 U.S.C. 1087uu) and except";

(iii) by amending subparagraph (D) to read as follows:

"(D) TRAINING SERVICES.—Training services authorized under this paragraph may include—

"(i) occupational skills training;

"(ii) on-the-job training;

"(iii) skill upgrading and retraining;

"(iv) entrepreneurial training;

"(v) education activities leading to a high school diploma or its equivalent, including a General Educational Development credential, in combination with, concurrently or subsequently, occupational skills training;

"(vi) adult education and literacy activities provided in conjunction with other training authorized under this subparagraph;

"(vii) workplace training combined with related instruction; and

"(viii) occupational skills training that incorporates English language acquisition.";

(iv) by amending subparagraph (E) to read as follows:

"(E) PRIORITY.—

"(i) IN GENERAL.—A priority shall be given to dislocated workers or workers who are in danger of being dislocated for the provision of intensive and training services under this subsection.

"(ii) DETERMINATIONS.—The Governor and the appropriate local board shall direct the one-stop operators in the local area with regard to making determinations with respect to the priority of service under this subparagraph.";

(v) in subparagraph (F), by striking clause (iii) and inserting the following:

"(iii) ENHANCED INDIVIDUAL TRAINING ACCOUNTS.—An individual who seeks training services and who is eligible pursuant to subparagraph (A), may, in consultation with a case manager, select an eligible provider of training services from the list or identifying information for providers described in clause (ii)(I). Upon such selection, the one-stop operator involved shall, to the extent practicable, refer such individual to the eligible provider of training services, and arrange for payment for such services through a enhanced individual training account.

"(iv) COORDINATION.—Each local board may, through one-stop centers, coordinate enhanced individual training ac-

counts with other Federal, State, local, or private job training programs or sources to assist the individual in obtaining training services.

"(v) ENHANCED INDIVIDUAL TRAINING ACCOUNTS.—Each local board may, through one-stop centers, assist individuals receiving enhanced individual training accounts through the establishment of such accounts that include, in addition to the funds provided under this paragraph, funds from other programs and sources that will assist the individual in obtaining training services."; and

(vi) in subparagraph (G)—

(I) in the subparagraph heading, by striking "INDIVIDUAL TRAINING ACCOUNTS" and inserting "ENHANCED INDIVIDUAL TRAINING ACCOUNTS";

(II) in clause (i) by striking "individual training accounts" and inserting "enhanced individual training accounts";

(III) in clause (ii)—

(aa) by striking ''an individual training account'' and inserting ''a enhanced individual training account'';

(bb) in subclause (II), by striking ''individual training accounts'' and inserting ''enhanced individual training accounts'';

(cc) in subclause (II) by striking ''or'' after the semicolon;

(dd) in subclause (III) by striking the period and inserting ''; or''; and

(ee) by adding at the end of the following:

''(IV) The local board determines that it would be most appropriate to award a contract to an institution of higher education in order to facilitate the training of multiple individuals in high-demand occupations, if such contract does not limit customer choice.''.

(IV) in clause (iv)—

(aa) by redesignating subclause (IV) as subclause (V) and

inserting after subclause (III) the following:

"(IV) Individuals with disabilities.".

(2) PERMISSIBLE ACTIVITIES.—Section 134(c) is amended by amending paragraph (1) to read as follows:

"(1) DISCRETIONARY ONE-STOP DELIVERY ACTIVITIES.—

"(A) IN GENERAL.—Funds allocated to a local area under section 133(b) may be used to provide, through the one-stop delivery system—

"(i) customized screening and referral of qualified participants in training services to employers;

"(ii) customized employment-related services to employers on a fee-for-service basis;

"(iii) customer support to navigate among multiple services and activities for special participant populations that face multiple barriers to employment, including individuals with disabilities;

"(iv) employment and training assistance provided in coordination with child

support enforcement activities of the State agency carrying out subtitle D of title IV of the Social Security Act (42 U.S.C. 651 et seq.);

"(v) activities to improve services to local employers, including small employers in the local area, and increase linkages between the local workforce investment system and employers;

"(vi) activities to facilitate remote access to services provided through a one-stop delivery system, including facilitating access through the use of technology; and

"(vii) activities to carry out business services and strategies that meet the workforce investment needs of local area employers, as determined by the local board, consistent with the local plan under section 118, which services—

"(I) may be provided through effective business intermediaries working in conjunction with the local board, and may also be provided on a fee-for-service basis or through the leveraging of economic development

and other resources as determined appropriate by the local board; and

"(II) may include—

"(aa) identifying and disseminating to business, educators, and job seekers, information related to the workforce, economic and community development needs, and opportunities of the local economy;

"(bb) development and delivery of innovative workforce investment services and strategies for area businesses, which may include sectoral, industry cluster, regional skills alliances, career ladder, skills upgrading, skill standard development and certification, apprenticeship, and other effective initiatives for meeting the workforce investment needs of area employers and workers;

"(cc) participation in seminars and classes offered in partnership with relevant organiza-

tions focusing on the workforce-related needs of area employers and job seekers;

"(dd) training consulting, needs analysis, and brokering services for area businesses, including the organization and aggregation of training (which may be paid for with funds other than those provided under this title), for individual employers and coalitions of employers with similar interests, products, or workforce needs;

"(ee) assistance to area employers in the aversion of layoffs and in managing reductions in force in coordination with rapid response activities;

"(ff) the marketing of business services offered under this title, to appropriate area employers, including small and mid-sized employers;

"(gg) information referral on concerns affecting local employers; and

"(hh) other business services and strategies designed to better engage employers in workforce investment activities and to make the workforce investment system more relevant to the workforce investment needs of area businesses, as determined by the local board to be consistent with the objectives of this title.".

SEC. 709. LIFE LONG LEARNING AWARENESS CAMPAIGNS.

(a) FEDERAL COMMUNICATIONS COMMISSION.—

(1) IN GENERAL.—The Federal Communications Commission shall require that each licensed broadcaster keep a record of the number and duration of public service announcements voluntarily broadcast with respect to the job training opportunities and services described in section 509 of the Workforce Investment Act of 1998.

(2) DEADLINE.—Not later than 90 days after the date of the enactment of this Act, the Federal Communications Commission shall take all actions

necessary to adopt a regulation to implement paragraph (1).

(3) REQUIREMENT.—The Federal Communications Commission shall consider the voluntary broadcast of any public service announcement described in paragraph (1) as—

(A) fulfilling part of a broadcaster's obligation to serve the public interest; and

(B) demonstrating such service for the purposes of license renewal.

(b) JOB TRAINING PROVIDERS.—Title V of the Workforce Investment Act of 1998 (20 U.S.C. 9271 et seq.) is further amended by adding at the end the following:

"SEC. 509. PUBLIC SERVICE ANNOUNCEMENTS.

"(a) IN GENERAL.—Each provider of a job training program shall make periodic public service announcements to inform the general public about job training opportunities and services, including—

"(1) the availability of job training opportunities under the program;

"(2) Federal Pell Grants available under title IV of the Higher Education Act of 1965 (20 U.S.C. 1070 et seq.);

"(3) the Job Corps centers;

1 ''(4) the one-stop delivery systems; and
2 ''(5) community colleges.
3 ''(b) REGULATIONS.—The Secretary shall promul-
4 gate regulations to assist providers of job training pro-
5 grams in carrying out the requirements described in sub-
6 section (a). In promulgating such regulations, the Sec-
7 retary shall consider whether the requirements may be sat-
8 isfied by—
9 ''(1) posting the required information on an
10 Internet Web site;
11 ''(2) publishing the required information in a
12 newspaper; or
13 ''(3) making an announcement containing the
14 required information on the television or radio.
15 ''(c) DEFINITION.—The term 'job training program'
16 has the meaning given such term in section 507(d).''.
17 **SEC. 710. GAO REPORTS.**
18 (a) IDENTIFYING DUPLICATION.—Not later than 1
19 year after the date of the enactment of this Act, the Comp-
20 troller General of the United States shall conduct a study
21 and submit a report to Congress on job training programs
22 that—
23 (1) identifies duplications among such pro-
24 grams; and

(2) if applicable, recommends the consolidation of such programs.

(b) EFFECTIVENESS OF PROGRAMS.—Not later than 2 years after the date of the enactment of this Act, and every 2 years thereafter, the Comptroller General of the United States shall conduct a study and submit a report to Congress that evaluates the effectiveness of job training programs based on the assessments of such programs carried out under section 508(b) of the Workforce Investment Act of 1998 (as amended by this Act).

(c) DEFINITION.—For purposes of this section, the term ''job training program'' has the meaning given such term in 507(d) of the Workforce Investment Act of 1998 (as amended by this Act).

TITLE VIII—SPENDING LIMITS AND DEFICIT CONTROL

SEC. 800. SHORT TITLE.

This title may be cited as the ''Spending Enforcement and Control Act of 2010''.

Subtitle A—Spending Limits and Deficit Control

SEC. 801. DISCRETIONARY SPENDING LIMITS.

(a) DISCRETIONARY SPENDING LIMITS.—Section 251 of the Balanced Budget and Emergency Deficit Control of Act of 1985 is amended to read as follows:

"(a) DISCRETIONARY SPENDING LIMITS.—The fiscal years for the discretionary spending limits shall be as follows:

"(1) Fiscal year 2011: $1,203,000,000,000 in outlays.

"(2) Fiscal year 2012: $1,144,000,000,000 in outlays.

"(3) Fiscal year 2013: $1,143,000,000,000 in outlays.

"(4) Fiscal year 2014: $1,143,000,000,000 in outlays.

"(5) Fiscal year 2015: $1,149,000,000,000 in outlays.

"(6) Fiscal year 2016: $1,165,000,000,000 in outlays.

"(7) Fiscal year 2017: $1,176,000,000,000 in outlays.

"(8) Fiscal year 2018: $1,184,000,000,000 in outlays.

"(9) Fiscal year 2019: $1,202,000,000,000 in outlays.

"(b) SPENDING REDUCTION ORDER.—A spending reduction ordered shall be implemented using the procedures set forth in section 256.".

(b) CONFORMING AMENDMENT.—The item relating to section 251 in the table of contents set forth in 250(c) of the Balanced Budget and Emergency Deficit Control Act of 1985 is amended to read as follows:

"Sec. 251. Discretionary spending limits.".

SEC. 802. TOTAL SPENDING LIMITS.

(a) TOTAL SPENDING LIMITS.—After section 252 of the Balanced Budget and Emergency Deficit Control Act of 1985, add the following new section:

"SEC. 252A. TOTAL SPENDING LIMITS.

"(a) PROJECTIONS.—

"(1) OMB REPORT.—OMB shall prepare a report comparing projected total spending under section 257 and the total spending limits in subsection (d), and include such report in the budget as submitted by the President annually under section 1105(a) of title 31, United States Code.

"(2) CBO REPORT.—CBO shall prepare a report comparing projected total spending under section 257 and the total spending limits in subsection (d) and include such report in the CBO annual baseline and reestimate of the President's budget.

"(3) INCLUSION IN SPENDING REDUCTION ORDERS.—Reports prepared pursuant to this subsection shall be included in the spending reduction report.

"(b) SPENDING REDUCTION ORDER.—A spending reduction order shall be implemented using the procedures set forth in section 256.

"(c) FISCAL YEARS OF THE TOTAL SPENDING PERIOD.—The fiscal years within the total spending period shall be as follows:

"(1) Fiscal year 2011: 22.8 percent.

"(2) Fiscal year 2012: 21.6 percent.

"(3) Fiscal year 2013: 21.8 percent.

"(4) Fiscal year 2014: 21.9 percent.

"(5) Fiscal year 2015: 21.7 percent.

"(6) Fiscal year 2016: 22.0 percent.

"(7) Fiscal year 2017: 21.7 percent.

"(8) Fiscal year 2018: 21.6 percent.

"(9) Fiscal year 2019: 22.3 percent.

"(10) Fiscal year 2020: 22.3 percent.

"(11) Fiscal year 2021: 22.4 percent.

"(12) Fiscal year 2022: 22.6 percent.

"(13) Fiscal year 2023: 22.8 percent.

"(14) Fiscal year 2024: 22.9 percent.

"(15) Fiscal year 2025: 22.9 percent.

"(16) Fiscal year 2026: 23.2 percent.

"(17) Fiscal year 2027: 23.5 percent.

"(18) Fiscal year 2028: 23.6 percent.

"(19) Fiscal year 2029: 23.7 percent.

1 ‘‘(20) Fiscal year 2030: 23.8 percent.
2 ‘‘(21) Fiscal year 2031: 23.9 percent.
3 ‘‘(22) Fiscal year 2032: 24.0 percent.
4 ‘‘(23) Fiscal year 2033: 24.1 percent.
5 ‘‘(24) Fiscal year 2034: 24.1 percent.
6 ‘‘(25) Fiscal year 2035: 24.1 percent.
7 ‘‘(26) Fiscal year 2036: 24.1 percent.
8 ‘‘(27) Fiscal year 2037: 24.1 percent.
9 ‘‘(28) Fiscal year 2038: 23.9 percent.
10 ‘‘(29) Fiscal year 2039: 23.7 percent.
11 ‘‘(30) Fiscal year 2040: 23.5 percent.
12 ‘‘(31) Fiscal year 2041: 23.5 percent.
13 ‘‘(32) Fiscal year 2042: 23.4 percent.
14 ‘‘(33) Fiscal year 2043: 23.1 percent.
15 ‘‘(34) Fiscal year 2044: 23.0 percent.
16 ‘‘(35) Fiscal year 2045: 22.7 percent.
17 ‘‘(36) Fiscal year 2046: 22.4 percent.
18 ‘‘(37) Fiscal year 2047: 22.2 percent.
19 ‘‘(38) Fiscal year 2048: 21.9 percent.
20 ‘‘(39) Fiscal year 2049: 21.7 percent.
21 ‘‘(40) Fiscal year 2050: 21.6 percent.
22 ‘‘(41) Fiscal year 2051: 21.4 percent.
23 ‘‘(42) Fiscal year 2052: 21.2 percent.
24 ‘‘(43) Fiscal year 2053: 20.9 percent.
25 ‘‘(44) Fiscal year 2054: 20.9 percent.

1 ''(45) Fiscal year 2055: 20.6 percent.
2 ''(46) Fiscal year 2056: 20.3 percent.
3 ''(47) Fiscal year 2057: 20.1 percent.
4 ''(48) Fiscal year 2058: 20.0 percent.
5 ''(49) Fiscal year 2059: 19.7 percent.
6 ''(50) Fiscal year 2060: 19.6 percent.
7 ''(51) Fiscal year 2061: 19.4 percent.
8 ''(52) Fiscal year 2062: 19.2 percent.
9 ''(53) Fiscal year 2063: 18.9 percent.
10 ''(54) Fiscal year 2064: 18.8 percent.
11 ''(55) Fiscal year 2065: 18.4 percent.
12 ''(56) Fiscal year 2066: 18.2 percent.
13 ''(57) Fiscal year 2067: 18.1 percent.
14 ''(58) Fiscal year 2068: 17.6 percent.
15 ''(59) Fiscal year 2069: 17.5 percent.
16 ''(60) Fiscal year 2070: 17.1 percent.
17 ''(61) Fiscal year 2071: 16.8 percent.
18 ''(62) Fiscal year 2072: 16.6 percent.
19 ''(63) Fiscal year 2073: 16.2 percent.
20 ''(64) Fiscal year 2074: 16.0 percent.
21 ''(65) Fiscal year 2075: 15.6 percent.
22 ''(66) Fiscal year 2076: 15.4 percent.
23 ''(67) Fiscal year 2077: 15.0 percent.
24 ''(68) Fiscal year 2078: 14.7 percent.
25 ''(69) Fiscal year 2079: 14.3 percent.

"(70) Fiscal year 2080: 14.0 percent.

"(71) Fiscal year 2081: 13.6 percent.

"(72) Fiscal year 2082: 13.4 percent.

"(73) Fiscal year 2083: 13.0 percent.".

(b) DEFINITIONS.—Section 3 of the Congressional Budget and Impoundment Control Act of 1974 (2 U.S.C. 622) is amended by adding at the end the following new paragraph:

"(11) The term 'total spending' means all outlays of the Federal Government including those from off-budget entities and budget authority and outlays flowing therefrom, as applicable, designated as emergencies.".

(c) CONFORMING AMENDMENT.—The table of contents set forth in 250(c) of the Balanced Budget and Emergency Deficit Control Act of 1985 is amended by inserting after the item relating to section 252A the following new item:

"Sec. 252A. Total spending limits.".

Subtitle B—Reports and Orders

SEC. 811. REPORTS AND ORDERS.

Section 254 of the Balanced Budget and Emergency Deficit Control Act of 1985 is amended to read as follows:

"SEC. 254. REPORTS AND ORDERS.

"(a) TIMETABLE.—

"Date:	**Action to be completed:**

5 days before the President's budget submission.	CBO sequestration preview report.
President's budget submission ..	OMB sequestration preview report.
August 10	CBO sequestration update report.
August 20	OMB sequestration update report.
10 days after end of session	CBO sequestration final report.
15 days after end of session	OMB sequestration final report; Presidential order.

1 "(b) SUBMISSION AND AVAILABILITY OF REPORTS.—
2 Each report required by this section shall be submitted
3 to the Committees on the Budget of the House of Rep-
4 resentatives and the Senate. On the following day a notice
5 of the report shall be printed in the Federal Register.
6 "(c) SEQUESTRATION PREVIEW REPORT.—
7 "(1) REPORTING REQUIREMENT.—On the dates
8 specified in subsection (a), OMB and CBO shall
9 issue a preview report regarding discretionary limits
10 and total spending limits, sequestration based on
11 laws enacted through those dates.
12 "(2) DISCRETIONARY SPENDING LIMIT SEQUES-
13 TRATION REPORT.—The preview report shall set
14 forth for the current year and the budget year the
15 following:
16 "(A) The discretionary spending limit;
17 "(B) The estimated discretionary spending
18 amount; and
19 "(C) The amount of reductions required
20 under section 251.

"(3) TOTAL SPENDING LIMIT SEQUESTRATION REPORT.—The preview reports shall set forth for the budget year estimates for the following:

"(A) The total spending limit;

"(B) The estimated total spending amount; and

"(C) The amount of reductions required under section 252A.

"(4) EXPLANATION OF DIFFERENCES.—The OMB reports shall explain the differences between OMB and CBO estimates for each item set forth in this subsection.

"(d) SEQUESTRATION UPDATE REPORT.—On the dates specified in subsection (a), OMB and CBO shall issue a sequestration update report, reflecting laws enacted through those dates, containing all of the information required in the sequestration preview report.

"(e) SEQUESTRATION FINAL REPORT.—

"(1) REPORTING REQUIREMENT.—On the dates specified in subsection (a), OMB and CBO shall issue a sequestration final report, reflecting laws enacted through those dates, containing all of the information required in the sequestration preview report.

"(2) PRESIDENTIAL ORDER.—On the date specified in subsection (a), if in its sequestration final report OMB estimates that any sequestration is required, the President shall issue an order fully implementing without change all sequestrations required by the OMB calculations set forth in that report. This order shall be effective on issuance.

"(f) GAO COMPLIANCE REPORT.—Upon request of the Committee on the Budget of the House of Representatives or the Senate, the Comptroller General shall submit to the Congress and the President a report on—

"(1) the extent to which each order issued by the President under this section complies with all of the requirements contained in this part, either certifying that the order fully and accurately complies with such requirements or indicating the respects in which it does not; and

"(2) the extent to which each report issued by OMB or CBO under this section complies with all of the requirements contained in this part, either certifying that the report fully and accurately complies with such requirements or indicating the respects in which it does not.

"(g) LOW-GROWTH REPORT.—At any time, CBO and OMB shall notify the Congress if—

"(1) during the period consisting of the quarter during which such notification is given, the quarter preceding such notification, and the 4 quarters following such notification, CBO or OMB has determined that real economic growth is projected or estimated to be less than zero with respect to each of any 2 consecutive quarters within such period; or

"(2) the most recent of the Department of Commerce's advance preliminary or final reports of actual real economic growth indicate that the rate of real economic growth for each of the most recently reported quarter and the immediately preceding quarter is less than one percent.

"(h) ECONOMIC AND TECHNICAL ASSUMPTIONS.—In all reports required by this section, OMB shall use the same economic and technical assumptions as used in the most recent budget submitted by the President under section 1105(a) of title 31, United States Code".

SEC. 812. SPENDING LIMITS ENFORCEMENT.

(a) CONFORMING AMENDMENTS TO SECTION 312.—Section 312 of the Congressional Budget Act of 1974 is amended—

(1) by striking subsection (a) and inserting the following:

"(a) BUDGET COMMITTEE DETERMINATIONS.—For purposes of this title, the levels of new budget authority, outlays, direct spending, deficits, revenues, and debt, or the increases or decreases of such levels for purpose of section 303, shall be determined on the basis of estimates made by the Committee on the Budget of the House of Representatives or the Senate, as applicable.".

(2) by striking subsections (b) and (c) and redesignating subsections (d), (e), and (f) as (g), (h), and (i), respectively.

(b) ENFORCEMENT AMENDMENTS TO SECTION 312.—Section 312 of the Congressional Budget Act of 1974 is further amended by adding the following new subsections:

"(b) DISCRETIONARY SPENDING LIMIT POINT OF ORDER.—It shall not be in order in the House of Representatives or the Senate to consider any bill, joint resolution, amendment, or conference report that—

"(1) causes the discretionary spending limits for the budget year to be breached; or

"(2) increases the discretionary spending limits for the budget year or any ensuing fiscal year.

"(c) TOTAL SPENDING LIMIT POINT OF ORDER.—It shall not be in order in the House of Representatives

or the Senate to consider any bill, joint resolution, amendment, or conference report that—

"(1) causes the total spending limits for the budget year, as a percentage of gross domestic product, to be breached; or

"(2) increases the total spending limits for the budget year or any ensuing fiscal year after the budget year, as a percentage of gross domestic product.

"(d) REVENUE LIMIT POINT OF ORDER.—It shall not be in order in the House of Representatives or the Senate to consider any bill, joint resolution, amendment, or conference report that increases levels of revenue above 19 percent of gross domestic product, as estimated by the Committee on the Budget of the applicable House.

"(e) WAIVER OR SUSPENSION.—The provisions of this section may be waived or suspended:

"(1) IN THE SENATE.—In the Senate only by the affirmative vote of three-fifths of the Members, duly chosen and sworn.

"(2) IN THE HOUSE OF REPRESENTATIVES.—In the House of Representatives:

"(A) Only by a rule or order proposing only to waive such provisions by an affirmative

vote of two-thirds of the Members, duly chosen and sworn.

"(B) It shall not be in order to consider a rule or order that waives the application of subparagraph (A).

"(C) It shall not be in order for the Speaker to entertain a motion to suspend the application of this section under clause 1 of rule XV of the Rules of the House of Representatives.".

SEC. 813. SPENDING REDUCTION ORDERS.

(a) IN GENERAL.—Section 256 of the Balanced Budget and Emergency Deficit Control Act of 1985 is amended to read as follows:

"SEC. 256. SPENDING REDUCTION ORDER.

"(a) GENERAL RULES.—

"(1) CALCULATION OF SPENDING REDUCTION PERCENTAGE.—OMB shall include in its final spending sequestration report a requirement that each nonexempt spending account shall be reduced by an amount of budget authority calculated by multiplying the baseline level of budgetary resources in that account at that time by the uniform percentage necessary to reduce outlays sufficient to eliminate an excess spending amount.

"(2) EXEMPTIONS.—The following shall be exempt from reduction under any order issued under this part:

"(A) Payments for net interest.

"(B) Benefits payable under the old-age, survivors, and disability insurance program established under title II of the Social Security Act if—

"(i) OASDI Trust Funds are actuarially solvent in the 75-year period utilized in the most recent annual report of the Board of Trustees provided pursuant to section 201(C)(2) of the Social Security Act; and

"(ii) OASDI Trust Funds have not run a cash deficit in the fiscal year prior to the transmittal of the most recent Sequestration Preview Report.

"(C) Benefits provided to veterans defined as direct spending payable by the Department of Veterans Affairs.

"(D) Obligated balances of budget authority carried over from prior fiscal years.

"(E) Any obligations of the Federal Government required to be paid under the United

States Constitution or legally contractual obligations.

"(F) Any program whose growth in the budget year is equal to or less than the consumer price index.

"(G) Intergovernmental transfers.

"(3) ONE-PERCENT REDUCTION LIMITATION.—No program shall be subject to a spending reduction of more than one percent of its budgetary resources.

"(4) CALCULATION OF SPENDING REDUCTION.—The percentage required to produce a spending reduction, as ordered by a spending reduction order, shall be calculated by OMB by adding all budgetary resources of the Government, and reducing that amount by an amount sufficient to reduce the total amount of outlays of the Government to equal, or lower, a level of outlays than the amount set forth in the guideline period.

"(5) APPLICATION.—Once issued, a spending reduction shall be applied to nonexempt programs as follows:

"(A) Budgetary resources subject to a spending reduction to any discretionary account shall be permanently canceled.

"(B) The same percentage spending reduction shall apply to all programs, projects, and activities within a budget account (with programs, projects, and activities as delineated in the appropriation Act or accompanying report for the relevant fiscal year covering that account, or for accounts not included in appropriation Acts, as delineated in the most recently submitted President's budget).

"(C) Administrative regulations implementing a spending reduction shall be made within 120 days of the issue of a spending reduction order.

"(6) OASDI SPECIAL PROCEDURES.—If the OASDI Trust Funds are subject to sequestration, then payments from such Trust Funds shall be treated the same as other programs, except—

"(A) reductions from such Trust Funds shall not exceed one percent of the 75-year unfunded liability set forth in the most current Social Security Trustees Report;

"(B) reduction in individual benefits shall be implemented by increasing the Normal Retirement Age (NRA) by an amount certified by the Social Security Office of the Chief Actuary;

"(C) the increase in the NRA shall not be applied to any beneficiary born in a year 55 years or before—

"(i) the year of the enactment of the Roadmap for America's Future Act of 2010; or

"(ii) the year in which the final spending sequestration report is issued; and

"(D) no change in the NRA shall be made before it is fully phased-in under the Social Security Act as in effect before the date of enactment of the Roadmap for America's Future Act of 2010.

"(b) EMERGENCIES.—No program shall be subject to sequestration or counted for purposes of calculating a sequester if it is designated as an emergency under this section and so designated by the President.".

(b) LOW-GROWTH AMENDMENT.—Section 258(b) of the Balanced Budget and Emergency Deficit Control Act of 1985 is amended to read as follows:

"(b) SUSPENSION OF SEQUESTRATION PROCEDURES.—Upon the enactment of a declaration of war or a joint resolution described in subsection (a)—

"(1) the subsequent issuance of any sequestration report to enforce the spending limits in sections 251 and 252A order is precluded;

"(2) sections 302(f), 310(d), and 311(a), of the Congressional Budget Act of 1974 are suspended; and

"(3) section 1103 of title 31, United States Code, is suspended.".

(c) TECHNICAL AND CONFORMING AMENDMENTS.—

(1) REPEALS.—Sections 255 and 275 of the Balanced Budget and Emergency Deficit Control Act of 1985 are repealed.

(2) CONFORMING AMENDMENT.—The item relating to section 256 in the table of contents set forth in section 250(a) of the Balanced Budget and Emergency Deficit Control Act of 1985 is amended to read as follows:

"Sec. 256. Spending reduction order.".

SEC. 814. ALTERNATE SPENDING REDUCTION LEGISLATION IN THE HOUSE OF REPRESENTATIVES.

(a) INTRODUCTION OF JOINT RESOLUTION.—At any time after the Director of OMB issues a final order for a fiscal year, but before the end of the session of Congress in session on the date of the issuance of such order, the majority leader of the House of Representatives may introduce a joint resolution which contains provisions direct-

ing the President to modify the most recent final order issued pursuant to this title, or provide an alternative to eliminate the spending excess for such fiscal year or years. After the introduction of the first such joint resolution in either House of Congress in any calendar year, then no other joint resolution introduced pursuant to this section shall be subject to the procedures set forth in this section.

(b) PROCEDURES FOR CONSIDERATION OF JOINT RESOLUTIONS.—

(1) Any committee of the House of Representatives to which an alternative spending compliance measure is referred shall report it to the House without amendment not later than the seventh legislative day after the date of its introduction. If a committee fails to report the bill within that period or the House has adopted a concurrent resolution providing for adjournment sine die at the end of a Congress, it shall be in order to move that the House discharge the committee from further consideration of the bill. Such a motion shall be in order only at a time designated by the Speaker in the legislative schedule within two legislative days after the day on which the proponent announces his intention to offer the motion. Such a motion shall not be in order after a committee has reported a spending

compliance measure with respect to that special message or after the House has disposed of a motion to discharge with respect to that special message. The previous question shall be considered as ordered on the motion to its adoption without intervening motion except twenty minutes of debate equally divided and controlled by the proponent and an opponent. If such a motion is adopted, the House shall proceed immediately to consider the spending compliance measure bill in accordance with paragraph (3). A motion to reconsider the vote by which the motion is disposed of shall not be in order.

(2) After a spending compliance measure is reported or a committee has been discharged from further consideration, or the House has adopted a concurrent resolution providing for adjournment sine die at the end of a Congress, it shall be in order to move to proceed to consider the spending compliance measure in the House. Such a motion shall be in order only at a time designated by the Speaker in the legislative schedule within two legislative days after the day on which the proponent announces his intention to offer the motion. Such a motion shall not be in order after the House has disposed of a motion to proceed with respect to that special mes-

sage. The previous question shall be considered as ordered on the motion to its adoption without intervening motion. A motion to reconsider the vote by which the motion is disposed of shall not be in order.

(3) The spending compliance measure shall be considered as read. All points of order against an approval bill and against its consideration are waived. The previous question shall be considered as ordered on an approval bill to its passage without intervening motion except five hours of debate equally divided and controlled by the proponent and an opponent and one motion to limit debate on the bill. A motion to reconsider the vote on passage of the bill shall not be in order.

(4) A spending compliance measure received from the Senate shall not be referred to committee.

(c) VOTING.—The vote on final passage of a joint resolution or conference report thereon referred to in paragraph (1) shall require approval of not less than three-fifths of the Members of the House of Representatives.

SEC. 815. ALTERNATE SPENDING REDUCTION LEGISLATION IN THE SENATE.

(a) INTRODUCTION OF JOINT RESOLUTION.—At any time after OMB issues a final order for a fiscal year, but before the end of the session of Congress in session on

the date of the issuance of such order, the majority leader of either House of Congress may introduce a joint resolution which contains provisions directing the President to modify the most recent final order provide an alternative to eliminate the spending excess for such fiscal year or years. After the introduction of the first such joint resolution in either House of Congress in any calendar year, then no other joint resolution introduced in such House in such calendar year shall be subject to the procedures set forth in this section.

(b) PROCEDURES FOR CONSIDERATION OF JOINT RESOLUTIONS.—

(1) REFERRAL TO COMMITTEE.—A joint resolution introduced in the Senate under subsection (a) shall not be referred to a committee of the Senate and shall be placed on the calendar pending disposition of such joint resolution in accordance with this subsection.

(2) CONSIDERATION IN THE SENATE.—On or after the third calendar day (excluding Saturdays, Sundays, and legal holidays) beginning after a joint resolution is introduced under subsection (a), notwithstanding any rule or precedent of the Senate, including rule XXII of the Standing Rules of the Senate, it is in order (even though a previous motion to

the same effect has been disagreed to) for any Member of the Senate to move to proceed to the consideration of the joint resolution. The motion is not in order after the eighth calendar day (excluding Saturdays, Sundays, and legal holidays) beginning after a joint resolution (to which the motion applies) is introduced. The joint resolution is privileged in the Senate. A motion to reconsider the vote by which the motion is agreed to or disagreed to shall not be in order. If a motion to proceed to the consideration of the joint resolution is agreed to, the Senate shall immediately proceed to consideration of the joint resolution without intervening motion, order, or other business, and the joint resolution shall remain the unfinished business of the Senate until disposed of.

(3) DEBATE IN THE SENATE.—

(A) In the Senate, debate on a joint resolution introduced under subsection (a), amendments thereto, and all debatable motions and appeals in connection therewith shall be limited to not more than 10 hours, which shall be divided equally between the majority leader and the minority leader (or their designees).

(B) A motion to postpone, or a motion to proceed to the consideration of other business is

not in order. A motion to reconsider the vote by which the joint resolution is agreed to or disagreed to is not in order, and a motion to recommit the joint resolution is not in order.

(C)(i) No amendment that is not germane to the provisions of the joint resolution shall be in order in the Senate. In the Senate, an amendment, any amendment to an amendment, or any debatable motion or appeal is debatable for not to exceed 30 minutes to be equally divided between, and controlled by, the mover and the majority leader (or their designees), except that in the event that the majority leader favors the amendment, motion, or appeal, the minority leader (or the minority leader's designee) shall control the time in opposition to the amendment, motion, or appeal.

(ii) In the Senate, an amendment that is otherwise in order shall be in order notwithstanding the fact that it amends the joint resolution in more than one place or amends language previously amended. It shall not be in order in the Senate to vote on the question of agreeing to such a joint resolution or any amendment thereto unless the figures then con-

tained in such joint resolution or amendment are mathematically consistent.

(4) VOTE ON FINAL PASSAGE.—Immediately following the conclusion of the debate on a joint resolution introduced under subsection (a), a single quorum call at the conclusion of the debate if requested in accordance with the rules of the Senate, and the disposition of any pending amendments under paragraph (3), the vote on final passage of the joint resolution shall occur.

(5) APPEALS.—Appeals from the decisions of the Chair shall be decided without debate.

(6) CONFERENCE REPORTS.—In the Senate, points of order under titles III and IV of the Congressional Budget Act of 1974 are applicable to a conference report on the joint resolution or any amendments in disagreement thereto.

(7) RESOLUTION FROM OTHER HOUSE.—If, before the passage by the Senate of a joint resolution of the Senate introduced under subsection (a), the Senate receives from the House of Representatives a joint resolution introduced under subsection (a), then the following procedures shall apply:

(A) The joint resolution of the House of Representatives shall not be referred to a committee and shall be placed on the calendar.

(B) With respect to a joint resolution introduced under subsection (a) in the Senate—

(i) the procedure in the Senate shall be the same as if no joint resolution had been received from the House; but

(ii)(I) the vote on final passage shall be on the joint resolution of the House if it is identical to the joint resolution then pending for passage in the Senate; or

(II) if the joint resolution from the House is not identical to the joint resolution then pending for passage in the Senate and the Senate then passes the Senate joint resolution, the Senate shall be considered to have passed the House joint resolution as amended by the text of the Senate joint resolution.

(C) Upon disposition of the joint resolution received from the House, it shall no longer be in order to consider the resolution originated in the Senate.

(8) SENATE ACTION ON HOUSE RESOLUTION.—If the Senate receives from the House of Representatives a joint resolution introduced pursuant to this section after the Senate has disposed of a Senate originated resolution which is identical to the House passed joint resolution, the action of the Senate with regard to the disposition of the Senate originated joint resolution shall be deemed to be the action of the Senate with regard to the House originated joint resolution. If it is not identical to the House passed joint resolution, then the Senate shall be considered to have passed the joint resolution of the House as amended by the text of the Senate joint resolution.

(9) The vote on final passage of a joint resolution or conference report thereon referred to in paragraph (1) shall require approval of not less than three-fifths of the Members of the Senate.

Subtitle C—Long-Term Budgeting

SEC. 821. CBO AND OMB PROJECTIONS.

(a) CONGRESSIONAL BUDGET OFFICE.—At the end of section 308 of the Congressional Budget Act of 1974, add the following:

''(d) LONG-TERM PROJECTIONS.—Not later than February 15 of each calendar year after the date of enactment of this subsection, the Director of the Congressional

1 Budget Office shall issue a report projecting total spend-
2 ing, revenue, deficits, and debt for 75 years beginning with
3 such fiscal year as a percentage of gross domestic product
4 annually based on current law levels as modified to main-
5 tain current policy.

6 ''(e) CBO SPENDING REVIEW REPORT ISSUANCE.—
7 As a component of the report required by subsection (d),
8 the Congressional Budget Office shall issue a Spending
9 Review Report and transmit such report to the Commit-
10 tees on the Budget of the House of Representatives and
11 the Senate.

12 ''(f) CONTENT OF SPENDING REVIEW REPORT.—The
13 content of the Spending Review Report referred to in sub-
14 section (e) shall include analyses of the following:

15 ''(1) OASDI.—The solvency of the Old-Age,
16 Survivors, and Disability Insurance Trust Fund.

17 ''(2) MEDICARE.—The long-range sustainability
18 of the spending levels of Medicare.

19 ''(3) MEDICAID.—The long-range sustainability
20 of the spending levels of Medicaid.

21 ''(4) OTHER DIRECT SPENDING.—The long-
22 range sustainability of spending levels of other direct
23 spending.

1 "(g) DEFINITIONS.—For purposes of the develop-
2 ment of the Spending Review Report referred to in sub-
3 section (b):

4 "(1) SOLVENCY OF THE OASDI.—The term 'sol-
5 vency' as used in this section means the solvency of
6 the Old-Age Security and Disability Insurance Trust
7 Funds over a 75-year period beginning in the year
8 the Spending Review Report is reported.

9 "(2) SUSTAINABILITY.—The term 'sustain-
10 ability' means the following:

11 "(A) MEDICARE.—The Medicare program
12 is sustainable if it is projected to grow, begin-
13 ning in the tenth year following the date of the
14 enactment of this Act from the fixed percentage
15 of Gross Domestic Product in the year prior to
16 the date of enactment of this subsection, ad-
17 justed by the adjustment formula as set forth
18 in section 252A(e) of the Balanced Budget and
19 Emergency Deficit Control Act of 1985.

20 "(B) MEDICAID.—The Medicaid program
21 is sustainable if its outlays, excluding those des-
22 ignated as emergencies, are projected to grow
23 from the fixed percentage of Gross Domestic
24 Product in the year prior to the date of the en-
25 actment of this Act, adjusted by a rate no high-

1 er than a blend of the Consumer Price Index
2 and the Medical Economic Index, as adjusted
3 after fiscal year 2018 using the same calcula-
4 tion, excluding benefits provided from the
5 OASDI Trust funds, as that set forth in section
6 252A(e) of the Balanced Budget and Emer-
7 gency Deficit Control Act of 1985 to reflect the
8 increase in the the number of Medicare eligible
9 retirees receiving benefiits in the program rel-
10 ative to fiscal year 2018.

11 ''(C) OTHER DIRECT SPENDING.—Other
12 direct spending is direct spending other than
13 OASDI, the Medicare and Medicaid program
14 and is sustainable if it grows from a fixed per-
15 centage of gross domestic product in fiscal year
16 2008.''.

17 (b) OFFICE OF MANAGEMENT AND BUDGET.—Sec-
18 tion 1105(a) of title 31, United States Code, (as amended
19 by section 142(e)) is further amended by adding at the
20 end the following:

21 ''(38) long-term projections of total spending
22 over 75 years as a percentage of gross domestic
23 product annually and the impact of proposed policies
24 over that period.''.

SEC. 822. GAO AND OMB STATEMENTS OF THE FEDERAL GOVERNMENT'S FINANCIAL CONDITION.

(a) GOVERNMENT ACCOUNTABILITY OFFICE.—On or before April 15 of each fiscal year, the Government Accountability Office shall submit a report on the federal government's financial condition, including the long-term unfunded obligations.

(b) DEFINITION OF LONG-TERM UNFUNDED OBLIGATIONS.—Section 3 of the Congressional Budget Act of 1974 is further amended by adding at the end the following new paragraph, and redesignate the paragraph accordingly:

"(11) UNFUNDED OBLIGATIONS.—The term 'Unfunded Obligations' means the dollar sum of the Total Net Position as displayed in the United States Government Balance Sheets contained within the most recently published Financial Report of the United States Government; plus the 75-year actuarial balances, using the intermediate open-group assumption, of Medicare's Hospital Insurance, Supplementary Medical Insurance, and Prescription Drug programs contained within the most recently published Annual Report of the Boards of Trustees of the Federal Hospital Insurance and Federal Supplementary Medical Insurance Trust Funds; plus the 75-year actuarial balance, using the intermediate

open group assumption, of the Old-Age Survivors and Disability Insurance program contained within the most recently published Annual Report of the Board of Trustees of the Federal Old-Age and Survivors Insurance and Federal Disability Insurance Trust Funds.''.

(c) OFFICE OF MANAGEMENT AND BUDGET.—Section 1105(a) of title 31, United States Code, (as amended by section 301(b)) is further amended by adding at the end the following:

''(39) a report on the Federal Government's financial condition, the including the long-term unfunded obligations.''.

SEC. 823. FIVE-YEAR FISCAL SUSTAINABILITY REVIEW.

Title III of the Congressional Budget Act of 1974 (as amended by section 126(a)) is further amended by adding at the end the following new section:

''FIVE-YEAR FISCAL SUSTAINABILITY REVIEW

''SEC. 318. (a) CONGRESSIONAL SPENDING REVIEW REPORT.—Not later than 15 calendar days after the date of the transmittal of the report referred to in subsection 308(e), the Committees on the Budget of the House of Representatives and the Senate shall issue, and have printed in the Congressional Record, an assessment of such report.

"(b) COMMITTEE RECOMMENDATIONS.—Not later than 15 calendar days after the date of the report of the review referred to in subsection (c), the committees of the House of Representatives and the Senate shall consider and vote to submit to the Committees on the Budget of the House of Representatives and Senate, as applicable, recommendations, if any, such committees deem appropriate in response to the Spending Review Report issued pursuant to subsection (c).

"(c) EXPEDITED CONSIDERATION OF SPENDING REVIEW LEGISLATION.—

"(1) CONSIDERATION IN THE HOUSE OF REPRESENTATIVES.—

"(A) INTRODUCTION OF SPENDING REVIEW LEGISLATION.—

"(i) If the report referred to in section 308 indicates that the OASDI Trust Funds are not solvent, or that Medicare, Medicaid or other direct spending programs are not sustainable, or total spending exceeds the limits set forth in section 252A for any year within the 75-year period referred to in such report, then not later than 30 calendar days after the transmittal of the report referred to in

subsection (a), if any, the majority leader and minority leader of the House of Representatives shall each introduce legislation implementing to the extent practicable the recommendations referred to in subsection (d), or if necessary additional spending reduction sufficient to achieve the spending levels referred to in subsection (b).

''(ii) If Spending Review Legislation is not introduced pursuant to this subparagraph by the majority leader or minority leader, then not later than 45 calendar days after the transmittal of the report referred to in subsection (a), the chairman or ranking member of the Committee on the Budget shall introduce Spending Review Legislation sufficient to achieve the same spending levels.

''(iii) Spending review legislation shall be referred solely to the Committee on the Budget of the House of Representatives which shall have sole jurisdiction of such legislation.

''(iv) Spending review legislation introduced pursuant to this section shall

cause total spending to be reduced by an amount equal or greater than the amount of the breach of the limits set forth in section 252A, and shall cause the OASDI Trust Funds to achieve solvency, and shall cause Medicare, Medicaid, and other direct spending programs to achieve sustainability.

"(B) REFERRAL AND REPORTING.—The Committee on the Budget of the House of Representatives shall report Spending Review Legislation to the House of Representatives not later than the seventh legislative day after the date of introduction of the legislation referred to in subparagraph (A). If such committee fails to report the Spending Review Legislation within that period or the House of Representatives has adopted a concurrent resolution providing for adjournment sine die at the end of a Congress, such committee shall be automatically discharged from further consideration of the Spending Review Legislation and it shall be placed on the appropriate calendar.

"(C) PROCEEDING TO CONSIDERATION.—After Spending Review Legislation is reported

by or discharged from the Committee on the Budget or the House of Representatives has adopted a concurrent resolution providing for adjournment sine die at the end of a Congress, it shall be in order to move to proceed to consider the Spending Review Legislation in the House of Representatives. Such a motion shall be in order in the legislative schedule within two legislative days after the day on which the proponent announces his intention to offer the motion. Such a motion shall not be in order after the House of Representatives has disposed of a motion to proceed with respect to that special message. The previous question shall be considered as ordered on the motion to its adoption without intervening motion. A motion to reconsider the vote by which the motion is disposed of shall not be in order.

"(D) CONSIDERATION.—The Spending Review Legislation shall be considered as read. All points of order against Spending Review Legislation and against its consideration are waived. The previous question shall be considered as ordered on an Spending Review Legislation to its passage without intervening motion except five

hours of debate equally divided and controlled by the proponent and an opponent and one motion to limit debate on the Spending Review Legislation. A motion to reconsider the vote on passage of the Spending Review Legislation shall not be in order.

"(E) SENATE SPENDING REVIEW LEGISLATION.—Spending Review Legislation received from the Senate shall not be referred to committee.

"(2) CONSIDERATION IN THE SENATE.—

"(A) MOTION TO PROCEED TO CONSIDERATION.—A motion to proceed to the consideration of Spending Review Legislation under this subsection in the Senate shall not be debatable. It shall not be in order to move to reconsider the vote by which the motion to proceed is agreed to or disagreed to.

"(B) LIMITS ON DEBATE.—Debate in the Senate on Spending Review Legislation under this subsection, and all debatable motions and appeals in connection therewith (including debate pursuant to subparagraph (D)), shall not exceed 10 hours, equally divided and controlled in the usual form.

"(C) APPEALS.—Debate in the Senate on any debatable motion or appeal in connection with Spending Review Legislation under this subsection shall be limited to not more than 1 hour, to be equally divided and controlled in the usual form.

"(D) MOTION TO LIMIT DEBATE.—A motion in the Senate to further limit debate on Spending Review Legislation under this subsection is not debatable.

"(E) MOTION TO RECOMMIT.—A motion to recommit Spending Review Legislation under this subsection is not in order.

"(F) CONSIDERATION OF THE HOUSE OF REPRESENTATIVES SPENDING REVIEW LEGISLATION.—

"(i) IN GENERAL.—If the Senate has received the House of Representatives companion resolution to the Spending Review Legislation introduced in the Senate prior to the vote required under paragraph (1)(C), then the Senate may consider, and the vote under paragraph (1)(C) may occur on, the House of Representatives companion resolution.

"(ii) PROCEDURE AFTER VOTE ON SENATE SPENDING REVIEW LEGISLATION.—If the Senate votes, pursuant to paragraph (1)(C), on the Spending Review Legislation introduced in the Senate, then immediately following that vote, or upon receipt of the House of Representatives companion resolution, the House of Representatives Spending Review Legislation shall be deemed to be considered, read the third time, and the vote on passage of the Senate resolution shall be considered to be the vote on the Spending Review Legislation received from the House of Representatives.

"(3) JURISDICTION.—The Committees on the Budget of the House of Representatives and Senate shall have exclusive jurisdiction over any Spending Review Legislation and all the provisions therein for all purposes of the rules of either House.".

SEC. 824. LONG-TERM RECONCILIATION.

(a) LONG-TERM RECONCILIATION.—Section 310 of the Congressional Budget Act of 1974 is amended as follows:

"(h) LONG-TERM RECONCILIATION DIRECTIVES.—

"(1) LONG-TERM RECONCILIATION DIRECTIVES.—In addition to a reconciliation measure as set forth in subsection (a), a concurrent resolution on the budget for any fiscal year, to the extent necessary to effectuate the spending levels as set forth for such categories in section 301(a) (providing for long-term spending levels as a percentage of gross domestic product) of such resolution, shall—

"(A) specify the total amount by which Medicare, Medicaid, the OASDI Trust Funds, and other direct spending outlays are to be reduced within the jurisdiction of a committee as a percentage of gross domestic product of such fiscal year; and

"(B) direct that committee to determine and recommend changes to accomplish a reduction of such total amount for such categories as a percentage of gross domestic product.

"(2) LIMITATION ON AMENDMENTS TO LONG-TERM RECONCILIATION LEGISLATION.—

"(A) It shall not be in order in the House of Representatives to consider any amendment to a reconciliation bill or reconciliation resolution if such amendment decreases outlay reductions below the level of such outlay reductions

provided (for the fiscal years covered) in the reconciliation instructions which relate to such long-term reconciliation bill.

"(B) It shall not be in order in the Senate to consider any amendment to a reconciliation bill or reconciliation resolution if such amendment decreases outlay reductions below the level of such outlay reductions provided (for the fiscal years covered) in the reconciliation instructions which relate to such long-term reconciliation bill.

"(C) Subparagraphs (A) and (B) shall not apply if a declaration of war by the Congress is in effect.

"(D) For purposes of this section, the levels of outlays as a percentage of a gross domestic product for a fiscal year shall be determined on the basis of estimates made by the Committee on the Budget of the House of Representatives or of the Senate.

"(E) The Committee on Rules of the House of Representatives may make in order amendments to achieve outlay reductions specified by reconciliation directives contained in a concurrent resolution on the budget if a com-

mittee or committees of the House of Representatives fail to submit recommended reductions in outlays as a percentage or gross domestic product to its Committee on the Budget pursuant to its instruction.

"(F) In the Senate, a motion to strike a provision shall always be in order.

"(3) SUBJECT MATTER.—Subject matter included in a long-term reconciliation bill may be any of the following:

"(A) Any part of the Medicare program.

"(B) Medicaid.

"(C) The Old-Age, Survivors, and Disability Insurance Trust Fund.

"(D) Other direct spending.

"(4) APPLICATION.—Subsections (c), (d), and (g) shall not apply to long-term reconciliation measures reported under this subsection.".

(b) CONFORMING AMENDMENT.—In section 310(b) of the Congressional Budget Act of 1974, strike "subsection (a)" and insert "subsections (a) and (h)".

SEC. 825. LONG-TERM SPENDING INCREASE POINT OF ORDER.

(a) IN GENERAL.—Title III of the Congressional Budget Act of 1974 (as amended by section 303) is fur-

ther amended by adding at the end the following new section:

"LONG-TERM SPENDING INCREASE POINT OF ORDER

"SEC. 317. (a) CONGRESSIONAL BUDGET OFFICE ANALYSIS OF PROPOSALS.—The Director of the Congressional Budget Office shall, to the extent practicable, prepare for each bill and joint resolution reported from committee (except measures within the jurisdiction of the Committee on Appropriations), and amendments thereto and conference reports thereon, an estimate of whether the measure causes, relative to current law, a net increase in direct spending in excess of $5,000,000,000 in any of the four 10-year periods beginning in fiscal year 2019 through fiscal year 2058.

"(b) IN THE SENATE.—

"(1) POINT OF ORDER.—It shall not be in order in the Senate to consider any bill, joint resolution, amendment, motion, or conference report that causes a net increase in deficits in excess of $5,000,000,000 in any of the four 10-year periods beginning in 2019 through 2058.

"(2) SUPERMAJORITY WAIVER AND APPEAL.—

"(A) This section may be waived or suspended only by the affirmative vote of three-fifths of the Members, duly chosen and sworn.

"(B) An affirmative vote of three-fifths of the Members, duly chosen and sworn, shall be required to sustain an appeal of the ruling of the Chair on a point of order raised under this section.

"(c) IN THE HOUSE OF REPRESENTATIVES.—

"(1) POINT OF ORDER.—It shall not be in order in the House of Representatives to consider any bill, joint resolution, amendment, motion, or conference report that causes a net increase in deficits in excess of $5,000,000,000 in any of the four 10-year periods beginning in 2019 through 2058.

"(2) SUPERMAJORITY WAIVER AND APPEAL.—

"(A) This section may be waived or suspended only by the affirmative vote of three-fifths of the Members, duly chosen and sworn.

"(B) An affirmative vote of two-thirds of the Members, duly chosen and sworn, shall be required to sustain an appeal of the ruling of the Chair on a point of order raised under this section.

"(d) DETERMINATIONS OF BUDGET LEVELS.—For purposes of this section, the levels of net deficit increases shall be determined on the basis of estimates provided by

the chairmen of the Senate and House Committees on the Budget, as applicable.''.

(b) CONFORMING AMENDMENT.—The table of contents set forth in section 1(b) of the Congressional Budget and Impoundment Control Act of 1974 is amended by inserting after the item relating to section 316 the following new item:

''Sec. 317. Long-term spending increase point of order.''.

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