

Title: To establish State options to offer preventative care accounts for children under CHIP and for adults under Medicaid.

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

SECTION 1. STATE OPTION TO OFFER KIDS PREVENTATIVE CARE ACCOUNTS UNDER CHIP.

(a) In General.—Title XXI of the Social Security Act (42 U.S.C. 1397aa et seq.), as amended by the Children’s Health Insurance Program Reauthorization Act of 2009, is amended by adding at the end the following:

“SEC. 2114. KIDS PREVENTATIVE CARE ACCOUNTS.

“(a) State Option.—

“(1) IN GENERAL.—A State may elect, through an amendment to its State child health plan and subject to the requirements specified in subsection (b), to provide child health assistance for classes or categories of targeted low-income children (without regard to the requirements of section 1902(a)(1) to the extent such section would otherwise apply in the case of a State child health plan that is offered through the State’s plan for medical assistance) by establishing a KIDS PREVENTATIVE CARE program under which such children are enrolled in high deductible health plans and contributions are made to KIDS PREVENTATIVE CARE accounts established on behalf of such children.

“(2) TREATMENT AS CHILD HEALTH ASSISTANCE.—

“(A) IN GENERAL.—Amounts paid by a State toward premiums for enrollment of targeted low-income children in high deductible health plans and amounts contributed by the State to KIDS PREVENTATIVE CARE accounts shall be treated as child health assistance for purposes of section 2105(a) and shall be provided in lieu of providing child health assistance that satisfies the requirements of section 2103.

“(B) OPT-OUT PROCEDURES.—

“(i) IN GENERAL.—A State shall—

“(I) establish procedures for a parent or caretaker relative of a child on whose behalf a KIDS PREVENTATIVE CARE account is established pursuant to this section (or, in the case of a child who has attained age 18, the child) to elect to disenroll the child from participation in the program; and

“(II) educate such parent or caretaker relative (and if appropriate, such child), about such procedures and other relevant health care financing considerations relating to disenrollment from the KIDS PREVENTATIVE CARE program.

“(ii) WAITING PERIOD PERMITTED.—The procedures established under clause (i) for disenrollment from the KIDS PREVENTATIVE CARE program may include a period of time that must elapse before a parent or caretaker relative of a child (or a child, in the case of a child

who has attained the age 18) who was previously enrolled in the KIDS PREVENTATIVE CARE program may reenroll in the program.

“(iii) TREATMENT OF FUNDS.—The procedures established under clause (i) for disenrollment from the KIDS PREVENTATIVE CARE program shall include a requirement that, upon the disenrollment from such program of a child on whose behalf a KIDS PREVENTATIVE CARE account is established, any balance of funds in the account shall be disbursed according to the following:

“(I) If the child is enrolled in a high deductible health plan (as defined in 223(c)(2) of the Internal Revenue Code of 1986), 50 percent of such funds shall be paid to the plan and applied toward the account under section 223 of the Internal Revenue Code of 1986 used in conjunction with such plan.

“(II) If the child is not so enrolled, an amount equal to the State’s contribution to the KIDS PREVENTATIVE CARE account shall be returned to the State and the remainder shall be available for expenditure by or on behalf of the child according to expenditure rules applicable to accounts under section 223 of such Code.

“(C) OPEN ENROLLMENT PERIOD.—The State shall designate biannual open enrollment periods for the KIDS PREVENTATIVE CARE program.

“(3) APPLICATION OF INTERNAL REVENUE CODE RULES.—Unless otherwise specified in this section, the Internal Revenue Code of 1986 shall be applied to a KIDS PREVENTATIVE CARE account in the same manner as if it were a health savings account established under section 223 of such Code.

“(b) Requirements.—The requirements specified in this subsection are as follows:

“(1) ELIGIBLE CHILDREN.—

“(A) STATE-SPECIFIED CRITERIA.—The State specifies in the State plan amendment—

“(i) the classes or categories of targeted low-income children who are eligible to have KIDS PREVENTATIVE CARE accounts established on their behalf;

“(ii) any additional criteria that the State may specify for a family of a targeted low-income child (or the child, in the case of a targeted low-income child who has attained age 18) to satisfy in order to elect to have a KIDS PREVENTATIVE CARE account established for the child (including criteria requiring disenrollment in accordance with subparagraph (D)); and

“(iii) the projected enrollment in such accounts.

“(B) VOLUNTARY PARTICIPATION.—A KIDS PREVENTATIVE CARE account is established on behalf of an eligible targeted low-income child only if a parent or caretaker relative of the child (or in the case of a child who has attained age 18, the child) voluntarily elects to have the account established.

“(C) OPTION TO LIMIT NUMBER OF PARTICIPANTS AND AREAS IN WHICH AVAILABLE.—

A State may limit the number of targeted low-income children within an eligible

class or category of such children who can obtain KIDS PREVENTATIVE CARE accounts and the geographic areas of the State in which the State offers the option to elect to enroll in the program established under this section.

“(D) DISENROLLMENT REQUIREMENTS.—A State requires the disenrollment of a child from the KIDS PREVENTATIVE CARE program if the family’s premium contribution to the child’s high deductible health plan required under paragraph (3)(B) for any month is at least 90 days overdue.

“(E) PROVISION OF DATA.—To be eligible to participate in the KIDS PREVENTATIVE CARE program a child and family shall agree to provide to the financial institution at which a KIDS PREVENTATIVE CARE account is established relevant enrollment data as required by the State.

“(2) ENROLLMENT ASSISTANCE; EDUCATION.—The State provides enrollment counselors and ongoing education regarding the maintenance and operation of KIDS PREVENTATIVE CARE accounts for parents and caretaker relatives of targeted low-income children (or the children, in the case of targeted low-income children who have attained age 18) who are interested in electing to participate in the program established under this section, particularly with respect to—

“(A) the importance of preventative care, the relationship between preventative care and the annual rollover of funds, and the extent of coverage for preventative care services in the KIDS PREVENTATIVE CARE program;

“(B) strategies and techniques for finding quality and low cost health care items and services;

“(C) the high cost of medical services;

“(D) the different forms of public and private health assistance and insurance options for which the child is eligible and factors for considering which option best meets the short and long-term financial and health care goals of the child;

“(E) the operation of the pre-paid electronic debit card and the process for signing up for a bank account for purposes of the KIDS PREVENTATIVE CARE account program; and

“(F) the maximum annual out-of-pocket expenditure established under paragraph (3)(B)(ii) for families of children on whose behalf such accounts are established.

“(3) CONTRIBUTIONS.—

“(A) STATE CONTRIBUTION.—The State makes an annual contribution to a KIDS PREVENTATIVE CARE account established under the program in an amount equal to the annual deductible applicable under the high deductible health plan in which the child on whose behalf the account is established is enrolled.

“(B) FAMILY CONTRIBUTIONS.—

“(i) IN GENERAL.—The State requires the family of the child on whose behalf the account is established (or the child, in the case of a child who has attained age 18) to contribute a portion of the monthly premiums imposed for enrollment in the high deductible health plan in which the child is enrolled

(without regard to the annual aggregate limitations on cost-sharing imposed by section 2103(e)(3)(B) but subject to the maximum annual out-of-pocket expenditure established under clause (ii)).

“(ii) MAXIMUM ANNUAL OUT-OF-POCKET EXPENDITURE.—The State establishes a maximum annual out-of-pocket expenditure for the family of a child enrolled in the KIDS PREVENTATIVE CARE Account program (without regard to any maximum out-of-pocket expenditure established under the State child health plan) equal to the annual deductible of such plan and fully funds the KIDS PREVENTATIVE CARE account with the amount of such deductible immediately upon receipt of confirmation of payment of the initial family contribution.

“(iii) COST-SHARING FOR CERTAIN HEALTH CARE SERVICES.—The State may require beneficiary cost-sharing for certain out-of-pocket expenses for health care services specified by the State without regard to the annual aggregate limitations on cost-sharing imposed by section 2103(e)(3)(B) but subject to the maximum annual out-of-pocket expenditure established under clause (ii).

“(iv) EFFECTIVE DATE OF COVERAGE.—The effective date of coverage under a high deductible health plan for a child on whose behalf a KIDS PREVENTATIVE CARE account is established is the first day of the first month that begins after the month in which the initial family contribution is received.

“(C) OTHER CONTRIBUTIONS.—Nothing in subparagraph (A) shall be construed as prohibiting an employer or other person or entity from making a contribution to a KIDS PREVENTATIVE CARE account established under this section, except that no Federal financial participation shall be provided under section 2105(a) with respect to any contributions made to such an account other than contributions made by the State in accordance with subparagraph (A).

“(D) NOTICE.—The State notifies the family of the child on whose behalf a KIDS PREVENTATIVE CARE account is established (or the child, in the case of a child who has attained age 18) through electronic mail (or, such other means as the State determines is most likely to provide notice to the family) of the amount of each contribution made to the account upon making or receiving a contribution to the account.

“(4) TREATMENT.—

“(A) EXEMPT FROM TAX.—Subject to section 223(f) of the Internal Revenue Code of 1986, amounts in, or contributed to, a KIDS PREVENTATIVE CARE account shall not be includible in the gross income of a targeted low-income child on whose behalf the account is established or in the gross income of a parent or caretaker relative of such child.

“(B) NO EFFECT ON ELIGIBILITY FOR, OR AMOUNT OF, OTHER BENEFITS OR ASSISTANCE.—Amounts in, or contributed to, a KIDS PREVENTATIVE CARE account shall not be counted as income or assets for purposes of determining eligibility for, or the amount of, benefits or assistance under any Federal means-tested public

benefit program for a targeted low-income child on whose behalf the account is established or for the family of such child.

“(C) QUALIFIED MEDICAL EXPENSES.—The costs of transportation and other costs related to an individual meeting with a financial institution or other entity for the establishment of a KIDS PREVENTATIVE CARE account, or related to meeting with State counselors under paragraph (2), shall be considered a qualified medical expense for which the individual may obtain reimbursement from the individual’s KIDS PREVENTATIVE CARE account.

“(5) REQUIREMENTS FOR ANNUAL ROLLOVER OF FUNDS.—

“(A) ANNUAL ROLLOVER OF UNUSED FUNDS.—

“(i) IN GENERAL.—Subject to the disenrollment procedures required under subsection (a)(2)(B)(iii) and subparagraph (C), any balance remaining in a KIDS PREVENTATIVE CARE account at the end of a year rolls over and remains available for expenditure during the succeeding year only if the State determines that the family of the child on whose behalf the account is established (or the child, in the case of a child who has attained age 18) has, with respect to the child, satisfied the State preventative care measures required for the year in accordance with subparagraph (B).

“(ii) MONITORING MECHANISMS REQUIRED FOR PARTICIPATING PLANS.—The State requires each high deductible health plan that participates in the KIDS PREVENTATIVE CARE program to establish mechanisms for determining that a child enrolled in the program and under the plan has satisfied a State preventative care measure applicable to the child for a year and for notifying the State before the end of the year of the extent to which the child has or has not satisfied all such measures for the year.

“(B) ANNUAL SPECIFICATION OF STATE PREVENTATIVE CARE MEASURES.—

“(i) IN GENERAL.—Not later than the first Monday of September of each year for which the State operates a KIDS PREVENTATIVE CARE program under this section, the State notifies each family of a child on whose behalf the account is established (or the child, in the case of a child who has attained age 18) of the preventative care measures required for the child for that year. Such measures shall be developed and to the extent the State determines appropriate, revised annually, and shall be based upon the age, sex, and preexisting conditions of the child.

“(ii) 100 PERCENT COVERAGE OF PREVENTATIVE CARE SERVICES.—The State requires a high deductible health plan as a condition of participating in the KIDS PREVENTATIVE CARE program to provide 100 percent coverage for all of the preventative care measures required for a child for each year of enrollment in the program.

“(C) NO ROLLOVER IF FAILURE TO SATISFY ANNUAL PREVENTATIVE CARE MEASURES.—

“(i) REQUIRED GRACE PERIOD.—If a child does not complete the State

preventative care measures required for the child by the end of each year in which a child is enrolled in the KIDS PREVENTATIVE CARE program, the State offers the child an additional 90-day grace period to comply.

“(ii) REVERSION OF FUNDS TO THE STATE.—If, after the end of a 90-day grace period provided in accordance with clause (i), a child has not completed the State preventative care measures required for the child for the year, any funds remaining at the end of the year in the KIDS PREVENTATIVE CARE account established for or on behalf of the child that are State-contributed funds shall revert to the State.

“(iii) STATE-CONTRIBUTED FUNDS.—In the case of an account subject to clause (ii), the amount of the funds remaining in the account that shall be considered State-contributed funds is the amount that bears the same relation to the total funds remaining in the account as the amount of the aggregate State contributions during that year to the account bears to the amount of all aggregate contributions to the account during that year.

“(6) CONTRACTUAL CREATION OF ACCOUNTS FOR CERTAIN INDIVIDUALS.—The State shall enter into a contract with not less than 6 entities who shall agree to serve as trustees to establish a KIDS PREVENTATIVE CARE account for any eligible child who has not otherwise had such an account established on his or her behalf, including a child whose account application has been denied. Such entities in the aggregate shall provide beneficiaries with not less than 2 available entities in each geographic region of the State that is covered by the KIDS PREVENTATIVE CARE program. An account established on behalf of a child shall be owned by the child or the child’s guardian, in the case of a child who has not attained age 18, with specific rights for the State to remove funds as authorized under this Act. The provisions of paragraph (7) shall apply with respect to accounts established under this paragraph.

“(7) OTHER ADMINISTRATIVE REQUIREMENTS.—The State—

“(A) annually issues a pre-paid electronic debit card to the family of each child on whose behalf the account is established (or the child, in the case of a child who has attained age 18) that is restricted for payment only for qualified medical expenses for items or services provided through providers approved by the high deductible health plan in which the child is enrolled; and

“(B) replaces such card (with any balance remaining for the year) if the card is lost, damaged, or stolen at no cost to the family or child.

“(8) BUDGET NEUTRALITY.—The State demonstrates that, with respect to a fiscal year, the amounts paid by the State toward premiums for enrollment of targeted low-income children in high deductible health plans and amounts contributed by the State to KIDS PREVENTATIVE CARE accounts will not result in greater Federal expenditures than the Federal expenditures that would have been made under this title for providing child health assistance that satisfies the requirements of section 2103 to such children.

“(c) Annual Audits.—The State, using data provided under subsection (b)(1)(E), shall conduct an annual audit of the KIDS PREVENTATIVE CARE program to determine the number of KIDS PREVENTATIVE CARE accounts that are established during the reporting period.

“(d) Definitions.—In this section:

“(1) CARETAKER RELATIVE.—The term ‘caretaker relative’ has the meaning given such term for purposes of sections 1925, 1931, 2105(c)(1), and 2107(f).

“(2) KIDS PREVENTATIVE CARE ACCOUNT.—The term ‘KIDS PREVENTATIVE CARE account’ has the meaning given the term ‘health savings account’ under section 223(d)(1) of the Internal Revenue Code of 1986.

“(3) HIGH DEDUCTIBLE HEALTH PLAN.—

“(A) IN GENERAL.—Subject to subparagraph (B), the term ‘high deductible health plan’ means a health plan that—

“(i) is described in section 223(c)(2) of the Internal Revenue Code of 1986; and

“(ii) provides covered benefits for 100 percent of expenses incurred for medical care (as defined in section 213(d) of such Code) that exceed the annual deductible for such plan.

“(B) APPLICATION OF OUT-OF-NETWORK LIMITATIONS.—A health plan shall be treated as a high deductible health plan described in subparagraph (A) without regard to whether the plan has an out-of-pocket limitation described in section 223(c)(2)(D)(i) of such Code.

“(C) OPTIONAL INCLUSION OF STATE PLANS.—The term ‘high deductible health plan’ may include a State-operated plan that satisfies the requirements of subparagraph (A).

“(4) QUALIFIED MEDICAL EXPENSES.—

“(A) IN GENERAL.—The term ‘qualified medical expenses’ has the meaning given that term in section 223(d)(2) of such Code.

“(B) HEALTH INSURANCE.—For purposes of this section, the term ‘qualified medical expenses’ includes expenses for health insurance for a targeted low-income child enrolled in the KIDS PREVENTATIVE CARE program.”.

SEC. 2. STATE OPTION TO OFFER WELLNESS ACCOUNTS FOR ADULTS UNDER MEDICAID.

(a) In General.—Title XIX of the Social Security Act (42 U.S.C. 1396 et seq.) is amended by adding at the end the following:

“SEC. 1943. WELLNESS ACCOUNTS.

“(a) State Option.—

“(1) IN GENERAL.—A State may elect, through an amendment to its State plan for medical assistance and subject to the requirements specified in subsection (b), to provide medical assistance for classes or categories of adult individuals (without regard to the requirements of section 1902(a)(1)) who are eligible for medical assistance under such State plan or a waiver of such plan (referred to in this section as ‘recipients’) by establishing a WELLNESS program under which recipients are enrolled in high deductible health plans and contributions are made to WELLNESS accounts established on behalf of such

recipients.

“(2) TREATMENT AS MEDICAL ASSISTANCE.—

“(A) IN GENERAL.—Amounts paid by a State toward premiums for enrollment of recipients in high deductible health plans and amounts contributed by the State to WELLNESS accounts shall be treated as medical assistance for purposes of section 1905(a) and shall be provided in lieu of providing medical assistance that satisfies the requirements of such section.

“(B) OPT-OUT PROCEDURES.—

“(i) IN GENERAL.—A State shall—

“(I) establish procedures for a recipient on whose behalf a WELLNESS account is established pursuant to this section to elect to disenroll from participation in the program; and

“(II) educate such recipient about such procedures and other relevant health care financing considerations relating to disenrollment from the WELLNESS program.

“(ii) WAITING PERIOD PERMITTED.—The procedures established under clause (i) for disenrollment from the WELLNESS program may include a period of time that must elapse before a recipient who was previously enrolled in the WELLNESS program may reenroll in the program.

“(iii) TREATMENT OF FUNDS.—The procedures established under clause (i) for disenrollment from the WELLNESS program shall include a requirement that, upon the disenrollment from such program of a recipient on whose behalf a WELLNESS account is established, any balance of funds in the account shall be disbursed according to the following:

“(I) If the recipient is enrolled in a high deductible health plan (as defined in 223(c)(2) of the Internal Revenue Code of 1986), 50 percent of such funds shall be paid to the plan and applied toward the account under section 223 of the Internal Revenue Code of 1986 used in conjunction with such plan.

“(II) If the recipient is not so enrolled, an amount equal to the State’s contribution to the WELLNESS account shall be returned to the State and the remainder shall be available for expenditure by or on behalf of the recipient according to expenditure rules applicable to accounts under section 223 of such Code.

“(C) OPEN ENROLLMENT PERIOD.—The State shall designate biannual open enrollment periods for the WELLNESS program.

“(3) APPLICATION OF INTERNAL REVENUE CODE RULES.—Unless otherwise specified in this section, the Internal Revenue Code of 1986 shall be applied to a WELLNESS account in the same manner as if it were a health savings account established under section 223 of such Code.

“(b) Requirements.—The requirements specified in this subsection are as follows:

“(1) ELIGIBLE RECIPIENTS.—

“(A) STATE-SPECIFIED CRITERIA.—The State specifies in the State plan amendment—

“(i) the classes or categories of adult recipients who are eligible to have WELLNESS accounts established on their behalf;

“(ii) any additional criteria that the State may specify for a recipient to satisfy in order to elect to have a WELLNESS account established for such recipient (including criteria requiring disenrollment in accordance with subparagraph (D)); and

“(iii) the projected enrollment in such accounts.

“(B) VOLUNTARY PARTICIPATION.—A WELLNESS account is established on behalf of an eligible recipient only if such recipient voluntarily elects to have the account established.

“(C) OPTION TO LIMIT NUMBER OF PARTICIPANTS AND AREAS IN WHICH AVAILABLE.—A State may limit the number of recipients within an eligible class or category of such recipients who can obtain WELLNESS accounts and the geographic areas of the State in which the State offers the option to elect to enroll in the program established under this section.

“(D) DISENROLLMENT REQUIREMENTS.—A State requires the disenrollment of a recipient from the WELLNESS program if the recipient’s premium contribution to such recipient’s high deductible health plan required under paragraph (3)(B) for any month is at least 90 days overdue.

“(E) PROVISION OF DATA.—To be eligible to participate in the WELLNESS program a recipient shall agree to provide to the financial institution at which a WELLNESS account is established relevant enrollment data as required by the State.

“(2) ENROLLMENT ASSISTANCE; EDUCATION.—The State provides enrollment counselors and ongoing education regarding the maintenance and operation of WELLNESS accounts for recipients who are interested in electing to participate in the program established under this section, particularly with respect to—

“(A) the importance of preventative care, the relationship between preventative care and the annual rollover of funds, and the extent of coverage for preventative care services in the WELLNESS program;

“(B) strategies and techniques for finding quality and low cost health care items and services;

“(C) the high cost of medical services;

“(D) the different forms of public and private health assistance and insurance options for which the recipient is eligible and factors for considering which option best meets the short and long-term financial and health care goals of the recipient;

“(E) the operation of the pre-paid electronic debit card and the process for signing up for a bank account for purposes of the WELLNESS account program; and

“(F) the maximum annual out-of-pocket expenditure established under paragraph (3)(B)(ii) for recipients on whose behalf such accounts are established.

“(3) CONTRIBUTIONS.—

“(A) STATE CONTRIBUTION.—The State makes an annual contribution to a WELLNESS account established under the program in an amount equal to the annual deductible applicable under the high deductible health plan in which the recipient on whose behalf the account is established is enrolled.

“(B) RECIPIENT CONTRIBUTIONS.—

“(i) IN GENERAL.—The State requires the recipient on whose behalf the account is established to contribute a portion of the monthly premiums imposed for enrollment in the high deductible health plan in which the recipient is enrolled (without regard to the limitations on cost-sharing imposed by section 1916 but subject to the maximum annual out-of-pocket expenditure established under clause (ii)).

“(ii) MAXIMUM ANNUAL OUT-OF-POCKET EXPENDITURE.—The State establishes a maximum annual out-of-pocket expenditure for a recipient enrolled in the WELLNESS Account program (without regard to any maximum out-of-pocket expenditure established under the State plan for medical assistance) equal to the annual deductible of such plan and fully funds the WELLNESS account with the amount of such deductible immediately upon receipt of confirmation of payment of the initial recipient contribution.

“(iii) COST-SHARING FOR CERTAIN HEALTH CARE SERVICES.—The State may require beneficiary cost-sharing for certain out-of-pocket expenses for health care services specified by the State without regard to the limitations on cost-sharing imposed under section 1916 or 1916A but subject to the maximum annual out-of-pocket expenditure established under clause (ii).

“(iv) EFFECTIVE DATE OF COVERAGE.—The effective date of coverage under a high deductible health plan for a recipient on whose behalf a WELLNESS account is established is the first day of the first month that begins after the month in which the initial recipient contribution is received.

“(C) OTHER CONTRIBUTIONS.—Nothing in subparagraph (A) shall be construed as prohibiting an employer or other person or entity from making a contribution to a WELLNESS account established under this section, except that no Federal matching amounts shall be provided under section 1903 with respect to any contributions made to such an account other than contributions made by the State in accordance with subparagraph (A).

“(D) NOTICE.—The State notifies the recipient on whose behalf a WELLNESS account is established through electronic mail (or, such other means as the State determines is most likely to provide notice to such recipient) of the amount of each contribution made to the account upon making or receiving a contribution to the account.

“(4) TREATMENT.—

“(A) EXEMPT FROM TAX.—Subject to section 223(f) of the Internal Revenue Code of 1986, amounts in, or contributed to, a WELLNESS account shall not be includible in the gross income of a recipient on whose behalf the account is established.

“(B) NO EFFECT ON ELIGIBILITY FOR, OR AMOUNT OF, OTHER BENEFITS OR ASSISTANCE.—Amounts in, or contributed to, a WELLNESS account shall not be counted as income or assets for purposes of determining eligibility for, or the amount of, benefits or assistance under any Federal means-tested public benefit program (including the State plan under this title) for a recipient on whose behalf the account is established.

“(C) QUALIFIED MEDICAL EXPENSES.—The costs of transportation and other costs related to an individual meeting with a financial institution or other entity for the establishment of a WELLNESS account, or related to meeting with State counselors under paragraph (2), shall be considered a qualified medical expense for which the individual may obtain reimbursement from the individual’s WELLNESS account.

“(5) REQUIREMENTS FOR ANNUAL ROLLOVER OF FUNDS.—

“(A) ANNUAL ROLLOVER OF UNUSED FUNDS.—

“(i) IN GENERAL.—Subject to the disenrollment procedures required under subsection (a)(2)(B)(iii) and subparagraph (C), any balance remaining in a WELLNESS account at the end of a year rolls over and remains available for expenditure during the succeeding year only if the State determines that the recipient on whose behalf the account is established has satisfied the State preventative care measures required for the year in accordance with subparagraph (B).

“(ii) MONITORING MECHANISMS REQUIRED FOR PARTICIPATING PLANS.—The State requires each high deductible health plan that participates in the WELLNESS program to establish mechanisms for determining that a recipient enrolled in the program and under the plan has satisfied a State preventative care measure applicable to such recipient for a year and for notifying the State before the end of the year of the extent to which such recipient has or has not satisfied all such measures for the year.

“(B) ANNUAL SPECIFICATION OF STATE PREVENTATIVE CARE MEASURES.—

“(i) IN GENERAL.—Not later than the first Monday of September of each year for which the State operates a WELLNESS program under this section, the State notifies each recipient on whose behalf the account is established of the preventative care measures required for such recipient for that year. Such measures shall be developed and to the extent the State determines appropriate, revised annually, and shall be based upon the age, sex, and preexisting conditions of the recipient.

“(ii) 100 PERCENT COVERAGE OF PREVENTATIVE CARE SERVICES.—The State requires a high deductible health plan as a condition of participating in the WELLNESS program to provide 100 percent coverage for all of the preventative care measures required for a recipient for each year of enrollment in the program.

“(C) NO ROLLOVER IF FAILURE TO SATISFY ANNUAL PREVENTATIVE CARE MEASURES.—

“(i) REQUIRED GRACE PERIOD.—If a recipient does not complete the State preventative care measures required for such recipient by the end of each year in which a recipient is enrolled in the WELLNESS program, the State offers the recipient an additional 60-day grace period to comply.

“(ii) REVERSION OF FUNDS TO THE STATE.—If, after the end of a 60-day grace period provided in accordance with clause (i), a recipient has not completed the State preventative care measures required for such recipient for the year, any funds remaining at the end of the year in the WELLNESS account established for or on behalf of such recipient that are State-contributed funds shall revert to the State.

“(iii) STATE-CONTRIBUTED FUNDS.—In the case of an account subject to clause (ii), the amount of the funds remaining in the account that shall be considered State-contributed funds is the amount that bears the same relation to the total funds remaining in the account as the amount of the aggregate State contributions to the account bears to the amount of all aggregate contributions to the account.

“(6) CONTRACTUAL CREATION OF ACCOUNTS FOR CERTAIN INDIVIDUALS.—The State shall enter into a contract with not less than 6 entities who shall agree to serve as trustees to establish a WELLNESS account for any eligible recipient who has not otherwise had such an account established on his or her behalf, including a recipient whose account application has been denied. Such entities in the aggregate shall provide beneficiaries with not less than 2 available entities in each geographic region of the State that is covered by the WELLNESS program. An account established on behalf of a recipient shall be owned by the recipient, with specific rights for the State to remove funds as authorized under this Act. The provisions of paragraph (7) shall apply with respect to accounts established under this paragraph.

“(7) OTHER ADMINISTRATIVE REQUIREMENTS.—The State—

“(A) annually issues a pre-paid electronic debit card to each recipient on whose behalf the account is established that is restricted for payment only for qualified medical expenses for items or services provided through providers approved by the high deductible health plan in which the recipient is enrolled; and

“(B) replaces such card (with any balance remaining for the year) if the card is lost, damaged, or stolen at no cost to the recipient.

“(8) BUDGET NEUTRALITY.—The State demonstrates that, with respect to a fiscal year, the amounts paid by the State toward premiums for enrollment of recipients in high deductible health plans and amounts contributed by the State to WELLNESS accounts will not result in greater Federal expenditures than the Federal expenditures that would have been made under this title for providing medical assistance that satisfies the requirements of section 1905 to such recipients.

“(c) Annual Audits.—The State, using data provided under subsection (b)(1)(E), shall conduct an annual audit of the WELLNESS program to determine the number of WELLNESS accounts that are established during the reporting period.

“(d) Definitions.—In this section:

“(1) WELLNESS ACCOUNT.—The term ‘WELLNESS account’ has the meaning given the term ‘health savings account’ under section 223(d)(1) of the Internal Revenue Code of 1986.

“(2) HIGH DEDUCTIBLE HEALTH PLAN.—

“(A) IN GENERAL.—Subject to subparagraph (B), the term ‘high deductible health plan’ means a health plan that—

“(i) is described in section 223(c)(2) of the Internal Revenue Code of 1986; and

“(ii) provides covered benefits for 100 percent of expenses incurred for medical care (as defined in section 213(d) of such Code) that exceed the annual deductible for such plan.

“(B) APPLICATION OF OUT-OF-NETWORK LIMITATIONS.—A health plan shall be treated as a high deductible health plan described in subparagraph (A) without regard to whether the plan has an out-of-pocket limitation described in section 223(c)(2)(D)(i) of such Code.

“(C) OPTIONAL INCLUSION OF STATE PLANS.—The term ‘high deductible health plan’ may include a State-operated plan that satisfies the requirements of subparagraph (A).

“(3) QUALIFIED MEDICAL EXPENSES.—

“(A) IN GENERAL.—The term ‘qualified medical expenses’ has the meaning given that term in section 223(d)(2) of such Code.

“(B) HEALTH INSURANCE.—For purposes of this section, the term ‘qualified medical expenses’ includes expenses for health insurance for a recipient enrolled in the WELLNESS program.”.