

The Patients' Choice Act
S. 1099 /H.R. 2025
Section-by-Section

Title I – Investing in Prevention

Sec. 101. Strategic Approach to Outcome-Based Prevention

Provides for the establishment of an Interagency Coordinating Committee that will develop a national strategic plan for prevention. Outlines a federal messaging campaign for health promotion and disease prevention using web-based wellness and prevention resources.

Sec. 102. State Grants For Outcome-Based Prevention Effort

Encourages the development of process outcomes to measure the effectiveness of wellness programs.

Sec. 103. Focusing the Food Stamp Program on Nutrition

Requires the development of a science-based nutrition counseling brochure to be distributed to food stamp recipients and prohibits the purchase of foods that do not meet science-based standards for proper nutrition.

Title II – State-Based Health Care Exchanges

Outlines the requirements for certification of state-based health care exchanges to facilitate the purchase of private health insurance based on price and quality. States are not required to create exchanges but have the option to do so.

States that choose to establish an exchange are encouraged to contract with health insurance plans or a third party administrator to run exchanges, thereby prohibiting price setting and ensuring a properly functioning market.

Any health insurance plan licensed in the state may participate in the exchange, *but plans are not required to participate*. Plan participation is optional. Plans may still sell health insurance outside the exchange [and individuals may use their tax credit money and/or Medicaid supplement – described in further detail below – to purchase health insurance outside the exchange.]

States shall not determine premiums or cost-sharing amounts for health insurance coverage offered through the exchange. Plans participating in the exchange must offer *at least* the same minimum health benefits made available to Members of Congress.

To facilitate enrollment, States may develop automatic enrollment procedures to ensure that any individual seeking health coverage has the opportunity to enroll in a plan. All health plans participating in the exchange must provide annual open enrollment periods to enroll newly eligible individuals. Individuals may opt-out from health coverage.

Medicaid SCHIP eligible individuals may enroll in health insurance plans through the exchange using tax credit and Medicaid supplement card [described in further detail below].

Plans offered through the exchange may not discriminate based on pre-existing conditions. Individuals are guaranteed access to a health insurance plan through the exchange so long as the individual agrees to make applicable premium and cost-sharing payments.

The exchange shall establish mechanisms to protect enrollees from the imposition of excessive premiums, to reduce adverse selection, and to share risk. Options for states choosing to establish an exchange include independent risk adjustment, health security pools and reinsurance [states must offer at least one of these options, or a comparable option, to address the problem of “uninsurable” individuals as part of their exchange certification].

States may form interstate compacts and multi-state pooling arrangements.

The Secretary may award grants and one-time increases in Medicaid payments to incentivize states to establish exchanges.

Title III – Fair Tax Treatment for Every American to Afford Health Care

Subtitle A – Refundable and Advanceable Credit for Certain Health Insurance Coverage

Sec. 301. Establishes a Refundable and Advanceable Tax Credit for Health Insurance

Qualifying individuals and families are eligible to receive an advanceable, refundable credit of at least \$2,290 and \$5,710 respectively. Should the credit allotment exceed the cost of a health insurance product, the excess amount will be deposited into a medical savings account [may be a health savings account or another tax-preferred type of medical savings account]. Medicaid and SCHIP eligible individuals are considered “qualifying individuals” for purposes of this section.

Qualifying health insurance is defined as any insurance constituting medical care which has a responsible annual and lifetime benefit maximum, in consultation with the Secretary, and provides coverage for inpatient and outpatient care, emergency benefits, and physician care.

The Secretary will establish a program for making payments on behalf of individuals or families receiving a refundable credit. Credit recipients indicate the health insurance plan of their choice using tax filing documents.

Ensures revenue-neutrality by allowing for adjustment of credit amounts. [Allocations made to the refundable/advanceable population are directed from savings generated by entitlement reform savings, and *not* from the repeal of the individual tax exclusion on health care benefits provided by employers, which is used to fund the credit for taxpayers].

Sec. 302. Provides for Employer Transparency of Health Care Costs

Employers must include on W-2 documents the aggregate cost for coverage of the employee health benefits.

Sec. 303. Brings Fairness to the Tax Code

Converts the current individual income tax exclusion for health care benefits to a tax cut for taxpayers [described above]. The exclusion of health benefits from FICA payroll taxes remains. Contributions made by employers toward employee health care are still deductible as a business expense deduction.

Subtitle B – Health Savings Accounts

Sec. 311. Improving Health Savings Accounts

The annual contribution limit to Health Savings Accounts is increased to \$3,000 for individuals and \$5,950 for families. Additionally, employers are provided with the flexibility to contribute additional funding to Health Savings Accounts for those employees with chronic diseases.

The use of Health Savings Account funds is expanded to include the cost of health insurance premiums, preventives services, and concierge-style primary care services.

Title IV—Fairness For Every American Patient

SUBTITLE A—MEDICAID MODERNIZATION

Provisions contained in this section are designed to hold the current dual-eligible Medicare/Medicaid populations harmless for any changes that will be made within the Medicaid program. Medicaid will continue to meet the acute care needs of individuals with disabilities and other special needs populations under current law and states will continue to receive funding under the current federal matching formula.

The current institutional bias in long-term care is eliminated and all individuals qualifying for long-term care under Medicaid will have the option to self-direct their own services and support. Long-term services and support are expanded to include an updated array of services including assistive technology, community treatment teams, recovery support, and transitional care *without the need for federal waivers*. States will have stable and predictable funding for long-term care that is indexed for annual growth.

Title XIX itself is reorganized into Parts A-F. The legislative reorganization includes authorization of \$100 million annually in new grants to states for program integrity. It also includes authorization of \$100 million in outreach grants and transition rules to ensure seamless transition and effective continuation of care.

SUBTITLE B—SUPPLEMENTAL HEALTH CARE ASSISTANCE FOR LOW-INCOME FAMILIES

Sec. 411. Supplemental Health Care Assistance For Low-Income Families

[For Medicaid/SCHIP-enrolled individuals, the refundable credit described above in Title III and supplemental coverage described in this section, replace current Medicaid/SCHIP coverage.]

To ensure every American is able to afford and access health care services, this section provides supplemental health care assistance for low-income families. Eligible families must have a gross income that does not exceed 200 percent of the poverty line, include at least 1 individual who is a dependent under the age of 19, and have no existing health insurance coverage.

Each eligible family that enrolls in the supplemental health care assistance program shall be issued a debit card with a dollar-amount value that may be used to pay for qualifying health care expenses. The debit card may be applied to care expenses include the purchase of health care insurance, any cost sharing, or the direct purchase of health care services and supplies. The debit card may not be used to make non-health related purchases. Beneficiaries would be allowed to roll over up to one-quarter of the amount on the debit card that is unexpended at the end of each 12-month period.

Amounts of financial assistance available to each eligible family during the calendar year 2011 are as follows: \$5,000 for families whose annual income does not exceed 100 percent of the poverty level; \$4,000 for families whose annual income is between 100 percent of poverty but does not exceed 120 percent of the poverty level; \$3,500 for families whose annual income is between 120 percent of poverty but does not exceed 140 percent of the poverty level; \$3,000 for families whose annual income is between 140 percent of poverty but does not exceed 160 percent of the poverty level; \$2,500 for families whose annual income is between 160 percent of the poverty level but does not exceed 180 percent of the poverty level; \$2,000 for families whose annual income is between 180 percent of the poverty level but does not exceed 200 percent of the poverty level.

An additional \$1,000 is made available for each family in which there is a pregnancy during a 12-month period. An additional \$500 is made available for each member of the family under the age of 1 year old.

The Secretary may adjust the amount of financial assistance available to an eligible family based on age, health indicators, and to other factors that represent distinct patterns of health care services utilization and cost.

The Secretary shall establish procedures and times for enrollment in the supplemental debit card program. Open enrollment shall be available not less than 4 times per calendar year. All individuals predetermined to be eligible for Medicaid or SCHIP and meeting the eligibility requirements, other than those that would have qualified for Medicaid or SCHIP as disabled, elderly, or a special population will be automatically enrolled in the supplemental debit card program. Individuals not meeting the new eligibility requirements (i.e., those in families with income above 200 percent of the federal poverty level), will remain eligible in Medicaid or SCHIP for six months to ensure their transition.

Choice Counseling

The Secretary may enter into contracts for the purpose of educating eligible families about their options and to assist in their enrollment in the supplemental debit card plan.

Title V—Fixing Medicare For American Seniors

Subtitle A – Increasing Programmatic Efficiency, Economy and Accountability

Sec. 501. Eliminate inefficiencies and increasing choice in Medicare Advantage

To promote competition among Medicare Advantage plans and to increase the quality of care furnished under such plans, this provision establishes a competitive bidding mechanism that will apply to these plans beginning in 2011. The bid benchmark will be set at a benefit package that is actuarially equivalent to 106 percent of the value of the Medicare fee-for-service program option. The benchmark will be risk adjusted. Includes a provision to allow for adjustment in rural areas to ensure that Medicare Advantage plans continue to offer coverage options in underserved areas.

Sec. 502. Medicare Accountable Care Organization demonstration program

The Secretary of Health and Human Services is authorized to conduct a demonstration program under which groups of providers meeting certain criteria may work together to manage and coordinate care for Medicare fee-for-service beneficiaries through an Accountable Care Organization (ACO). An ACO will have contracts with a core group of key specialist physicians, as well as a leadership and management structure, and processes to promote evidence-based medicine and coordinate care.

ACOs will generally follow consensus-based guidelines established by non-government professional medical societies. Patient satisfaction and risk-adjusted outcomes shall be determined through an independent entity with medical expertise. Bonus payments to ACOs will be half of the percentage point difference between the two-year average of their patients' Medicare expenditures and 98 percent of the two-year average benchmark.

Sec. 503. Reduce government handouts to wealthier seniors

The annual indexing of income thresholds for reduced part B premium subsidies is eliminated. In the case of individual whose modified adjusted gross income is above \$85,000, would pay more for their Part B premiums after December 2010. Part D will be means-tested at the same level for higher-income retirees.

Sec. 504. Reward seniors' prevention in Medicare

This provision would allow Medicare premiums to be modified based on whether or not an individual participates in certain healthy behaviors, such as weight management, exercise, nutrition counseling, refraining from tobacco use, designating a health home, among other behaviors

Sec. 505. Promote healthcare provider transparency

To promote competition and fair pricing for patients, providers will be required to provide a cost estimate for non-emergency treatments. After the treatment providers must furnish an itemized list of component charges for such treatment at the time of billing.

Sec. 506. Availability of Medicare and Medicaid Claims and Patient Encounter Data

Secretary shall make available to the public (including through an Internet website) data on claims and patient encounters under titles XVIII and XIX of the Social Security Act during the preceding calendar year. Such data shall be appropriately disaggregated and patient deidentified.

Subtitle B – Reducing Fraud and Abuse

Sec. 511. Requiring the Secretary of Health and Human Services to Change the Medicare Beneficiary Identifier Used to Identify Medicare Beneficiaries Under the Medicare Program

Changes the current system of using social security numbers as the Medicare Beneficiary Identifier (MBI) to numbers like we have on credit cards, in an effort to protect beneficiaries from identity theft. New cards would have biometric ID protections.

HHS is required to establish a process to assign a new MBI in the discovery of fraud or identity theft. It authorizes and require data matching across federal agencies to check for social security numbers in Medicare and Medicaid of dead, imprisoned, or otherwise ineligible beneficiaries and providers.

Providers and suppliers using the identifications of dead, imprisoned or otherwise ineligible individuals must be investigated immediately by HHS OIG. Directs the Secretary to level direct financial penalties to facilities receiving Medicare or Medicaid dollars that choose to employ any physician, executive, or administrator convicted of Medicare or Medicaid fraud in any state or responsible for a settlement with the government.

Sec. 512. Use of Technology for Real Time Data Review

Requires Secretary of HHS to establish procedures to identify and investigate unusual billing to prevent fraud and abuse.

Sec. 513. Detection of Medicare Fraud and Abuse

Requires HHS to implement a real time data review of all Medicare claims to provide data analysis of claims for reimbursement and to help identify and investigate unusual billing or order practices. [This should be front-end, pre-payment technology similar to that employed by private hedge funds, investment funds, and banks.]

Sec. 514. Edits of 855S Medicare Enrollment Application and Exemption of Pharmacists for Surety From Surety Bond Requirement

Requires Medicare carriers to check with the National Supplier Clearinghouse (NSC) to ensure that the supplier number is active and valid. Limits payment to providers to accredited services.

Disallows payments to providers who submit claims for reimbursement that do not match the service specialty or specialties the provider indicated on the 855S enrollment form. Adds to CMS-855S form that prospective DME providers must fill out the phrase, “under penalty of perjury, federal criminal prosecution, and possible imprisonment” by the signature block.

Directs that the submission of a fraudulent DME claims gives HHS the immediate authority to revoke the supplier’s billing number. Directs that HHS, within one year of enactment, must establish an appeals process where appeals of billing number revocations may be appealed and resolved in no more than 60 days. Exempts Pharmacists from the requirement of a surety bond for Durable Medical Equipment.

Sec. 515. GAO Study and Report on Effectiveness of Surety Bond Requirements for Suppliers of Durable Medical Equipment in Combating Fraud

Requires GAO to conduct a study on the effectiveness of surety bond requirements in combating fraud.

Title VI - Ending Lawsuit Abuse**Sec. 601. State Grants to Create Health Court Solutions**

Establishes a grant program to encourage states to develop alternatives to tort litigation for medical malpractice claims. Grant amounts are equivalent to a 1 percent increase in Medicaid payments for 1 year.

Funding is available for States to elect establish either review panels or health care tribunals. Qualifying review panels are composed of medical experts and attorneys appointed by the state who review health care claims and make a determination as to the liability of the parties involved. Parties may reject the determination and file a claim relating to the injury in a state court. Any party filing in state court forfeits awards from panel determination.

Qualifying health care tribunals are composed of judges with explicit expertise in health care litigation who review cases at the request of individuals who have a health care claim. After review of the case, the tribunal would make a determination as to the liability of the parties involved. Parties may reject the determination and file a claim relating to the injury in a state court. Any party filing in state court forfeits awards from panel determination.

Third options allows states to utilize a combination of the review panel and health care tribunal. The same restrictions and provisions apply.

Title VII – Promoting Health Information Technology***Subtitle A – Assisting the Development of Health Information Technology*****Sec. 702. Health Record Banking**

Requires the Secretary of Health and Human Services to establish a system that provides for the certification and auditing of Independent Health Record Banks. Ensures account holders retain ownership over information contained in the electronic medical records.

Sec. 703. Security and Confidentiality Standards

Extends Health Insurance Portability and Accountability Act protections to all medical information held by Independent Health Record Banks. Also ensures that current State security and confidentiality laws apply to these banks as well. Holds harmless individuals who install or provide health information technology systems.

Subtitle B – Removing Barriers to the Use of Health Information Technology

Suspends the physician-self referral prohibitions for the adoption and deployment of health information technology software and platforms.

Title VIII – Health Care Services Commission

Subtitle A – Establishment and General Duties

Sec. 801. Establishment

Establishes a Health Care Services Commission to be composed of 5 commissioners, appointed by the President and with the advice and consent of the Senate. The agency will be managed by five commissioners chosen from the private sector, appointed by the President, and approved by the Senate. The purpose of the HSC is to enhance the quality, appropriateness, and effectiveness of health care services through the publication and enforcement of quality and price information.

Sec. 802. General Authorities and Duties

The commissioners shall conduct and support research, demonstration projects, evaluations, training, guideline development, and the dissemination of information with respect to effectiveness, outcomes, clinical practice, health care technologies, costs, disease prevention, statistics, and medical liability. Commissioners must support research with respect to rural and underserved populations.

Sec. 803. Dissemination.

The forum will publish, for public comment, a preliminary analysis on standards for reporting price, quality, and effectiveness of health care services. After the comment period, the group will publish a final report containing guidelines for regulating the publication and dissemination of health care information. The HSC is authorized to enforce these standards.

Subtitle B – Forum for Quality and Effectiveness in Health Care

Sec. 811. Establishment of Office

Establishes a Forum for Quality and Effectiveness in Health Care within the Health Care Services Commission. The Forum shall have a director appointed by the commissioners.

Sec. 812. Membership

Forum membership shall be composed of 15 individuals consisting entirely of private-sector representation, with the authority to establish and promulgate metrics to report price and quality data. The forum members will represent views from medical providers, insurers, researchers, and consumers, and will serve independently of any other employment.

Sec. 813. Duties

The forum must promote transparency in price, quality, appropriateness, and effectiveness of health care. The director shall arrange for the development and periodic review and updating of standards, performance measures, and medical review criteria through which health care providers and other entities may review. In carrying out these duties, the director may enter into contracts with public or nonprofit entities. The forum must publicly disclose recommendations through the issuance of quarterly reports.

Sec. 814. Adoption and Enforcement of Guidelines and Standards

Commissioners shall adopt recommendations of the forum and has the authority to make recommendations to the Secretary of HHS.

*Subtitle C – General Provisions***Sec. 822. Funding**

Authorizes appropriations for such sums as necessary.

Sec. 823. Definitions

Defines the Commissioner, Director, and Secretary.

*Subtitle D – Terminations and Transition***Sec. 831. Termination of Agency for Healthcare Research and Quality**

Eliminates the Agency for Healthcare Research and Quality [to be replaced by the Healthcare Services Commission]. Ongoing activities may continue.

*Subtitle E – Independent Health Record Trust***Sec. 842. Purpose**

Establishes a nationwide health information technology network that would promote wellness, disease prevention by increasing the availability and transparency of health information while providing security provisions to protect patient records.

Sec. 843. Definitions

Defines Independent Health Record Trusts.

Sec. 844. Establishment, Certification, and Membership of Independent Health Record Trusts

Defines a process through which IHRTs may become certified and details the standards by which the Federal Trade Commission may regulate these entities.

Sec. 845. Duties for IHRT Participants

Establishes protections for medical information contained within an electronic record as well as penalties that would be levied for violating these protections. Penalties include lost of certification, a fine of no more than \$50,000, and imprisonment of not more than 5 years.

Sec. 846. Availability and Use of Information from Records in IHRT

Ensures that patients and record holders have primary ownership over information contained within an IHRT. Provides health care providers and IHRT managers with directions for updating and recording information within a patient's medical record. Provides for revenue sharing arrangement between IHRT managers and patients for any anonymous information that is provided with consent to authorized researchers.

Sec. 847. Voluntary Participation in IHRT and Information Sharing

Prohibits any employer, health insurance issuer, group health plan, or health care provider from requiring individuals to participate in an IHRT.

Sec. 848. Financing of Activities

Allows IHRT to generate revenue by charging account fees and user fees for allowed research purposes. Prohibits charges to health care providers for sending or otherwise uploading medical information requested by an IHRT account holder.

Sec. 849. Regulatory Oversight

Established an Interagency Steering Committee within the Federal Trade Commission to develop regulations governing the actions and activities of IHRT entities.

Title IX – Miscellaneous**Sec. 901. Health Care Choice for Veterans**

This section permits veterans, survivors and dependents of veterans to receive health care at non-Department of Veteran Affairs providers and facilities and requires the Secretary of Veteran Affairs to establish a system to provide payments for these services.

The Secretary is required to ensure that aggregate payments made to private providers not exceed payments that would have otherwise been paid.

Sec. 902. Health Care Choice for Indians

This section permits Indians who are eligible for health care and services under a health care program operated or financed by the Indian Health Service or by other qualifying organizations to receive healthcare from private health providers.

The Secretary of Health and Human Services is required to establish a payment system but not to exceed payments that would have otherwise been paid.

Sec. 903; Terminates the Federal Coordinating Council of Comparative Effectiveness

Eliminates the Agency the Federal Coordinating Council of Comparative Effectiveness.

Sec. 904; Commissions HHS and GAO to Report Jointly on Costs of the 5 Medical Conditions that have the Greatest Impact

This Secretary of Health and Human Services is to conduct a study on the costs of the top 5 medical conditions facing the public which have the greatest impact in terms of morbidity, mortality, and financial cost. The study is to pay specific attention to heart disease, obesity, diabetes, stroke, cancer, and Alzheimer's.