The Patients' Choice Act, S. 1099
Introduced by Senator Coburn on May 20, 2009

Summary of Provisions

TITLE I – INVESTING IN PREVENTION

Interagency Coordinating Committee
An Interagency Coordinating Committee (Committee), chaired by the Secretary of Health and Human Services (Secretary) is established and responsible for developing a national strategic plan for prevention with the participation of the heads of fourteen federal agencies. A report must be submitted to Congress within the Committee's first year of operation with its recommendations for health promotion and disease prevention activities. The report will include: 1) a list of national priorities; 2) science-based initiatives to achieve the goals of Healthy People 2010; 3) plans for consolidating federal health programs and centers; 4) plans to ensure full coordination of all health programs with science-based recommendations promulgated by the Director of the Centers for Disease Control and Prevention (CDC); 5) and a list of new non-federal and non-government partners. All prevention programs will be reviewed and graded by the Secretary at least every five years.

CDC Wellness & Prevention Messaging Campaign
Within the first year of the Committee's operation, the Secretary, acting through the Director of the CDC, must establish and implement a federal web-based wellness and prevention resource messaging campaign for health promotion and disease prevention. The campaign must address proper nutrition, regular exercise, smoking cessation, obesity reduction, the five leading disease killers, and disease screening promotion and may include the use of television, radio, Internet, and other marketing venues.

State Grants for Prevention Efforts
Grants will be awarded to states for outcome-based prevention efforts, with wellness bonuses to those states demonstrating the greatest progress in reducing disease rates and risk factors and increasing healthy behaviors. Funding will be terminated for states failing to meet objectives after receiving technical assistance.

Food Stamp Program
The Secretary of Agriculture will develop lists of food that do not meet science-based standards for proper nutrition. Science-based nutrition counseling brochures will be developed by the Director of the CDC and distributed by the Secretary of Agriculture to individuals and families of the Food Stamp Program. Enrollees of the program will be prohibited from purchasing foods that do not meet science-based standards for proper nutrition. These limitations on food purchases will be enforced through the food stamp's automated system.

State Authority to Purchase Vaccines
States may use funds for immunization programs to purchase vaccines for use in provider offices and schools. Technical assistance will be provided to states failing to achieve a benchmark of 80 percent coverage and funding will be reduced if the benchmark is not achieved after the assistance. Bonus grants will be awarded to states achieving 90 percent or greater coverage.

TITLE II – STATE-BASED HEALTH CARE EXCHANGES

The Secretary shall establish a process for certification of state health care exchanges. These exchanges are intended to facilitate the individual purchase of private health insurance (although individuals are specifically not required to purchase insurance coverage) and to create a market where private health insurance plans compete for enrollees based on price and quality.

State Grants and Operation of Health Care Exchanges
The Secretary may award grants to states to help them carry out a health care exchange in the form of one-time bonus payments equal to 1% of the federal Medicaid contribution. States have a great deal of flexibility in creating and operating their exchanges. Exchanges may directly contract with the health insurance plans or contract with a third-party administrator to operate the exchange. Two or more states may enter into interstate compacts for the regulation of insurance in those states or implement a multi-state health care pooling arrangement.

States must allow all licensed health insurance plans who comply with the law to sell insurance through the exchange, must ensure an effective method of collecting premiums and shared costs, and are prohibited from setting premium or cost-sharing amounts. States may not require insurance issuers to provide benefits different than the required benefits in plans offered to Members of Congress. States also must create uniform enrollment mechanisms, guarantee access to individuals in their choice of plans, ensure that enrollees can change their enrollment, and have procedures to permit Medicaid and SCHIP beneficiaries to enroll in private coverage through the exchange.

Preexisting Condition Exclusions
Plans are only subject to the same limits on preexisting condition exclusions as apply to group health plans. However, states must establish some mechanism to protect enrollees from exorbitant premiums and to reduce adverse selection in exchange coverage, such as risk-adjustment offered through a contract with a private, independent board, health security pools for high-risk individuals, or reinsurance mechanisms.

TITLE III – FAIR TAX TREATMENT FOR EVERY AMERICAN TO AFFORD HEALTH CARE

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

Monthly Allowable Limit
For eligible individuals, the monthly allowable limit for the refund or advance credit for certain health insurance coverage is one-twelfth of the applicable adult amount for taxpayers, their spouses, and adult dependents, and one-twelfth of the applicable child amount for child dependents. The aggregate monthly limitations for any month shall not exceed one-twelfth of

the applicable aggregate amount (adults, $2,290; children, $1,710; aggregate, $5,710). For eligible individuals under high deductible plans, the monthly limit is one-twelfth of the sum of the greater of either the sum of the annual deductible and out-of-pocket expenses or $3,000 for self-covered individuals, or $5,950 for families.

For individuals with long-term care contracts, the monthly limit is one-twelfth of the lesser of the annual premium or $1,000. Annual out of pocket expenses used in calculating limitations on monthly contributions will be reduced by any out-of-pocket expense payable under a separate plan. For eligible married individuals, the limit for each spouse is equal to the spouse's applicable share of the combined marital limit, defined as the excess of the lesser of either the sum of the limitations computed separately for each spouse, or $10,000, over the aggregate amount paid to Archer medical savings accounts for the taxable year.

Subtitle B – Health Savings Accounts

High Deductible Health Plans

A high deductible health plan is now defined, under the Internal Revenue Code, as a plan with an annual deductible not less than $1,150 (increased from $1,000) for self-only coverage and $2,300 (increased from $2,000) for families and where the sum of the annual deductible and other out-of-pocket expenses do not exceed $5,800 (increased from $5,000) for self-only coverage and $11,600 (increased from $10,000) for families. These amounts will increase each year by an amount multiplied by a blended cost-of-living adjustment. A new allowance will be granted for purchasing an individual high-deductible health insurance plan through a health savings account and high-deductible health plans will be allowed to cover preventive services and maintenance costs of chronic diseases.

Tax Deductions

The term "qualified medical expenses" is redefined to include capitated primary care payments so they may be included in the amount allowed as a deduction for each taxable year. In determining eligibility for this deduction, those who are eligible for Veterans or Indian health benefits are not precluded from taking this deduction merely because they receive periodic hospital care or medical services provided by Veterans Affairs or the Bureau of Indian Affairs. For out-of-pocket amounts allowed as a deduction, the term "medical care" is redefined to include pre-paid physician fees.

Employer Contributions to Health Savings Accounts

Employers are required to make comparable health savings account contributions to their employees. Any contribution to the account of an employee who is chronically ill in an amount greater than a contribution to an employee who is not chronically ill will not violate this comparable contribution requirement so long as the excess employer contributions are the same for all chronically ill individuals who are similarly situated.

TITLE IV – FAIRNESS FOR EVERY AMERICAN PATIENT

Subtitle A – Medicaid Modernization

Acute Medical Assistance Payments

Acute medical assistance payments will be made to states from U.S. Treasury appropriations as necessary for fiscal year 2011 and each fiscal year thereafter. States will receive an amount intended for acute care medical assistance under the state plan and a separate payment for administrative expenses incurred for implementing the plan. These provisions seek to enable states to provide acute care medical assistance to eligible individuals whose income and resources and insufficient to meet the cost of necessary medical services and rehabilitation and other services to help individuals retain capability for independence or self-care.

Long-Term Care

Long-term care and services support allotments are determined for fiscal year 2011 through fiscal year 2019. The allotments are based on state expenditures from the preceding year, increased by a predetermined percentage. No other federal funds will be available for long-term care services and supports after December 31, 2010. States must maintain expenditures for long-term care services and supports. If the federal appropriation is insufficient to fund each state's allotment for that fiscal year, the allotment will be reduced by a specified applicable percentage.

Eligibility

Eligible individuals are persons who are blind or disabled, who satisfy state-determined income and resources requirements, citizenship or status as a qualified alien tests, children in foster care under the responsibility of the state, low-income women with breast or cervical cancer, or certain individuals infected with Tuberculosis. Grandfathered eligible individuals include those previously indentified as well as those persons for whom the state would have provided medical assistance under the previous Medicaid program, as long as the person continues to satisfy the old eligibility requirements.

Benefits

Acute care medical assistance includes mandatory and optional benefits. Mandatory benefits remain unchanged and are outlined in the current Medicaid provisions, section 1905(a) paragraphs (1) through (5), (17), and (21) [e.g., inpatient and outpatient hospital services, laboratory and X-ray services, nursing facility services, early and periodic screening, diagnostic and treatment services for individuals under 21, family planning services and supplies, physicians services, medical and surgical services by a dentist, nurse mid-wife services and pediatric nurse practitioner or certified family nurse practitioner services]. Optional benefits remain the same as outlined in the current Medicaid section 1905(a), other than paragraph (16) [inpatient psychiatric services]. However, services described in current section 1905(a) (15), (22), (23), (24), and (26) will only be provided under Part B [e.g., intermediate care facilities for the mentally retarded, home and community care for functionally disabled elderly individuals, community supported living arrangement services, personal care services, and services furnished under Program of All-Inclusive Care for the Elderly (PACE)].

Limited Long-Term Care Services and Supports

Long-term care services shall not be provided for more than 30 days in any 12-month period. This limitation does not apply to care for an individual who is an inmate of a public institution or

a patient in an institution for mental diseases, regardless of age. States will be granted increased flexibility in the operation of a system of long-term care services and supports that will encourage the provision of services to individuals with disabilities in their own homes and communities and end the institutional bias that existed under the Medicaid program prior to January 1, 2011.

Applicability of Current Provisions after January 1, 2011

Certain pre-modernized Medicaid will continue to be applicable after January, 2011 including provisions relating to: eligibility and service provision, definitions, enrollment, drug rebates, managed care, reporting, allowance for monthly personal needs for certain institutionalized individuals and couples, services to a Program of All-Inclusive Care for the Elderly (PACE) program eligible individuals, services and supports related to long-term care, third party liability, claims processing, state plan requirements and administrative issues.

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

Contribution of States

States are required to contribute 50 percent of the total amount expended under the supplemental debit card program as a condition for receiving federal funds under Medicaid. Each state is also penalized with interest for failing to pay the Secretary the amount owed.

Enrollment

The Secretary is required to establish procedures and timeframes for enrollment in the supplemental debit card program. In addition, all states must inform individuals enrolled in SCHIP or Medicaid of changes in their program and provide for automatic enrollment of eligible individuals into the supplemental debit card program.

Administration

The Secretary is required to establish an automated means by which benefits under the new program will be transferred to eligible families. The Secretary is also required to establish an independent appeals process to be administered by an entity separate from that which makes eligibility determinations. Finally, penalties of 110 percent will apply to any person who provides false information to qualify for the supplemental debit card program.

Implementation Plan

The Secretary is required to submit an implementation plan to Congress no later than six months after the date of enactment.

Authorization of Appropriation Plan

Three hundred million dollars for fiscal year 2009; one billion for fiscal year 2010; and three billion for fiscal year 2011 are authorized to provide for supplemental debit card benefits under the program.

TITLE V – FIXING MEDICARE FOR AMERICAN SENIORS

Subtitle A – Increasing Programmatic Efficiency, Economy and Accountability

Competitive Bidding Mechanism

The Secretary is required to establish a competitive bidding mechanism for Medicare Advantage plans to promote competition and improve health care quality. The bids would be measured against a risk-adjusted benchmark, which may be adjusted in rural counties to encourage participation, and bids must be for a benefit package that is actuarially equivalent to 106% of the value of the original Medicare fee-for-service program option.

Medicare Accountable Care Organization

The Secretary is authorized to conduct a Medicare Accountable Care Organization ("ACO") demonstration program, which would enable groups of providers to manage and coordinate care for Medicare fee-for-service beneficiaries through an ACO that meets certain requirements and would reward providers based on performance. The program would automatically assign beneficiaries to participating primary care providers based on the physician who provided them with the most primary care in the previous year. Providers satisfy quality performance measures if they generally follow consensus-based guidelines established by non-government professional medical societies. If the ACO saves at least two percent of the average Medicare costs per beneficiary, measured against the average two-year benchmark cost, an ACO would be eligible to receive a bonus payment equal to half the cost savings.

Other Cost-Saving Provisions

Two other cost-saving provisions reduce Medicare subsidies to wealthier seniors. The first eliminates the inflation adjustment to the threshold income level at which Part B premium subsidies are reduced and premiums increased, effectively capping the threshold for premium subsidies at $80,000 for individual beneficiaries without any future adjustments for inflation. The second provision changes the way in which the income-related Part D premium subsidy is calculated to significantly increase the amount of beneficiaries' Part D premiums by 30% to 165%, depending on income level. The Secretary is also authorized to adjust the Part B premium amount based on whether the individual participates in certain healthy behaviors.

Increased Transparency of Information

To increase transparency of pricing information, providers are required to provide to each beneficiary receiving treatment (except emergency care) with the estimated price of the treatment at the time of scheduling. The Secretary must make de-identified Medicare and Medicaid data on claims and patient encounters available to the public.

Subtitle B – Reducing Fraud and Abuse

Security of Social Security Account Numbers

The Secretary is required to establish procedures to ensure that social security account numbers are not used as identifiers for present or future Medicare beneficiaries. The procedures are to include biometric identification protections for the new identifiers, maintenance of the existing Health Insurance Claim Number structure, and a process for changing an individual's identifier in cases of fraud, including identity theft. An education and outreach program will be created to

inform Medicare beneficiaries, providers of services and suppliers about new Medicare beneficiary identifier changes.

Matching HHS and Social Security Records Data

Upon the request of the Secretary, the Commissioner of Social Security is required to enter into an agreement with the Secretary for the purpose of matching data in the system of records of the Commissioner with data in the system of records of the Secretary to determine whether a beneficiary, provider of services or supplier under a Title XVIII (Medicare), XIX (Medicaid), or XXI (CHIP) program is not eligible to participate. The Secretary is required, through an agreement with the Commissioner, to investigate claims involving individuals who are not eligible for benefits or are not eligible providers of services or suppliers.

Additional provisions require creation of: procedures for the use of technology for real-time data analysis of claims; a new system for detecting Medicare service provider and supplier fraud; expanded procedures and an online data base for assuring that Medicare claims for durable medical equipment, prosthetics, orthotics and supplies are valid; and exemptions for pharmacists from the surety bond requirement for Medicare suppliers of durable medical equipment. The Comptroller General is required to conduct a study and report to Congress on the effectiveness of the surety bond requirement for Medicare suppliers of durable medical equipment.

TITLE VI – ENDING LAWSUIT ABUSE

Alternatives to Tort Litigation

States must demonstrate how the proposed alternative will make the medical liability system more reliable, encourage the early disclosure of health care errors, enhance patient safety, and maintain access to medical liability insurance. Patients must be notified when they are receiving services that fall within the scope of the alternative selected. States must identify the sources from, and methods by which, compensation would be paid and funding methods should provide financial incentives for activities that improve patient safety.

Expert Panel Review Model

States can select their alternative from three models: an expert panel review and early offer model; an administrative health care tribunal model; or a combination of both. The expert panel review and early offer model would be composed of three medical experts and three attorneys to resolve disputes who make determinations as to the liability and compensation based on a schedule developed by the panel (economic and non-economic damages). If the parties accept the determination, the claimant agrees to forgo further action. If any party does not to accept the determination, the state can choose whether to allow the panel to review the determination de novo, with deference, or to allow the parties to reject the determination. Parties have the right to file a claim in state court once they have exhausted administrative remedies, however they will forfeit any compensation made and any determinations made by the panel are admissible in state court.

Administrative Health Care Tribunal Model

Under the administrative health care tribunal, parties can request a hearing to review any dispute concerning injuries allegedly caused by health care providers or health care organizations. Tribunals are presided over by special judges with health care expertise, provide authority to such judges to make binding rulings, establish a legal standard for the tribunal that would be the same as a standard applicable in state court, and provide for an appeals process. Determinations

made as to the liability and compensation shall be based on a schedule of compensation developed by the tribunal (economic and non-economic). Individuals unsatisfied with the determination may file a claim in state court, however any compensation awarded by the tribunal must be forfeited and all determinations by the tribunal are admissible in state court.

Combination Model

The third model is the expert panel review and administrative health care tribunal combination. Prior to submitting disputes to an administrative health care tribunal the state must form an expert panel to review the allegations. If either party does not accept the determination of the panel, the dispute is referred to the tribunal. Once a party requests a tribunal hearing concerning liability and compensation, they forfeit any compensation awarded by the expert panel and all determinations of the expert panel are admissible in any tribunal proceeding. Individuals may still file claims in state court, however they will forfeit any compensation made and all determinations of the panel and tribunal are admissible into evidence in state court.

Funding

Funding for state grants to develop alternatives to tort litigation is provided through a one-time increase in Medicaid payment. The total amount of the federal payment determined for the state under the Social Security Act will be increased by an amount equal to one percent of the total amount of payments made to the state for that fiscal year. These amounts paid to a state under a grant will remain available until expended.

TITLE VII – PROMOTING HEALTH INFORMATION TECHNOLOGY

Subtitle A – Assisting the Development of Health Information Technology

Health Recording Banking System

The Secretary is authorized to establish a "health record banking" system that would allow movement of a medical record from a system of paper files to electronic health record banks. The health record banks would improve the coordination and flow of health information through an infrastructure designed to facilitate the secure and authorized exchange and use of such health information. To establish the health record banks, the Secretary is required to promulgate regulations detailing the process for certification and auditing of the banks. The patient will be the legal owner of an electronic medical record stored in any certified bank and also have the right to review the contents of such medical record. Current federal privacy standards under the Health Insurance Portability and Accountability Act (HIPAA) and security standards under the Social Security Act will apply to this system of electronic health record banking, and state privacy and/or confidentiality laws will also remain in effect.

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

Amendments to Anti-Kickback and Stark Laws

In order to remove barriers to physician adoption of health information technology (HIT), the federal anti-kickback and Stark laws are modified to include new safe-harbors and exceptions from civil and criminal liability for HIT. With respect to the anti-kickback law, which criminalizes the receiving of kickbacks for induced referrals in any application for benefits or payment under federal health care programs, "inducements" shall not include any nonmonetary

remuneration by specified entities to physicians in the form of HIT or the related installation, maintenance, support, or training services.

The civil monetary penalties law that prohibits payments from hospitals to providers to induce a reduction or limitation of services for those patients receiving care through public programs is also modified. Inducements to reduce or limit services shall not include the practical or other advantages resulting from HIT or the related installation, maintenance, support, or training services. With respect to the physician self-referral or Stark law, which prohibits certain physician referrals, an exception is added to the listed ownership and compensation arrangement prohibitions for any nonmonetary remuneration made by a specified entity to physicians in the form of HIT or the related installation, maintenance, support, or training services.

The safe harbors in the anti-kickback law and the exception in the Stark law allowing for the provision of nonmonetary remuneration by specified entities to physicians in the form of HIT must be arranged for in a written agreement signed by all parties and specifying that the remuneration has been made for the primary purpose of better coordination of care and for the improvement of health quality, efficiency, or research. Moreover, these agreements cannot limit certain functions of the technology as a condition of the remuneration or require the referral of patients or business to the specified entity as a condition of the remuneration.

Definitions

"Health Information Technology" is defined as hardware, software, license, right, intellectual property, equipment, or other information technology that is designed or provided primarily for the electronic creation, maintenance, or exchange of health information to better coordinate care or improve quality, efficiency, or research. A "specified entity" entitled to make nonmonetary remuneration in the form of HIT to physicians is defined as a hospital, group practice, prescription drug plan sponsor, a Medicare Advantage organization, or any other such entity as specified by the Secretary.

State Law & Impact of Changes

No state may pass or maintain a law that prohibits the behavior authorized by these amendments, and that the Secretary must study the impact of the anti-kickback safe harbors and the Stark exception by looking at: 1) the effectiveness of each safe harbor/exception in increasing adoption of HIT; 2) the types of HIT provided under each safe harbor/exception; 3) the extent to which financial or other business relationships between providers have changed as a result of the safe harbors/exception in a way that adversely affects or benefits the health care system or choices available to consumers; and 4) the impact of the adoption of HIT on health care quality, cost, and access under each safe harbor/exception.

Both the anti-kickback and Stark laws also are amended to allow a specified entity to form a consortium composed of health care providers, payers, employers, and other interested entities to collectively purchase and donate HIT, and offer health care providers a choice of HIT products in order to take into account the varying needs of providers receiving such products.

TITLE VIII – HEALTH CARE SERVICES COMMISSION

Subtitle A – Establishment and General Duties

Health Care Services Commission

The Commission is to be comprised of five commissioners appointed by the President, and no more than three commissioners can be from the same political party. The commissioners from different parties shall be appointed alternately, and no commissioner can engage in any other business, vocation, or employment while serving as a commissioner. Each of the five commissioners serving on the Health Care Services Commission shall serve a term of five years, except that the terms of the original five commissioners shall expire 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. Also, the President shall appoint a Chairman of the Commission from among the five commissioners.

Commissioner Responsibilities

Generally, 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. Specifically, these activities shall be 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-orientated 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. Moreover, the commissioners must 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.

The commissioners are required to promptly publish, make available, or otherwise disseminate the results of the Commission's research, demonstration projects, and evaluations, as well as the guidelines, standards, and review criteria developed under this title in a form that is understandable and through methods to maximize use of the research. The commissioners also must make available to the public data developed in such research, demonstration projects, and evaluations, in addition to providing technical assistance to state and local governments to foster dissemination. The commissioners may not restrict the publication or dissemination of data from, or the results of, projects conducted by the Commission, except for certain personally identifiable information.

National Library of Medicine

To facilitate these dissemination activities, the commissioners and the Director of the National Library of Medicine shall enter into an agreement providing for the implementation of publication and dissemination activities.

Subtitle B – Forum for Quality and Effectiveness in Health Care

Establishes an Office of the Forum for Quality and Effectiveness in Health Care to develop a program called the Forum for Quality and Effectiveness in Health Care. The Forum will arrange

for the development and periodic review and updating of standards of quality, performance measures, and medical review criteria for use by health care providers, to promote transparency in price, quality, appropriateness, and effectiveness of health care.

Requirements

The guidelines, standards, performance measurers, and review criteria developed by the Forum for Quality and Effectiveness in Health Care must be: 1) based on the best available research and professional judgment regarding the effectiveness and appropriateness of health care services and procedures; and 2) 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.

Officer Composition & Term

The Office of the Forum for Quality and Effectiveness in Health Care will be composed of 15 individuals nominated by private sector health care organizations and appointed by the Commission, and shall include representation from at least: 1) the health insurance industry; 2) health care provider groups; 3) non-profit organizations; and 4) rural health organizations. The Office of the Forum for Quality and Effectiveness in Health Care shall be headed by a Director as appointed by the commissioners, and the Director may enter into contracts with public or non-profit private entities. Members of the Office of the Forum for Quality and Effectiveness in Health Care shall serve a term of five years, but the original members appointed upon the enactment of this Act shall have a staggered rotation of five members for two years, five members for three years, and five members for four years. Each member of the Office of the Forum for Quality and Effectiveness in Health Care shall serve the Office independently from any other position of employment.

Quarterly Reports and Recommendations

Beginning in 2010 and for each following fiscal year, the Director of the Office of the Forum for Quality and Effectiveness in Health Care shall make publically available: 1) quarterly reports for public comment that include proposed recommendations for guidelines, standards, performance measurers, and review criteria and any updates thereto; and 2) a final report that contains the final recommendations for such guidelines, standards, performance measurers, and review criteria after consideration of the comments submitted. The commissioners shall assure the development of an initial set of guidelines, standards, performance measurers, and review criteria not later than January 1, 2012.

For each fiscal year, the commissioners must adopt the recommendations made for such year in the final report from the Director of the Office of the Forum for Quality and Effectiveness in Health Care for guidelines, standards, performance measurers, and review criteria that have been developed. The commissioners, in consultation with the Secretary, have the authority to make recommendations to the Secretary to enforce compliance of health care providers with the guidelines, standards, performance measurers, and review criteria adopted under this subtitle. Such recommendations may include: 1) exclusion from participation in federal health care programs, and/or 2) the imposition of civil monetary penalties on such a non-compliant provider.

Subtitle C – General Provisions

Several administrative authorities for the operation and funding of the Health Care Services Commission described in subtitles A, B, and C are developed. The commissioners may accept voluntary and uncompensated services in carrying out the provisions of Title VIII, and the necessary funding for the operation of the Commission is appropriated for fiscal years 2010 through 2014.

Subtitle D – Terminations and Transitions

The Agency for Healthcare Research and Quality ("AHRQ") is terminated by repealing the Agency's authorizing statute. All orders, grants, contracts, privileges, and other determinations or actions of the AHRQ 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.

Subtitle E—Independent Health Record Trust

Referred to as the "Independent Health Record Trust Act of 2009," the Act establishes a nationwide HIT network that: 1) improves health care quality, reduces medical errors, increases efficiency and advances the delivery of evidence-based services; 2) promotes wellness, prevention and management of chronic illnesses by increasing the availability and transparency of information; 3) ensures appropriate information is available in a usable form; 4) produces greater value for health care expenditures by reducing costs; 5) promotes a more effective marketplace and greater competition, systems analysis, increased choice, and improved outcomes; 6) improves coordination of information through an effective infrastructure for the secure and authorized exchange and use of health information; and 7) ensures that the privacy, security, and confidentiality of individually identifiable health information is protected.

Fiduciary Duty

The IHRT has a fiduciary duty to act for the benefit of and in the interests of participants, including a duty to obtain the affirmative consent of a participant prior to the release of information. Violators of this duty are subject to penalties. Primary and secondary uses of information within an electronic health record of a participant are permitted only upon the authorization of such use. Primary use is for the individual's self-care or care by health care professionals and secondary use is any use not considered primary use and includes uses for public health research. Additional authorization is required for a secondary use.

Privacy Protection

A privacy protection agreement between the participant and the trust must be maintained by an IHRT and will preempt any state law or regulation relating to the privacy of individually identifiable health information. However, the provisions of the agreement will not preempt any state law or regulation that recognizes privileged communications between physicians, health care practitioners, and their patients. Participation in an IHRT or authorizing access to information is voluntary. No employer, health insurance issuer, group health plan or health care provider can require that an individual participate in, or authorize access to information from, an IHRT, or they will be subject to penalties.

Revenue
An IHRT may generate revenue to pay for its operation through participant account fees, user fees, the sale of information or any other activity determined appropriate by the Federal Trade Commission (FTC). An IHRT may not charge a fee for the transmittal of information from a provider to be included in an electronic health record, including the transmission of or access to emergency care services records by appropriate emergency responders.

Committee Support
The Secretary will establish an Interagency Steering Committee and serve as its chairperson to implement IHRT provisions based upon the Steering Committee's recommendations and regulations provided by the FTC. The National Committee for Vital and Health Statistics will serve as an advisory committee for IHRTs and will issue reports and review privacy and security policies, economic progress, and interoperability standards. Within the first year, the FTC must submit a report on compliance by and progress of IHRTs to Congress.

TITLE IX –MISCELLANEOUS

Health Care Choice for Veterans
No later than two years after enactment of this Act, the Secretary of Veterans Affairs may permit veterans, and survivors and dependents of veterans, who are eligible for health care and services under the laws administered by the Secretary to receive such care and services through non-Department of Veterans Affairs providers and facilities approved by the Secretary.

Health Care Choice for Indians
Beginning no later than two years after the date of enactment, the Secretary shall permit Indians who are eligible for health care and services under a health care program operated or financed by the Indian Health Service or by an Indian Tribe, Tribal Organization, or Urban Indian Organization (and any such other individuals who are so eligible as the Secretary may specify), to receive such care and services through other private providers and facilities as the Secretary approves.

Termination of Federal Coordinating Council for Comparative Effectiveness Research
The Federal Coordinating Council for Comparative Effectiveness Research is terminated and Section 804 of the American Recovery and Reinvestment Act of 2009 establishing and funding the Council is repealed.

Joint HHS/Comptroller General Study
The Secretary and the Comptroller General of the United States must jointly conduct a study on the costs of the top five medical conditions facing the public which have the greatest impact in terms of morbidity, mortality, and financial cost.