

Republican Health Care Reform Rep. Paul Ryan – Patient’s Choice Act - HR 2520

Co-sponsors: Kevin Brady (R-TX8), Ken Calvert (R-CA44), John Campbell (R-CA48), Steven LaTourette (R-OH14), John Linder (R-GA7), Kenny Marchant (R-TX24) Tom McClintock (R-CA4), Devin Nunes (R-CA21), Dana Rohrabacher (R-CA46), Peter Sessions (R-TX32), John Shimkus (R-IL19), Mark Souder (R-IN3)

Summary

Features of the Republican [Ryan-Coburn’s Health Care Proposal]		
Issues	Ryan-Coburn HR 2520	Breyer
Tax Increase	<p>INCREASE TAXES to employees through shift of employer health care benefit cost to the taxable annual gross income; Set standards are below current average insurance premium credit (Household Employer-employee Premium: \$13,000 (current average); \$5970 (Ryan’s reform)</p> <p>Increase tax to employer through repeal of health insurance exclusion.</p> <p><i>Outcome: Reduction in the health benefits of employees for employers will not necessarily provide their share of health benefits to the employee’s salary. However, if they do the employees will have higher adjusted Gross Income subject to taxation of Medicare, SSI and Income - increase taxes on health benefit shift. Potential unemployment increase.</i></p>	<p>NO TAX INCREASE because cost of insurance premium will be decreased for all Americans through an efficient national health delivery structure that reduces medical errors, efficient information dissemination and medical decision for health care providers and patient. – One Central Inter-State Network System (CNS) through the federal government will negotiate for insurance premium discount (20%-30% with credits for prevention) for all current Americans (300 Million) providing an efficient system that would help some of the national dissemination needs and interstate barriers for insurance companies.</p> <p><i>Outcome: Savings and reduction (20%-30%) in insurance premium for all Americans. Cost reduction for insurance companies in offering inter-state to national services.</i></p>
Federal Responsibilities	<p>Health and Human Service Secretary will work with 12 Federal Agency representatives for a year to plan a strategic approach of solving the preventive care promotion campaign. <i>Funding: Planning Conference and Campaign \$500 Million; Education & Program Integrity \$1.1 Billion</i></p> <p>Information Health Record Trust that will promote use of software from multiple certified providers to collect Medical Records from patients. <i>Funding: Patients/ Participants will be charged for fees and collected medical records can be sold to a third party within the required guidelines.</i></p> <p>Other Source of IHRT Revenues:</p> <ul style="list-style-type: none"> - charging IHRT participants account fees for use of the trust; - charging authorized EHR data users for accessing electronic health records maintained in the trust; - the sale of information contained in the trust (as provided for in section - any other activity determined appropriate by the Federal Trade Commission. <p>Health Care Service Commission with 5 Commissioners to establish broad base of scientific research through promotion of improvements in clinical practice and in the organization, financing, and delivery of health care services. Establish the Forum for Quality and Effectiveness in Health Care with a Director and 12 members. <i>Funding: Funding will be appropriated but the amount for 10 years reform is not stated in the proposed bill.</i></p> <p>Centers for Disease Control and Prevention (CDC), shall develop and implement a plan for the dissemination of health promotion and disease prevention information consistent with national priorities described in the strategic and implementing plans. <i>Funding: Grants on Outcome-based</i></p>	<p>One Central Inter-State Network System (CNS) - All private insurance but facilitated under one federal insurance exchange that will negotiate to all health care providers for 20%- 30% cost decrease while increasing the risk pool through interstate or nationwide enrollment.</p> <p>One major nation-wide Information Health Record Database designed for patient-oriented health and access - similar to the current nationwide highly secured and confidential health electronic database of the VA Medical Center. One standard framework that can integrate with new innovative modular software. Clinical consortia can pool records during their study but such records cannot be sold to a third party and can only be used for its original intent of creation. De-identified health information, health trends and risk will be available for patients and providers for access and resource in making empowered health decision. No transaction fees for patients but federally negotiated nationwide discount for providers to be part of the program.</p> <p>Innovative payment and savings system that provides 30% -40% savings to current insurance premium for all groups, non-groups, state and federal health programs. Additional tax credits for every savings donated to support federal programs (i.e., uninsured, low-income, homeless) Integrated decision on best practices guidelines, risk assessment, experts and provider resources and health record collection in one central unit provides a real-time evaluation of best policies, practices, oversight and rewards.</p> <p>Through the Secretary of the DHHS, the National Institute of Health and Centers for Disease Control, VA Medical Center and Department of Defense, will collaboratively work together with basic, clinical and</p>

	<p><i>prevention - \$300 Million; Immunization - \$50 Million;</i></p> <p>Inter Agency Steering Committee Oversight – 60% membership from nongovernmental entities to encourage, track and oversight on health record trust privacy, policies and sales; Federal Trade Commission, National Committee of Vital and Health Statistics, Government Accountability Office, etc.</p> <p><i>Funding: Outreach \$550 Million; Certifications \$3.3 Billion</i></p>	<p>community research to establish baseline population reference and risk for initial criteria and guidelines. Payment, savings and preventive care criteria and process will be further designed in collaboration with Social Security, IRS, EPA, and FDA, CMS and other a federal agencies. Outcome: A patient –centered and physician web-based record and payment system with real-time evaluation system.</p> <p>CNS works through the Secretary with CDC in dissemination and promotion campaign of disease prevention. NIH, VA (for veterans) and Department of Defense (active military health) in collaborative research and innovative technology development. Federal Trade Commission, National Committee of Vital and Health Statistics, Government Accountability Office and Congressional Budget Office for quarterly and annual review of data and procedures.</p>
<p>State Responsibilities</p>	<p>State- Based Health Care Insurance Exchange Two or more states can enter in inter-state coverage. Two years planning and development for states with additional 2 years for states who fails in the first 2 years (total of 4 years for full national implementation. No mandate for insurance coverage; all private insurance. Funding:</p> <p>Public-State Plan for Acute Care Medical and Long-Term Medical Assistance. Funding: State contribution of 45% for Acute care State Plan; Long Term care allotment depends on the ratio of non-institutional spending to the total long term spending for a given year. Funding: Acute Care – 55% supplement for benefit; Long Term - \$690.8 Billion for 10 years.</p> <p>State-based Tort Reform - Review of State Court after exhaustion of Remedy (Impact to the relative time or statute of limitation for State Law Suit is not addressed). Remedies are Expert Panel and Health Tribunal to review the cases. <i>Funding: Amount of funding for grants provided to the States to establish the program was not provided in HR2520 while CBO reported nationwide savings for Tort Reform was \$54 Billion.</i></p>	<p>CNS will work with the Secretary and CDC grants in providing States support for health care promotion, addressing health disparity, community outreach and prevention programs.</p> <p>Coordination between Central Network, Federal and State programs for Medicaid, Medicare, and SCHIP, for eligible individuals subsidies, private insurance, acute care, long-term care and tort reforms. States that can effectively and efficiently coordinate quality and cost-effective health prevention and treatment will be able to save their current State Medicaid and SCHIP contribution (45%-55% of the state program budget) for education and other state-based expenses.</p> <p>Tort-reform is integrated in a standard, nationwide, secured, validated technology and health-care delivery. Access to expert panels throughout the nation for case evaluation and support compound by real-time data collection, validation, evaluation and response.</p> <p>Through State Administration and the Secretary of Health, Agriculture and Commerce collaboration will be set up with academic institutions, economic development agencies and business groups for efficient implementation of the different health programs that engages the business community and serves the health needs of their workers. Coordinate these needs so innovative technologies and approaches could be integrated to CNS, federal and state programs to serve these needs.</p>
<p>Medicaid and Low Income</p>	<p>Supplemental health care assistance for low income families from \$5000 (AGI<100% FPL) to \$2000 (AGI = 180% -200% FPL); \$1000 per pregnancy and \$500 per child 9<1 yr old <i>Funding: State contributes 50% of total amount to be paid within 30 days to the Secretary of HHS. Interest will accrue upon failure to pay in a given time.</i></p>	<p>Savings of 20 cents for every dollar saved through the CNS program participation will be provided to the uninsured and low income Medicaid, SCHIP, VA or Tricare eligible individuals. Tax credit will be provided to this contribution.</p>
<p>Medicare and Social Security</p>	<p>Medicare Part B and D Premium Subsidy Reduction Reduction in Premium Subsidy Based on Income Medicare Fraud and Abuse. Fund: \$50 Million</p>	<p>Current Medicare programs will be incorporated into CNS without decrease in benefits nor increase in payment. For CNS participant below the retirement age, an algorithm of payment, savings and reporting system will be set up to be</p>

	<p>Reduction in the Social Security Benefits</p>	<p>able to slowly transition the Medicare and Social Security payment structure to an individual savings retirement account structure that satisfies the current Medicare and Social Security Retirement Agreement between Federal government and the people. New Savings Account can be passed to the next generation without gift or death taxes and cumulative over time or generation.</p>
<p>Health Savings Account</p>	<p>Tax credit which would be allowable if only qualified refund eligible health insurance were taken into account under this section, exceeds the limitation imposed for the taxable year, such excess shall be paid by the Secretary into the designated account of the taxpayer.</p> <p>Health Savings limitations for high deductible health plan, the monthly limitation for Individual \$3000 and Household \$ 5970.</p> <p>Eligible individual who has coverage under a qualified long-term care insurance contract the lesser of the annual premium for such coverage, or \$1,000.</p>	<p>Individual Savings Account (ISA) will be set up to CNS participants below retirement age. Savings will be designed similar to a 401K (earning interest >4%) with tax exempt contribution, no transaction fees and an investment supported by the government. In return, percentage (5-10%) of the interest earned per dollar will go to Social Security and Medicare Trust Funds in order to meet the retirement and medical needs of the individual and all enrollees. A solution that will enable the nation to address the insolvency of Medicare and Social Security while meeting all the health care and retirement commitments to the people (with no tax increase and decreased in benefits)</p>
<p>Bureaucracies, Efficiency & Administrative Cost</p>	<p>Bureaucracies and inefficiency of this reform is magnified at both Federal and State levels. Administrative cost will sky rocket starting with \$500 M of 15 inter-federal agency planning and campaign to redundant or overlapping responsibilities and small fragmented administration of 5 commissioners in Health Services Commission, a separate Health Information Trust, and coordination with 50 administration of state-based insurance exchanges, state to federal payment system.</p> <p>Expenses to purchase/rent buildings and equipment that the federal government capitalizes and depreciates are part of the Budget Deficits but not included in the Net Operating Cost. If these are included in the salaries, benefits and pensions of State and Federal employees, then public administrative cost will be higher than private sectors. Further increase of expense by the multiple committees, commissions and delayed response time due to this structure - Government Accountability Office Report, Sept. 2009.</p>	<p>Efficiency in coordinating the multiplex structure in health care planning and decision, real-time response and process evaluation are all integrated in one system algorithm design. Multiple intra- interagency oversights over a period of time (i.e., monthly, quarterly, and annually) provides additional checks in the system. Convergence of the collaborating agencies, academics, business, patients, physicians, experts and other stakeholder roles, resource and responsibilities on one process and site.</p>
<p>Impact on Unemployment</p>	<p>BIGGER STATE AND FEDERAL GOVERNMENT. Increase in State and Federal Employees through the State-based insurance exchange and programs and in the field of Information Technology.</p> <p>Increase Government spending at the expense of increase taxes in the private sectors will lower the %GDP contribution of private sectors - decrease available capitals for businesses.</p> <p>Potential increase in unemployment since businesses/employers will lose health benefit exclusion. Businesses will lay off employees in order to continue to provide health care benefits to their best employees.</p>	<ul style="list-style-type: none"> - No tax increase and reduction in health insurance premium cost for currently insured employees will provide more capital for businesses/employers to invest and employ people. - Promote savings and investment that will be made available to the business community - Promote infrastructure for efficient development and dissemination of new technologies, treatment, therapies and healthy activities. Investment in the private sectors for innovative technologies will have a synergistic effect in the overall economy and employment. - Savings to the States and Federal government can be channeled to fund other educational, and economic programs. States will have more funds to support education programs strengthening the workforce ability to adapt to the economic needs of the country.
<p>Problems, Fraud, Waste and Abuse</p>	<p>Outreach and health care delivery structure are not sufficient to provide quality care for the Homeless, thus increasing emergency cost and premium for privately insured people.</p> <p>Non-documented Aliens are not allowed to buy private</p>	<ul style="list-style-type: none"> - Annual health care insurance enrolment of low-income and underserved groups are integrated to their preventive health program. - Provides access to foreigners to purchase health insurance premiums eliminating or

insurance but will still default in current program that caters to their emergency needs - higher cost shifted to privately insured individual.

Inefficiencies and confusing, if not lack of, accountability, exist in the interagency structure that separates health decision policies of Health Care Services; payments from state to Health & Human Services, Health Information Trust Fund and Social Security Commission; oversight from, GAO and other federal agency; and multi-million dollar promotion campaign from multiple federal and state agencies. Serious challenge for real-time evaluations and flexibility of emergency response and policy changes.

Sale of confidential patient information database (raw information) to the third party have issues on potential breach or questions regarding ownership of intellectual properties on innovative technologies and algorithms. Very serious issues on patients privacy, security and potential practices that may lead not well-informed patient signing a form while unknowingly releasing their rights to all third party purchase of their health records.

CDC is one of several federal and state agencies involve in health care promotion and effective disease evaluation but such programs heavily relies on the data and understanding of the inter-individual, inter-racial biological differences, and health disparity --- most data are still unknown for minority groups. This problem is not address in the reform.

Serious challenges in the oversight of fraud in the security of multiple (if not hundreds) health information software across 50 states.

preventing costly unnecessary emergency burden that shifts health care cost to the privately insured people.

- Real- time evaluation algorithm can monitor the progress and immediately detect problems in the system providing faster response time in cases of emergency.
- Use of secure and validated, over time and states, Health Information Technology Database for nationwide application with flexibility for modular integration of new health care related software, process and systems.
- Intra and inter- agencies oversight (i.e., monthly, quarterly and annual)
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Department, Agencies and Institutional Roles and Responsibilities

Department of Health and Human Services

A \$500 Million funding will be set up on the first year for media campaign and planning meeting of the following agencies headed by the Secretary of Health and Human Services: Director of the National Institutes of Health; Director of the Centers for Disease Control and Prevention; Administrator of the Agency for Healthcare Research and Quality; Administrator of the Substance Abuse and Mental Health Services Administration; Administrator of the Health Resources and Services Administration; Secretary of Agriculture; Director of the Centers for Medicare & Medicaid Services; Administrator of the Environmental Protection Agency; Director of the Indian Health Service; Administrator of the Administration on Aging; Secretary of Veterans Affairs; Secretary of Defense; Secretary of Education; Secretary of Labor.

Secretary, in consultation with *private-sector experts*, shall maintain or enter into a contract to maintain an Internet website to provide science-based information on guidelines for nutrition, regular exercise, obesity reduction, smoking cessation, and specific chronic disease prevention. Such **website shall be designed to provide information to health care providers and consumers.**

The Secretary shall establish an Internet portal for accessing risk-assessment tools developed and maintained by private and academic entities.

Centers for Disease Control and Prevention

Nutrition Guidelines Development; science-based prevention recommendations promulgated by the Director of the Centers for Disease Control and Prevention; list of new non-Federal and non-government partners identified by the committee to build Federal capacity in health promotion and disease prevention efforts. DHHS Secretary through CDC shall enter into a contract with a qualified entity for the development and operation of a **Federal Internet website personalized prevention plan tool** that include transferring the from the Secretary of Agriculture to the Director of the Centers for Disease Control and Prevention; (D) specific plans to ensure that all Federal health care programs are fully coordinated with science-based prevention recommendations promulgated by the Director of the Centers for Disease Control and Prevention;

(E) specific plans to ensure that all non- Department of Health and Human Services prevention programs are based on the science based guidelines developed by the Centers for Disease Control and Prevention under subparagraph (D); and (F) a list of new non-Federal and non-government partners identified by the committee to build Federal capacity in health promotion and disease prevention efforts.

Section 103. Focusing the Food Stamp Program on Nutrition.

The Director of the Centers for Disease Control and Prevention shall develop, and the Secretary of Agriculture shall distribute to each individual and family enrolled in the Food Stamp Program under the Food Stamp

US Department of Agriculture

Secretary shall distribute to each individual and family enrolled in the Food Stamp Program under the Food Stamp Act, a science-based nutrition counseling brochure.

*Secretary of Agriculture shall, based on scientific, peer reviewed recommendations provided by a Commission that includes public health, medical, and nutrition experts and the **Director of the Centers for Disease Control and Prevention, develop lists of foods that do not meet science-based standards for proper nutrition and that may not be purchased under the food stamp program.** Such list shall be updated on an annual basis to ensure the most current science based recommendations are applied to the food stamp program.*

(2) **AUTOMATED ENFORCEMENT.**—*The Secretary of Agriculture shall, through regulations, ensure that the limitations on food purchases under paragraph (1) is enforced through the food stamp program’s automated system.*

Health Care Services Commission

Health Care Services Commission (in this title, referred to as the “Commission”) to be composed of 5 commissioners (in this title referred to as the “Commissioners”) to be appointed by the President by and with the advice and consent of the Senate. Not more than 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 5 years and until a successor is appointed and has qualified, except that —

(1) such Commissioner 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; (2) any Commissioner appointed to fill a vacancy occurring prior to the expiration of the term

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.

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) 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.

Section 803. Dissemination. 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 title and the guidelines, standards, and review criteria developed under this title; (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.

Forum for Quality and Effectiveness in Health Care

Section 811. Establishment of Forum for Quality and Effectiveness in Health Care. 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 title as the “Director”) who shall be appointed by the Commissioners. The Office of the Forum for Quality and Effectiveness in Health Care shall be composed of 15 individuals nominated by private sector health care organizations and appointed by the Commission and shall include representation from at least the following: (1) Health insurance industry; (2) Health care provider groups; (3) Non-profit organizations; (4) Rural health organizations

For the purpose of promoting transparency in price, quality, appropriateness, and effectiveness of health care, the Director, using the process set forth in section 814, shall arrange for the development and periodic review an updating of standards of quality, performance measures, and medical review criteria through which health care providers and other appropriate entities may assess or review the provision of health care and assure the quality of such care.

CERTAIN REQUIREMENTS.—Guidelines, standards, performance measures, and review criteria under subsection (a) shall—(1) be based on the best available research and professional judgment regarding the effectiveness and appropriateness of health care services and procedures; and (2) be presented in formats appropriate for use by physicians, health care practitioners, providers, medical educators, and medical review organizations and in formats appropriate for use by consumers of health care.

(c) **AUTHORITY FOR CONTRACTS.**—In carrying out this subtitle, the Director may enter into contracts with 24 public or nonprofit private entities.

d) **PUBLIC DISCLOSURE OF RECOMMENDATIONS.**— For each fiscal year beginning with 2010, the Director shall make publicly available the following: (1) Quarterly reports for public comment that include proposed recommendations for guidelines, standards, performance measures, and review criteria under subsection (a) and any updates to such guidelines, standards, performance measures, and review criteria.

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

Commissioner of Social Security

Section 503. 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.

Procedure to Assure Correct Income- Related Reduction in Premium Elimination of Annual Indexing of Income Threshold for Reduced Medicare Part B Premium Subsidies (page 145)

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 Security shall enter into agreements with the Secretary, the Director of the Office of Personnel Management, and the Railroad Retirement Board as necessary in order to allow other agencies to collect the amount described in subparagraph (A) that was not withheld under such subparagraph.” Page 150

Independent Health Record Trust Act

Section 841. Independent Health Record Trust Act 2009 It is the purpose of this subtitle to provide for the establishment of a nationwide health information technology network that improves health care quality, reduces medical errors, increases the efficiency of care, and advances the delivery of appropriate, evidence-based health care services; 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; 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; produces greater value for health care expenditures by reducing health care costs that result from inefficiency, medical errors, inappropriate care, and incomplete information; promotes a more effective marketplace, greater competition, greater systems analysis, increased choice, enhanced quality, and improved outcomes in health care services; 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.

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. 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)

FIDUCIARY DUTY OF IHRT; PENALTIES FOR VIOLATIONS OF 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 information in such participant’s electronic health record in accordance with the requirements of this subtitle.

PENALTIES.—If the IHRT knowingly or recklessly breaches the fiduciary duty described in paragraph (1), the IHRT shall be subject to the following penalties: Loss of certification of the IHRT; A fine that is not in excess of \$50,000; A term of imprisonment for the individuals involved of not more than 5 years.

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.

RULES FOR SECONDARY USES OF RECORDS FOR RESEARCH AND OTHER PURPOSES.— With respect to the electronic health record of an IHRT participant (or specified parts of such electronic health record) maintained by an IHRT, the IHRT may sell such record (or specified parts of such record) only if — 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 entered into between such participant and such IHRT; 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; the information involved is to be used for research or other activities only as provided for in the agreement; the recipient of the information provides assurances that the information will not be further transferred or reused in violation of such agreement; and the transfer otherwise meets the requirements and standards prescribed by the Federal Trade Commission.

Section 848. FINANCING OF ACTIVITIES. Except as provided in subsection an IHRT may generate revenue to pay for the operations of the IHRT through— charging IHRT participants account fees for use of the trust; charging authorized EHR data users for accessing electronic health records maintained in the trust; the sale of information contained in the trust; and any other activity determined appropriate by the Federal Trade Commission.

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

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

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

Federal Trade Commission – Interagency Steering Committee

Section 849. REGULATORY OVERSIGHT. In carrying out this subtitle, the Federal Trade Commission shall promulgate regulations for independent health record trusts.

ESTABLISHMENT OF INTERAGENCY STEERING COMMITTEE.— The Secretary of Health and Human Services shall establish an Interagency Steering Committee in accordance with this subsection.

CHAIRPERSON.—The Secretary of Health and Human Services shall serve as the chairperson of the Interagency Steering Committee.

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.

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

National Committee of Vital and Health Statistics – Federal Advisory Committee

FEDERAL ADVISORY COMMITTEE.— 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.

The National Committee for Vital and Health Statistics shall issue periodic reports and review policies concerning IHRTs based on each of the following factors: Privacy and security policies; Economic progress; Interoperability standards;

POLICIES RECOMMENDED BY FEDERAL - The Federal Trade Commission, in consultation with the National Committee for Vital and Health Statistics, shall recommend policies to —

- Provide assistance to encourage the growth of independent health record trusts;
- Track economic progress as it pertains to operators of independent health records trusts and individuals receiving nontaxable income with respect to accounts; conduct public education activities regarding the creation and usage of the independent health records trusts;
- Establish standards for the interoperability of health information technology to ensure that in requiring a delay in releasing sensitive health care test results and other similar information to patients directly in order to give physicians time to contact the patient;
- Recommendations for entities operating IHRTs, including requiring analysis of the potential risk of health transaction security breaches based on set criteria. The conduct of audits of IHRTs to ensure that they are in compliance with the requirements and standards established under this subtitle.
- Disclosure to IHRT participants of the means by which such trusts are financed, including revenue from the sale of patient data.
- Prevention of certification of an entity seeking independent health record trust certification based on:
 - (A) the potential for conflicts between the interests of such entity and the security of the health information involved; and
 - (B) the involvement of the entity in any activity that is contrary to the best interests of a patient.
- Prevention of the use of revenue sources that are contrary to a patient's interests. (9) Public disclosure of audits in a manner similar to financial audits required for publicly traded stock companies.
- 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.

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 subtitle. 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.

PENALTIES.—If the IHRT knowingly or recklessly breaches the fiduciary duty described in paragraph (1), the IHRT shall be subject to the following penalties: Loss of certification of the IHRT; A fine that is not in excess of \$50,000; A term of imprisonment for the individuals involved of not more than 5 years.

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.

Government Accountability Office and Comptroller General

Section 904. HHS AND GAO JOINT STUDY AND REPORT ON COSTS OF THE 5 MEDICAL CONDITIONS THAT HAVE THE GREATEST IMPACT.

(a) *STUDY.*—The Secretary of Health and Human Services (in this section referred to as the “Secretary”) and the Comptroller General of the United States (in this section referred to as the “Comptroller General”) shall jointly 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. Such study shall include—

(1) current estimates as well as a “generational score” to capture the financial cost and health toll certain medical conditions will inflict on the baby boomer generation and on other individuals; and

(2) a careful review of certain medical conditions, including heart disease, obesity, diabetes, stroke, cancer, Alzheimers, and other medical conditions the Secretary and Comptroller General determine appropriate. (b)

REPORT.—Not later than 1 year after the date of enactment of this Act, the Secretary and the Comptroller General shall jointly submit to Congress a report containing the results of the study conducted under subsection (a), together with recommendations for such legislation and administrative action as the Secretary and the Comptroller General determine appropriate.

US STATES

Section 102. State Grants for Outcome-based prevention effort (15% can be used for Regional program & 5% Administrative expenses)--

Beginning 2 years after the date on which a grant is awarded to State, the Secretary determines that the State is failing to make adequate progress in meeting the process-based outcomes and milestones contained in the State plan, the Secretary shall provide the State with technical assistance on how to make such progress. Such technical assistance shall continue for a period of 2 years.

Failure of states to meet goals -- the Secretary determines that the State is failing to make adequate progress in meeting the outcomes and milestones contained in the State plan over a 5-year period, the Secretary shall terminate all funding to the State under a grant under this section.

The Secretary shall award wellness bonus payments to at least 5, but not more than 10, States that demonstrate the greatest progress in reducing disease rates and risk factors and increasing healthy behaviors.

Section 201. State-based Health Care Exchange

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.

Requirement from States: A State shall not determine premium or cost sharing amounts for health insurance coverage offered through the State Exchange. **Limitation on Exorbitant Premiums** -- The State Exchange shall ensure that risk-adjustment implemented under this subparagraph shall be based on a blend of patient diagnoses and estimated costs; a health security pool to guarantee high-risk individuals access to affordable, quality health care; implementation of a successful reinsurance mechanisms to guarantee high-risk individuals access to affordable, quality health care.

State shall not impose any requirement that such issuers provide coverage that includes benefits different than requirements on plans offered to Members of Congress. Exchange shall establish a mechanisms to protect enrollees from the imposition of excessive premiums, to reduce adverse selection, and to share risk.

State Exchange shall include an incentive for eligible individuals to remain insured from plan year to plan year, and may include incentives such as State tax incentives or premium-based incentives. 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.

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

Section 1904. State Plan Requirements for Acute Care Medical Assistance. *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.*

Requirement from States: *State contribution will be the same ratio of 45% 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. Federal funding will be provided at 100% of what is left after the state's required funding.*

Section 1912. State Plan for Long Term Care

Requirement from States: *State must demonstrate in each fiscal year that it made long-term care service and supports expenditures including funding from local government sources) equal to the amount of **not less than 95% of the nonfederal share amount spent** in fiscal year 2009 under the State plan under old title XIX on long term care services and supports **If the amount appropriated for fiscal year 2011 under subsection (a)(1) is less than the amount necessary to fund each State's allotment for that fiscal year, the Secretary shall reduce the allotment for each State for that fiscal year based on the applicable percentage determined for the State under paragraph (2) provide a reduced percentage basis as follows: **Each state shall receive a percentage of its allotment based on the ratio of non-institutional spending to total long term care spending in FY 2009.*****

Section 1952. Cost Sharing Protections.

The State may (in a uniform manner) require payment of monthly premiums or other cost sharing set on a sliding scale based on family income. Family that exceeds 150% of the poverty line, the aggregate annual amount of such premium and other cost-sharing charges imposed under the plan does not exceed 5% of the individual's annual income. Family that exceeds 250% of the poverty line, the aggregate annual amount of such premium and other cost-sharing charges do not exceed 7.5 percent of the individual's annual income.

Requirement from States: *A State shall not require prepayment of any premium or cost-sharing imposed pursuant to and shall not terminate eligibility of an individual under the State plan on the basis of failure to pay any such premium or cost-sharing until such failure continues for a period of at least 60 days from the date on which the premium or cost-sharing became past due. The State may waive payment of any such premium or cost-sharing in any case where the State determines that requiring such payment would create an undue hardship.*

Section 411. Supplemental Health Care Assistance for Low-Income Families.

GENERAL.—*The Secretary shall issue to each eligible family that enrolls in the program in accordance with subsection (f) a supplemental debit card with a dollar-amount value, in accordance with subsection (d), that may be used to pay for qualifying health care expenses. Rollover of unused amounts: **Not more than one-quarter of the annual dollar amount of a supplemental debit card that is unexpended at the end of each 12-month period may rollover***

- (1) *annual income does not exceed 100 percent of the poverty level, as applicable to a family of the size involved, shall receive \$5,000*
- (2) *annual income exceeds 100 percent but does not exceed 120 percent, of the poverty level, \$4,000.*
- (3) *annual income exceeds 120 percent but does not exceed 140 percent, of the poverty level, \$3,500.*
- (4) *annual income exceeds 140 percent but does not exceed 160 percent, of the poverty level, \$3,000.*
- (5) *annual income exceeds 160 percent but does not exceed 180 percent, of the poverty level, \$2,500.*
- (6) *annual income exceeds 180 percent but does not exceed 200 percent, of the poverty level, \$2,000.*

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, 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.

Requirement from States: *Federal funds under Part A or Part B of Medicaid, each State shall contribute **50%** of the total amount expended under the supplemental debit card program by the participating families that reside within the State during the time that the family resides in that State. For purposes of this section, the residency of a family is determined by the residency the legally responsible head of the household. **Each State shall make a payment to the Secretary, in the amount billed, not later than 30 days after the billing notification date. PENALTIES.—If a State fails to pay to the Secretary an amount required under subparagraph (B), interest shall accrue on such amount at the rate provided under the Social Security Act. The amount so owed and applicable interest shall be immediately offset against amounts otherwise payable to the State under this section, in accordance with the Federal Claims Collection Act of 1996 and applicable regulations. Page 131.***

TORT REFORM - SEC. 399R. STATE GRANTS TO CREATE HEALTH COURT SOLUTIONS.

Review by State Court After Exhaustion of Administrative Remedies

Requirement from States: Formation of Expert Panel, Health Care Tribunals and Counsel

EXPERT REVIEW PANEL REPRESENTATION BY COUNSEL.—A State that receives a grant under this section may not preclude any party to a dispute that falls within the jurisdiction of the alternative to current tort litigation that is implemented under the grant from obtaining legal representation at any point during the consideration of the claim under such alternative. An expert panel under this paragraph shall be composed of 3 medical experts (either physicians or health care professionals) and 3 attorneys to be appointed by the head of the State agency responsible for health.

ADMINISTRATIVE HEALTH CARE TRIBUNALS 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 ensure that such tribunals are presided over by special judges with health care expertise who meet applicable State standards for judges and who agree to preside over such court voluntarily;

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-pecuniary losses of any kind or nature, to the extent permitted under State law.

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.

AMERICAN PEOPLE - Employees, Employers, Independent Business Owners

Fair Tax Treatment for All Americans to Afford health Care

Section 301. Refundable and Advanceable Credit for Certain Health Insurance Coverage

Section 303. Changes to Existing Tax Preference for Medical Coverage, for Individuals Eligible for Qualified Health Insurance

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.’*

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.*

Tax exclusion or credit shall not apply with respect to any employer provided coverage under an accident or health plan beyond the total aggregated amount specified by this reform.

The applicable health credit for **ADULT** amount is **\$2,290**; **CHILD** amount is **\$1,710**; **FAMILY** household amount is **\$5,710**.

Potential State Tax Increase to Individuals: **“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.”*

Republican Health Care Reform Rep. Paul Ryan – Patient’s Choice Act - HR 2520

Co-sponsors: Kevin Brady (R-TX8), Ken Calvert (R-CA44), John Campbell (R-CA48), Steven LaTourette (R-OH14), John Linder (R-GA7), Kenny Marchant (R-TX24) Tom McClintock (R-CA4), Devin Nunes (R-CA21), Dana Rohrabacher (R-CA46), Peter Sessions (R-TX32), John Shimkus (R-IL19), Mark Souder (R-IN3)

Budget Appropriation

Total Cost of the Plan for 10 years > \$1,092,634,303,472

1. HR 2520: Page 4-12

SEC. 101. Strategic Approach to Outcome-based Prevention Composition of the Committee: Director of the National Institutes of Health; Director of the Centers for Disease Control and Prevention; Administrator of the Agency for Healthcare Research and Quality; Administrator of the Substance Abuse and Mental Health Services Administration; Administrator of the Health Resources and Services Administration; Secretary of Agriculture; Director of the Centers for Medicare & Medicaid Services; Administrator of the Environmental Protection Agency; Director of the Indian Health Service; Administrator of the Administration on Aging; Secretary of Veterans Affairs; Secretary of Defense; Secretary of Education; Secretary of Labor.

*PRIORITY FUNDING.—Funding for the activities authorized under this section (Committee meeting, planning, Media Campaign and Website for dissemination to providers) shall take priority over funding from the Centers for Disease Control and Prevention provided for grants to States and other entities for similar purposes and goals as provided for in this section. **Not to exceed \$500,000,000** shall be expended on the campaigns and activities required under this Act.*

Not later than 1 year after the date of enactment of this Act, the Secretary, acting through the coordinating committee convened under paragraph (1), shall submit to Congress a report concerning the recommendation of the committee for health promotion and disease prevention activities.

Funding Cost: Not to Exceed **\$500 Million**

Outcome: A Plan to solve the problem of Prevention (Personalized Prevention Plan) Regular committee meetings and presentation of the Secretary to the **Congress: Media Campaigns, TV, Radio, etc.; Internet Portal Website DHHS Internet portal for accessing risk-assessment tools**

2. HR 2520: Page 12-16

US STATES - Section 102: State Grants for Outcome-based prevention effort

Funding Cost: Centers for Disease Control and Prevention provided for grants to States **not to exceed \$300 Million**

Outcome: An outline and interventions plan to be carried out under this grant will reduce morbidity and mortality within the State over a 5-year period; a plan and potential approach for innovative incentive structures to encourage individuals to adopt specific prevention behaviors such as reducing their body mass index or for smoking cessation.

3. HR 2520: Page 17

Section 104. Immunizations

Funding Cost: Centers for Disease Control and Prevention provided for grants to States **\$50 Million per year.**

Outcome: States to attained a benchmark of 80% immunization. Failure to achieve the benchmark after 2 years will result in reduction of funding by 5%.

4. HR 2520: Page 25

Section 203. State Exchange Incentive:

Funding Cost: Federal payment to the State for year 2011 shall be increased by an amount equal to **1%** of the total amount of payments made to the State for fiscal year 2010 for purposes of carrying out a grant awarded under this section.

Outcome

5. HR 2520: Page 68-71

Section 1904. State Plan Requirements for Acute Care Medical Assistance

Funding Cost: State will bear the same ratio of **45%** of the square of the per capita income of such State bears to the square of the per capita income of the continental United States. The federal government will provide medical assistance to fulfill the rest of the funds which is 100% less the State percentage (45% etc..)

6. HR 2520: Page 75

Section 1911. Grants to States for Long Term Care Services and Supports. A State must have an approved State plan or long-term care services and supports. A State long term care services and supports plan shall include a description, consistent with the requirements for fiscal year (2011) - \$65,274,560,000; (2012) - \$67,885,540,000; (2013) - \$70,600,964,100; (2014) -- \$73,425,000,000; (2015) - \$76,362,000,000; (2016) -- \$79,416,480,000; (2017) -- \$82,593,140,000; (2018) --- \$85,896,870,000; (2019) ----- \$89,332,743,000. Total (2011-2019) =

7. HR 2520: Page 104

Section 1931. Grants to States for Survey and Certification of Medical Facilities and other Requirements

Funding Cost: 2011 - \$300 Million with 5% increase every year. Total (2011-2019) = **\$3,307,969,296**

8. HR 2520: Page 106

Section 1941. Grants to States for Program Integrity

Funding Cost: 2011 - \$100 Million with 5% increase every year. Total (2011-2019) = **\$1,102,656,432**

Outcome: Authority for use of funds for transportation and travel expenses for attendees at education, training or consultative activities

9. HR 2520: Page 111

Section 1951. Administration Payment to States for Acute-Care (Part A) and Long –Term (Part B)

Funding Cost: 2011 - \$7.0 Billion with 3% increase every year. Total (2011-2019) = **\$71,113,742,893**

Outcome:

10. HR 2520: Page 120

Section 402. Outreach

Funding Cost: 2009 - \$100 Million . Total (2009-2012) = **\$550,000,000**

Outcome: 2009 = 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; 2010 to 2012 = outreach.

10. HR 2520: Page 135

Section 340A. Supplemental Debit Card for Health Care Expenditures

Funding Cost:

Administration: 2009 - \$300 Million; 2010 - \$1 Billion; 2011 - \$3 Billion Total (2009-2012) = **\$31,300,000,000**

Benefits: 2011 - \$24.02 Billion; 2012 - \$25.22 Billion; 2013 - \$26.48 Billion; 2014 - \$27.81 Billion; 2015 - \$29.2 Billion

Outcome: Debit Card Benefit to Low Income

10. HR 2520: Page 157

Section 513. Detection of Medicare Fraud and Abuse.

Funding Cost: Such sums as may be necessary, not to exceed **\$50,000,000**, for each of fiscal years 2010 through 2014;

Outcome: Such sums as may be necessary, not to exceed an amount the Secretary determines appropriate in the most recent report submitted to Congress under section 1893(j)(4) of the Social Security Act, as added by subsection (a), for each subsequent fiscal year. The Secretary shall establish a system to identify the 50 counties most vulnerable to fraud with respect to items and services furnished by providers of services (other than hospitals and critical access hospitals) and suppliers based on the degree of county-specific reimbursement and analysis of payment trends under this title

Data analysis to establish prepayment claim edits designed to target the claims for payment under this title for such items and services that are most likely to be fraudulent

Prepayment benefit integrity reviews for claims for payment under this title for such items and services that are suspended as a result of such edits.

Section 822. Funding for Forum for Quality and Effectiveness in Health Care

Funding Cost: For the purpose of carrying out this title, there are authorized to be appropriated such sums as may be necessary for fiscal years 2010 through 2014.