

103^D CONGRESS
1ST SESSION

H. R. 1691

To provide universal access for all Americans to basic health care services
and long-term care services.

IN THE HOUSE OF REPRESENTATIVES

APRIL 5, 1993

Mr. ANDREWS of Maine introduced the following bill; which was referred jointly to the Committees on Energy and Commerce, Ways and Means, Education and Labor, Rules, Armed Services, Veterans' Affairs, and Post Office and Civil Service

A BILL

To provide universal access for all Americans to basic health
care services and long-term care services.

1 *Be it enacted by the Senate and House of Representa-*
2 *tives of the United States of America in Congress assembled,*

3 **SECTION 1. SHORT TITLE; TABLE OF CONTENTS.**

4 (a) **SHORT TITLE.**—This Act may be cited as the
5 “National Health Security Act of 1993”.

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

Sec. 1. Short title; table of contents.

Sec. 2. Statement of principles.

Sec. 3. General definitions.

TITLE I—ELIGIBILITY AND ENROLLMENT

- Sec. 101. Eligibility and entitlement.
- Sec. 102. Enrollment.
- Sec. 103. Portability.

TITLE II—BENEFITS

Subtitle A—Health Care Services

- Sec. 201. Covered health care services.
- Sec. 202. Limitations and exclusions.
- Sec. 203. Patient cost-sharing.

Subtitle B—Long-Term Care Services

- Sec. 211. Covered long-term care services.
- Sec. 212. Long-Term Care Services Assessment Commission.

Subtitle C—Modification of Services

- Sec. 221. Modification of services covered under this Act.

TITLE III—FEDERAL AND STATE ADMINISTRATION

Subtitle A—Federal Administration

- Sec. 301. Federal Health Board.
- Sec. 302. Federal Health Advisory Council.
- Sec. 303. Federal Health Priorities Council.
- Sec. 304. Authorization of appropriations.

Subtitle B—State Administration

- Sec. 311. State programs.
- Sec. 312. Use of fiscal intermediaries.
- Sec. 313. State waivers; managed care.
- Sec. 314. State regional consortia.
- Sec. 315. Grants to States.
- Sec. 316. Technical assistance to States.

TITLE IV—FINANCING

Subtitle A—Health Budgets

- Sec. 401. National health budget.
- Sec. 402. Payments to States.
- Sec. 403. State program budgets.

Subtitle B—Payments to Providers

- Sec. 411. Payments to hospitals and other health care and long-term care institutions.
- Sec. 412. Payments for practitioners services.
- Sec. 413. Special nonphysician practitioner provisions.
- Sec. 414. Mandatory assignment.

Subtitle C—Revenues

- Sec. 421. Federal sources of revenues.

- Sec. 422. Tax treatment of American Health Security Plan and private health and long-term care insurance.
 Sec. 423. Federal Health Trust Fund.
 Sec. 424. State sources of revenues.

TITLE V—CONGRESSIONAL CONSIDERATION

- Sec. 501. Rules governing congressional consideration.

TITLE VI—PRIVATE OPTIONS

- Sec. 601. Private supplemental insurance.
 Sec. 602. Option to purchase duplicative private insurance.
 Sec. 603. Limits on private insurance.

TITLE VII—EXPANSION OF OUTCOMES RESEARCH AND DELIVERY OF SERVICES IN UNDERSERVED AREAS

- Sec. 701. Expansion of outcomes research.
 Sec. 702. National health service corps.
 Sec. 703. Community and migrant health centers.

TITLE VIII—MALPRACTICE REFORM

- Sec. 801. Grants to States.
 Sec. 802. Criteria for State malpractice reforms.
 Sec. 803. Authorization of appropriations.

TITLE IX—EFFECTIVE DATES; TERMINATIONS; TRANSITION; RELATION TO ERISA.

- Sec. 901. Effective dates.
 Sec. 902. Termination of other programs.
 Sec. 903. Transition.
 Sec. 904. Relation to ERISA.

1 **SEC. 2. STATEMENT OF PRINCIPLES.**

2 The principles of this Act are—

3 (1) to provide universal access to basic health
 4 care services for all Americans regardless of their fi-
 5 nancial and medical conditions;

6 (2) to establish the institutional and political
 7 capacity to control the Nation's escalating health
 8 care costs and eliminate administrative waste;

9 (3) to ensure the portability of health care cov-
 10 erage to all regions of the country;

1 (4) to build on the strengths of American fed-
2 eralism, with the Federal Government contributing
3 progressive financing and specifying minimum na-
4 tional standards while State governments supply ad-
5 ditional funding and administer the program with
6 the flexibility needed to address the specific concerns
7 of each region;

8 (5) to maintain the proven advantages of the
9 American health care delivery system, including pri-
10 vate practice, the freedom to choose among practi-
11 tioners, and superiority in biomedical technology;

12 (6) to encourage the effective use of preventive
13 and primary care;

14 (7) to enhance the autonomy of practitioners by
15 limiting the intrusiveness of government intervention
16 in the actual delivery of care;

17 (8) to promote the role of competition among
18 practitioners and to encourage innovation that re-
19 sults in higher quality and more efficient care;

20 (9) to reduce the incentives providers face to
21 perform medically unnecessary or inappropriate serv-
22 ices;

23 (10) to reinforce the public accountability of the
24 health care system, permitting explicit and open de-

1 liberation about the allocation of society’s resources
2 to health care; and

3 (11) to provide that all Americans share in the
4 responsibility of maintaining an efficient health care
5 system.

6 **SEC. 3. GENERAL DEFINITIONS.**

7 (a) IN GENERAL.—For purposes of this Act:

8 (1) The term “Board” means the Federal
9 Health Board established in section 301.

10 (2) The term “Advisory Council” means the
11 Federal Health Care Advisory Council established in
12 section 302.

13 (3) The term “Priorities Council” means the
14 Federal Health Priorities Council established in sec-
15 tion 303.

16 (4) The term “State program” means a State
17 health care program approved under section 311.

18 (5) The term “State” includes the District of
19 Columbia, the Commonwealth of Puerto Rico, the
20 United States Virgin Islands, Guam, American
21 Samoa, and the Commonwealth of the Northern
22 Mariana Islands.

23 (6) The term “Trust Fund” means the Federal
24 Health Trust Fund established in section 423.

1 (b) OTHER DEFINITIONS.—Except as otherwise pro-
2 vided, the definitions contained in section 1861 of the So-
3 cial Security Act (42 U.S.C. 1395x), as in effect on the
4 day before the date of the enactment of this Act, shall
5 apply in this Act.

6 **TITLE I—ELIGIBILITY AND**
7 **ENROLLMENT**

8 **SEC. 101. ELIGIBILITY AND ENTITLEMENT.**

9 (a) IN GENERAL.—Every individual who is a resident
10 of the United States and is a citizen or national of the
11 United States or lawful resident alien (as defined in sub-
12 section (d)) is entitled to health care services and long-
13 term care services covered under this Act in the State in
14 which the individual maintains a primary residence.

15 (b) TREATMENT OF CERTAIN NONIMMIGRANTS.—

16 (1) IN GENERAL.—The Board may make eligi-
17 ble for health care services and long-term care serv-
18 ices covered under this Act such classes of aliens ad-
19 mitted to the United States as nonimmigrants as the
20 Board may provide.

21 (2) CONSIDERATION.—In providing for eligi-
22 bility under paragraph (1), the Board shall consider
23 reciprocity in health care and long-term care services
24 offered to United States citizens who are
25 nonimmigrants in other foreign states, and such

1 other factors as the Board determines to be appro-
2 priate.

3 (c) TREATMENT OF OTHER INDIVIDUALS.—The
4 Board may make eligible for health care services and long-
5 term care services covered under this Act other individuals
6 not described in subsection (a) or (b), and regulate the
7 nature of the eligibility of such individuals for the pur-
8 poses of fulfilling the following criteria:

9 (1) Preserving the public health of commu-
10 nities.

11 (2) Compensating States for the additional
12 health care financing burdens created by such indi-
13 viduals.

14 (3) Preventing adverse financial and medical
15 consequences of uncompensated care.

16 (4) Inhibiting travel and immigration to the
17 United States for the sole purpose of obtaining
18 health care services or long-term care services cov-
19 ered under this Act.

20 (d) LAWFUL RESIDENT ALIEN DEFINED.—For pur-
21 poses of this section, the term “lawful resident alien”
22 means an alien lawfully admitted for permanent residence
23 and any other alien lawfully residing permanently in the
24 United States under color of law, including an alien with
25 lawful temporary resident status under section 210, 210A,

1 or 245A of the Immigration and Nationality Act (8 U.S.C.
2 1160, 1161, or 1255a).

3 **SEC. 102. ENROLLMENT.**

4 (a) IN GENERAL.—Each State program shall provide
5 a mechanism for enrollment of individuals entitled to bene-
6 fits under this Act and, in conjunction with such enroll-
7 ment, the issuance of a State health insurance card which
8 may be used for purposes of identification and processing
9 of claims for benefits under this Act.

10 (b) ENROLLMENT AT BIRTH OR IMMIGRATION.—The
11 mechanism under subsection (a) shall include a process
12 for the automatic enrollment of individuals at the time of
13 birth in the State or at the establishment of permanent
14 residence in the State, including at the time of immigra-
15 tion into the United States, other acquisition of lawful
16 resident status in the United States, or eligibility for other
17 individuals established under section 101(c).

18 **SEC. 103. PORTABILITY.**

19 To ensure continuous access to health care services
20 and long-term care services covered under this Act, each
21 State program—

22 (1) shall utilize a uniform claims form as devel-
23 oped by the Board;

24 (2) shall not impose any minimum period of
25 residence in the State, or waiting period, in excess

1 of 3 months before residents of the State are enti-
2 tled to such services;

3 (3) shall provide continuation of payment for
4 such services to individuals who have terminated
5 their residence in the State and established their
6 residence in another State, for the duration of any
7 waiting period imposed in the State of new residency
8 for establishing entitlement to such services; and

9 (4) shall provide for the payment for health
10 care services covered under this Act provided to indi-
11 viduals while temporarily absent from the State
12 based on the following principles:

13 (A) Payment for such health care services
14 is at the rate that is approved by the State pro-
15 gram in the State in which the services are pro-
16 vided, unless the States concerned agree to ap-
17 portion the cost between them in a different
18 manner.

19 (B)(i) Except as provided in clause (ii),
20 payment for such health care services provided
21 outside the United States is made on the basis
22 of the amount that would have been paid by the
23 State program for similar services rendered in
24 the State, with due regard, in the case of hos-

1 pital services, to the size of the hospital, stand-
2 ards of service, and other relevant factors.

3 (ii) Payment for services described under
4 clause (i) which are elective services may be
5 subject to prior consent of the agency that ad-
6 ministers and operates the State program if
7 such elective services are available on a sub-
8 stantially similar basis in the State.

9 (iii) For the purposes of this subpara-
10 graph, the term “elective services” means
11 health care services covered under this Act
12 other than services that are provided in an
13 emergency or in any other circumstance in
14 which medical care is required without delay.

15 **TITLE II—BENEFITS**

16 **Subtitle A—Health Care Services**

17 **SEC. 201. COVERED HEALTH CARE SERVICES.**

18 (a) IN GENERAL.—Every eligible individual is enti-
19 tled to have payment made for the health care services
20 covered under this Act by a participating provider if the
21 service is necessary or appropriate for the maintenance of
22 health or for the diagnosis or treatment of, or rehabilita-
23 tion following, injury, disability, or disease.

1 (b) SPECIFIC SERVICES.—Subject to limitations de-
2 scribed in section 202, health care services covered under
3 this Act are as follows:

4 (1) Inpatient and outpatient hospital care, in-
5 cluding 24-hour per day emergency services.

6 (2) Diagnostic and screening tests.

7 (3) Medical and other health services furnished
8 by health care professionals who are authorized to
9 provide such services under State law, including
10 medically necessary dental care.

11 (4) Preventive health care, including care for
12 well-defined causes of illness and injury (such as
13 breast, cervical, and colon cancer), immunizations
14 (for children, according to an immunization schedule
15 issued by the American Academy of Pediatrics), pre-
16 natal and postnatal care (according to guidelines of
17 the American College of Obstetrics and Gynecology,
18 and including prenatal and postnatal care coordina-
19 tion, and nutrition education), family planning serv-
20 ices, and well-baby and well-child care (including
21 physical examinations and vision, dental, hearing,
22 and developmental examinations).

23 (5) Prescription drugs, biologicals, and devices.

24 (6) Substance abuse treatment services, includ-
25 ing comprehensive residential treatment services for

1 pregnant women and women with children seeking
2 treatment for substance abuse.

3 (7) Inpatient and outpatient mental health
4 services to provide an active preventive, diagnostic,
5 therapeutic, or rehabilitative service with respect to
6 emotional or mental disorders.

7 (8) Hospice care for patients certified to be ter-
8 minally ill, provided under a State approved pro-
9 gram.

10 (9) Habilitation and rehabilitation services, in-
11 cluding physical, speech, and occupational therapies.

12 (10) Home medical equipment and prosthetic
13 devices prescribed by a licensed practitioner.

14 (11) Experimental treatment as deemed nec-
15 essary by the review of the Board and the State Ad-
16 visory Boards.

17 **SEC. 202. LIMITATIONS AND EXCLUSIONS.**

18 (a) NO LIMITS IN GENERAL.—Except as provided in
19 this section, section 203, and section 221, a State program
20 may not limit the amount, duration, or scope of health
21 care services covered under this Act.

22 (b) SPECIFIC EXCLUSIONS.—Health care services ex-
23 cluded from coverage under this Act include the following:

24 (1) Cosmetic surgery, except medically nec-
25 essary reconstruction.

1 (2) Certain amenities in inpatient facilities,
2 such as private rooms and other amenities deter-
3 mined by the Board, unless medically necessary.

4 **SEC. 203. PATIENT COST-SHARING.**

5 (a) IN GENERAL.—Except as provided in this section,
6 a State program may not impose cost-sharing for services
7 under this Act.

8 (b) ESTABLISHMENT OF COST-SHARING SCHED-
9 ULE.—

10 (1) IN GENERAL.—Co-payments and out-of-
11 pocket limits shall be established by the Board con-
12 sistent with paragraph (2). The Board shall base its
13 determinations on the following principles:

14 (A) Assurance of administrative simplicity
15 and efficiency.

16 (B) Maintenance of the fiscal integrity of
17 the public health insurance program.

18 (C) Deterrence of unnecessary use of serv-
19 ices.

20 (D) Encouragement of healthy behaviors.

21 (E) Encouragement of the use of preven-
22 tive services.

23 (F) Maximization of economic fairness.

24 (G) Minimization of financial barriers to
25 appropriate medical care.

1 (2) SPECIFICS.—In establishing co-payments
2 and out-of-pocket limits under paragraph (1)—

3 (A) there shall be no cost-sharing imposed
4 with respect to preventive health care (described
5 in section 201(b)(4)), and

6 (B) there shall no deductible for any serv-
7 ices.

8 (3) STUDIES OF MODIFICATIONS.—

9 (A) IN GENERAL.—The Priorities Council
10 shall study—

11 (i) whether the out-of-pocket limits
12 should be modified to take into account
13 family size and family composition,

14 (ii) whether the use of co-payments is
15 a cost-effective means of containing health
16 care costs and whether the use of co-pay-
17 ments is an excessive administrative bur-
18 den on health care providers and fiscal
19 providers (designated under section
20 311(b)(2)),

21 (iii) the effects of the continuation of
22 duplicative private insurance (as allowed in
23 section 602), upon the quality, access, and
24 cost of the public health insurance pro-
25 gram,

1 (iv) whether cost sharing require-
2 ments should be different for individuals
3 that engage in certain practices deemed to
4 increase the likelihood such individuals will
5 utilize more health care resources than in-
6 dividuals who do not engage in such prac-
7 tices.

8 (B) SPECIFIC RECOMMENDATIONS.—The
9 Priorities Council within 2 years of the date de-
10 scribed in section 901(b)(1) shall issue rec-
11 ommendations regarding the studies described
12 in subparagraph (A). The recommendations
13 must balance the following goals:

14 (i) Preserve the fiscal integrity of the
15 public health insurance program.

16 (ii) Minimize the shifting between in-
17 dividuals and families of the burden of fi-
18 nancing the public program.

19 (iii) Encourage behaviors by govern-
20 ments, intermediaries, providers, and indi-
21 viduals that lead to reduced costs to the
22 health care system.

23 (3) REGULATIONS BASED ON RECOMMENDA-
24 TIONS.—

1 (A) IN GENERAL.—The Board is author-
2 ized to promulgate regulations, as it deems ap-
3 propriate, for implementing the recommenda-
4 tions of the Priorities Council.

5 (B) MODIFICATIONS.—The Board is also
6 authorized to promulgate regulations to make
7 periodic adjustments for inflation to income cat-
8 egories, co-payments, and deductibles.

9 (C) EFFECT OF REGULATIONS.—The regu-
10 lations incorporating these modifications to the
11 cost sharing and out-of-pocket limits described
12 in this section shall have the force of law, un-
13 less within 60 days of the promulgation of the
14 regulations, the Congress enacts a disapproval
15 resolution under the procedures described in
16 section 501.

17 **Subtitle B—Long-Term Care** 18 **Services**

19 **SEC. 211. COVERED LONG-TERM CARE SERVICES.**

20 (a) IN GENERAL.—The Board, by regulation, shall
21 set standards for eligibility, long-term care services cov-
22 ered, cost-sharing, income protection, and case coordina-
23 tion, subject to the criteria described in the following sub-
24 sections.

25 (b) ELIGIBILITY.—

1 (1) IN GENERAL.—The Board shall determine
2 the standards for eligibility for institutional and for
3 home and community-based long-term care services
4 based on an individual’s ability to perform activities
5 of daily living (ADLs) and instrumental activities of
6 daily living (IADLs), and comparable cognitive or
7 behavioral impairments.

8 (2) DETERMINATION.—Eligibility for long-term
9 care services shall be based on a determination by
10 a case manager of the individual’s ability to perform
11 the minimum level of ADLs and IADLs, according
12 to the standard set by the Board.

13 (3) STANDARD.—The Board shall, pursuant to
14 recommendations by the Advisory Council and the
15 Long-Term Care Services Assessment Commission,
16 periodically make recommendations about the effi-
17 cacy of using deficits in ADLs and IADLs, or meas-
18 ures of comparable cognitive or behavioral impair-
19 ment, or both, to determine eligibility for long-term
20 care services.

21 (c) SERVICES COVERED.—

22 (1) IN GENERAL.—The Board shall determine
23 the long-term care services to be covered under this
24 Act to meet the long-term care needs of the eligible
25 population.

1 (2) MINIMUM SERVICES.—At a minimum, long-
2 term care services to be covered under this Act, sub-
3 ject to standards set by the Board, shall include:

4 (A) Home and community-based services,
5 such as nursing care and rehabilitative and re-
6 storative care.

7 (B) Nursing home care.

8 (C) Hospice care.

9 (D) Home medical equipment.

10 (E) Services for individuals with devel-
11 opmental disabilities and mental illness.

12 (d) COST SHARING.—The Board shall establish an
13 income-related cost-sharing schedule for individuals eligi-
14 ble for long-term care services covered under this Act, tak-
15 ing into account such factors as what out-of-nursing home
16 expenses would have been.

17 (e) INCOME PROTECTION.—

18 (1) IN GENERAL.—The Board shall reduce the
19 cost sharing to ensure that the income and assets of
20 the individual using long-term care services covered
21 under this Act are sufficient to enable such individ-
22 ual to retain a personal needs allowance sufficient—

23 (A) to cover all items needed in addition to
24 those provided by the long-term care facility,

1 (B) to maintain such individual's primary
2 residence, and

3 (C) to maintain such individual's independ-
4 ence once the individual no longer needs long-
5 term care services.

6 (2) SPOUSAL PROTECTION, ETC.—The Board
7 shall reduce the cost sharing to ensure that the in-
8 come of the spouse, dependent, parent, or guardian
9 of the individual using long-term care services cov-
10 ered under this Act is not reduced below levels deter-
11 mined appropriate by the Board, but in no case less
12 than the spousal protection levels under title XIX of
13 the Social Security Act, as in effect on the day be-
14 fore the date of the enactment of this Act.

15 (f) CASE MANAGEMENT.—

16 (1) IN GENERAL.—The Board shall set stand-
17 ards for case coordination of long-term care services
18 covered under this Act.

19 (2) CASE COORDINATOR.—

20 (A) IN GENERAL.—Under the case coordi-
21 nation system, services shall be made available
22 to individuals through a case coordinator who
23 will be responsible for matching services to each
24 individual's needs, and coordinating the delivery
25 of services.

1 (B) SPECIFIC RESPONSIBILITIES.—The
2 specific responsibilities of the case coordinator
3 include:

4 (i) The assessment and periodic reas-
5 sessment of an individual’s need for serv-
6 ices, and the availability and efficacy of in-
7 formal services.

8 (ii) The development of plan of care
9 for the individual.

10 (iii) The authorization and coordina-
11 tion of services designed to meet an indi-
12 vidual’s unmet needs.

13 (g) EFFECT OF REGULATIONS.—The regulations in-
14 corporating the standards described in subsection (a) shall
15 have the force of law, unless within 60 days of the promul-
16 gation of the regulations, the Congress enacts a dis-
17 approval resolution under the procedures described in sec-
18 tion 501.

19 **SEC. 212. LONG-TERM CARE SERVICES ASSESSMENT COM-**
20 **MISSION.**

21 (a) ESTABLISHMENT.—Due to the seriousness of the
22 current problems in long-term care, the Director of the
23 Congressional Office of Technology Assessment (hereafter
24 in this section referred to as the “Director”) shall provide
25 for the appointment of a special task force, to be known

1 as the “Long-Term Care Services Assessment Commis-
2 sion” (hereafter in this section referred to as the “Com-
3 mission”).

4 (b) MEMBERSHIP.—The Commission shall consist of
5 10 individuals appointed for a seven-year term, beginning
6 on October 1, 1994. The membership of the Commission
7 shall include long-term care service providers, other health
8 and social service professionals, individuals skilled in the
9 conduct and interpretation of biomedical, health services,
10 and health economics research, and representatives of con-
11 sumers, the elderly, and the disabled. The Director shall
12 fill any vacancy in the membership of the Commission in
13 the same manner as the original appointment. The va-
14 cancy shall not affect the power of the remaining members
15 to execute the duties of the Commission.

16 (c) COMPENSATION.—All members of the Commis-
17 sion shall be reimbursed by the Board for travel and per
18 diem in lieu of subsistence expenses during the perform-
19 ance of duties of the Commission in accordance with sub-
20 chapter I of chapter 57 of title 5, United States Code.

21 (d) ORGANIZATION.—The Commission shall cease to
22 exist at the end of the 7-year term described in subsection
23 (b).

1 (e) FACA NOT APPLICABLE.—The provisions of the
2 Federal Advisory Committee Act shall not apply to the
3 Commission.

4 (f) DUTIES.—

5 (1) IN GENERAL.—The Commission shall make
6 recommendations to the Board not later than Janu-
7 ary 31 of 1995 (and of each subsequent year) re-
8 garding—

9 (A) the adequacy and appropriateness of
10 the long-term care services covered under this
11 Act,

12 (B) the criteria for eligibility for long-term
13 care services,

14 (C) the effect of the cost sharing require-
15 ments for long-term care services,

16 (D) the financial protections provided indi-
17 viduals in the use of such services and the abil-
18 ity of the patient and any spouse, dependent,
19 parent, or guardian of the patient in the com-
20 munity to remain financially independent once
21 the patient no longer needs long-term care serv-
22 ices,

23 (E) the effect of the long-term care serv-
24 ices covered under this Act on the availability

1 and use of informal long-term care services and
2 private long-term care insurance, and

3 (F) the overall functioning of the provision
4 of long-term care services covered under this
5 Act, once fully implemented.

6 (2) REVIEW.—The Commission shall review and
7 analyze any long-term care services regulations or
8 proposed regulations of the Board and report to the
9 Congress its assessment of the appropriateness of
10 the regulations in meeting the statutory criteria es-
11 tablished under this Act.

12 (g) AUTHORIZATION OF APPROPRIATIONS.—There
13 are authorized to be appropriated such sums as are nec-
14 essary for the establishment and operation of the Commis-
15 sion to carry out the purposes of this Act.

16 **Subtitle C—Modification of**
17 **Services**

18 **SEC. 221. MODIFICATION OF SERVICES COVERED UNDER**
19 **THIS ACT.**

20 (a) RECOMMENDATIONS BY PRIORITIES COUNCIL.—
21 Not later than January 31 of 1998 (and of each subse-
22 quent year), the Priorities Council shall issue a report to
23 the Board describing any changes, additions, deletions, or
24 clarifications the Priority Council recommends for the

1 health care services and long-term care services covered
2 under this Act.

3 (b) BOARD REGULATIONS.—

4 (1) IN GENERAL.—The Board is authorized to
5 promulgate regulations, as the Board deems appro-
6 priate, for implementing the recommendations of the
7 Priorities Council. Such regulations are to be pro-
8 mulgated within 1 year of the submission of the Pri-
9 orities Council’s report.

10 (2) EFFECT.—The regulations incorporating
11 modifications in the health care services and long-
12 term care services covered under this Act shall have
13 the force of law, unless within 60 days of the pro-
14 mulgation of the regulations, the Congress enacts a
15 disapproval resolution under the procedures de-
16 scribed in section 501.

17 **TITLE III—FEDERAL AND STATE**
18 **ADMINISTRATION**

19 **Subtitle A—Federal Administration**

20 **SEC. 301. FEDERAL HEALTH BOARD.**

21 (a) IN GENERAL.—There is hereby established a
22 Federal Health Board.

23 (b) APPOINTMENT AND TERMS OF MEMBERS.—

24 (1) APPOINTMENT.—The Board shall be com-
25 posed of 9 individuals appointed by the President,

1 with the advice and consent of the Senate, not later
2 than October 1, 1994, and shall be chosen on the
3 basis of backgrounds in health policy, health eco-
4 nomics, the healing professions, and the administra-
5 tion of health care institutions. At least 1 member
6 of the Board shall represent consumer interests, and
7 due regard must be given to geographic, urban, and
8 rural representation. No more than 5 members may
9 be affiliated with a single political party.

10 (2) TERMS OF MEMBERS.—The individuals ap-
11 pointed shall serve for a term of 9 years (or until
12 a successor is appointed), except that the terms of
13 individuals initially appointed shall be (as specified
14 by the President) for such fewer number of years as
15 will provide for the expiration of terms on a stag-
16 gered basis.

17 (3) REMOVAL FOR CAUSE ONLY.—Upon con-
18 firmation, members of the Board may not be re-
19 moved except for cause upon notice and hearing.

20 (c) VACANCIES.—

21 (1) IN GENERAL.—The President shall fill any
22 vacancy in the membership of the Board in the same
23 manner as the original appointment. The vacancy
24 shall not affect the power of the remaining members
25 to execute the duties of the Board.

1 (2) VACANCY APPOINTMENTS.—Any member
2 appointed to fill a vacancy shall serve for the re-
3 mainder of the term for which the predecessor of the
4 member was appointed.

5 (3) REAPPOINTMENT.—The President may re-
6 appoint an appointed member of the Board for a
7 second term in the same manner as the original ap-
8 pointment.

9 (d) CHAIRPERSON AND VICE CHAIRPERSON.—The
10 Board shall select a Chairperson and a Vice Chairperson
11 from among the members of the Board.

12 (e) COMPENSATION.—Members of the Board shall be
13 compensated at a level comparable to level II of the Execu-
14 tive Schedule, in accordance with section 5313 of title 5,
15 United States Code.

16 (f) STAFF.—The Board shall employ such staff as the
17 Board may determine necessary.

18 (g) APPLICABILITY OF CIVIL SERVICE PROVI-
19 SIONS.—The staff of the Board may be appointed without
20 regard to the provisions of title 5, United States Code,
21 governing appointments in the competitive service and be
22 compensated without regard to the provisions of chapter
23 51, and subchapter III of chapter 53 of title 5 relating
24 to classification and General Schedule pay rates, except
25 that no individual may receive pay less than 120 percent

1 of the minimum rate of basic pay payable for GS-15 of
2 the General Schedule or more than the rate of basic pay
3 payable for level IV of the Executive Schedule.

4 (h) DUTIES.—

5 (1) IN GENERAL.—The Board is responsible for
6 the overall administration of this Act, including such
7 duties specifically designated by this Act.

8 (2) ADDITIONAL DUTIES.—The duties of the
9 Board also include—

10 (A) facilitating the exchange of informa-
11 tion among States,

12 (B) establishing, evaluating, and updating
13 national minimum quality standards,

14 (C) establishing uniform reporting require-
15 ments,

16 (D) developing a uniform claims form,

17 (E) reviewing and approving interstate
18 consortia,

19 (F) assisting States in developing systems
20 to minimize fragmented care, and

21 (G) developing and evaluating activities
22 combating fraud and abuse within the health
23 care system.

24 (i) REPORTS.—

1 (1) INITIAL REPORT.—Not later than January
2 1, 1996, the Board shall report to the Congress re-
3 garding the implementation of the program estab-
4 lished under this Act, including any recommenda-
5 tions for further implementing legislation.

6 (2) ANNUAL REPORTS.—Beginning January 1,
7 1997, the Board shall annually report to Congress
8 on the status of expenditures under this Act and the
9 long-range plans and goals of the Board for the or-
10 ganization and delivery of health care services and
11 long-term care services under this Act.

12 **SEC. 302. FEDERAL HEALTH ADVISORY COUNCIL.**

13 (a) APPOINTMENT.—Not later than January 1, 1995,
14 the Board shall provide for appointment of a Federal
15 Health Advisory Council to advise the Board on its activi-
16 ties.

17 (b) MEMBERSHIP.—Such Advisory Council shall con-
18 sist of 15 members who are representatives of consumers,
19 providers, unions, health care experts, senior citizen
20 groups, public health officials, experts in long-term care,
21 rural health care and mental illness, and other individuals
22 with an interest in the health care system. Such members
23 shall serve for terms of 3 years, except that, in the initial
24 appointment, 5 members shall be each appointed for terms
25 of 1-year, 2-years, and 3-years.

1 (c) VACANCIES.—

2 (1) IN GENERAL.—The Board shall fill any va-
3 cancy in the membership of the Advisory Council in
4 the same manner as the original appointment. The
5 vacancy shall not affect the power of the remaining
6 members to execute the duties of the Advisory Coun-
7 cil.

8 (2) VACANCY APPOINTMENTS.—Any member
9 appointed to fill a vacancy shall serve for the re-
10 mainder of the term for which the predecessor of the
11 member was appointed.

12 (3) REAPPOINTMENT.—The Board may re-
13 appoint an appointed member of the Advisory Coun-
14 cil for a second term in the same manner as the
15 original appointment.

16 (d) CHAIRPERSON AND VICE CHAIRPERSON.—The
17 Advisory Council shall select a Chairperson and a Vice
18 Chairperson from among the members of the Advisory
19 Council.

20 (e) COMPENSATION.—All members of the Advisory
21 Council shall be reimbursed by the Board for travel and
22 per diem in lieu of subsistence expenses during the per-
23 formance of duties of the Advisory Council in accordance
24 with subchapter I of chapter 57 of title 5, United States
25 Code.

1 (f) FACA NOT APPLICABLE.—The provisions of the
2 Federal Advisory Committee Act shall not apply to the
3 Advisory Council.

4 (g) DUTIES.—The Advisory Council shall conduct
5 studies and make recommendations to the Board on the
6 overall functioning of the program established under this
7 Act and consumer and provider satisfaction with such pro-
8 gram.

9 **SEC. 303. FEDERAL HEALTH PRIORITIES COUNCIL.**

10 (a) IN GENERAL.—There is hereby established a
11 Federal Health Priorities Council.

12 (b) APPOINTMENT AND TERMS OF MEMBERS.—

13 (1) APPOINTMENT.—The Priorities Council
14 shall be composed of 15 individuals appointed by the
15 President, with the advice and consent of the Sen-
16 ate, not later than October 1, 1994. Such individuals
17 shall be representatives from the fields of medicine,
18 dentistry, mental health care, nursing, social serv-
19 ices, ethics, economics, business, and consumer
20 groups.

21 (2) TERMS OF MEMBERS.—The individuals ap-
22 pointed shall serve for a term of 5 years, except that
23 the terms of individuals initially appointed shall be
24 (as specified by the President) for such fewer num-

1 ber of years as will provide for the expiration of
2 terms on a staggered basis.

3 (c) VACANCIES.—

4 (1) IN GENERAL.—The President shall fill any
5 vacancy in the membership of the Priorities Council
6 in the same manner as the original appointment.
7 The vacancy shall not affect the power of the re-
8 maining members to execute the duties of the Prior-
9 ities Council.

10 (2) VACANCY APPOINTMENTS.—Any member
11 appointed to fill a vacancy shall serve for the re-
12 mainder of the term for which the predecessor of the
13 member was appointed.

14 (3) REAPPOINTMENT.—The President may re-
15 appoint an appointed member of the Priorities
16 Council for a second term in the same manner as
17 the original appointment.

18 (d) PRESIDENT AND VICE PRESIDENT.—The Prior-
19 ities Council shall select a President and a Vice President
20 from among the members of the Priorities Council.

21 (e) COMPENSATION.—Members of the Priorities
22 Council shall be compensated at a level comparable to level
23 II of the Executive Schedule, in accordance with section
24 5313 of title 5, United States Code.

1 (f) STAFF.—The Priorities Council shall employ such
2 staff as the Priorities Council may determine necessary.

3 (g) APPLICABILITY OF CIVIL SERVICE PROVI-
4 SIONS.—The staff of the Priorities Council may be ap-
5 pointed without regard to the provisions of title 5, United
6 States Code, governing appointments in the competitive
7 service and be compensated without regard to the provi-
8 sions of chapter 51, and subchapter III of chapter 53 of
9 title 5 relating to classification and General Schedule pay
10 rates, except that no individual may receive pay less than
11 120 percent of the minimum rate of basic pay payable for
12 GS-15 of the General Schedule or more than the rate of
13 basic pay payable for level IV of the Executive Schedule.

14 (h) COMMITTEES.—The Priorities Council may estab-
15 lish such committees of its members and other medical,
16 economic, or health services advisers as it determines to
17 be necessary to assist the Priorities Council in the per-
18 formance of its duties.

19 (i) FUNCTIONS.—In order to build a consensus on the
20 values to be used to guide health resource decisions, the
21 Priorities Council shall have the following functions:

22 (1) Conduct public hearings and solicit testi-
23 mony and information from advocates for children,
24 senior citizens, the disabled, consumers of mental

1 health services, low-income people, providers of
2 health care, business leaders, and others.

3 (2) Building on outcomes research and the de-
4 velopment of practice guidelines, conduct studies and
5 make recommendations for how health care dollars
6 should be allocated in the context of a publicly fund-
7 ed national health insurance plan.

8 (j) REPORTS.—The Priorities Council shall report to
9 the Board a list of health services ranked by priority, from
10 the most important to the least important, representing
11 the comparative benefits of each service to the Nation's
12 population. The recommendation shall be accompanied by
13 a report of an independent actuary retained for the Board
14 to determine rates necessary to cover the costs of the in-
15 cluded services in order to establish an appropriate annual
16 global budget. The recommendation is to be used in evalu-
17 ating and modifying the health care services and the long-
18 term care services covered under this Act. The reports
19 from the Priorities Council to the Board are to be submit-
20 ted by January 31 of 1996 (and of each subsequent year),
21 to be acted on by the Board by the following January 31.

22 **SEC. 304. AUTHORIZATION OF APPROPRIATIONS.**

23 There are authorized to be appropriated such sums
24 as are necessary for the establishment and operation of

1 the Board, Advisory Council, and Priorities Council to
2 carry out the purposes of this Act.

3 **Subtitle B—State Administration**

4 **SEC. 311. STATE PROGRAMS.**

5 (a) SUBMISSION OF PROGRAMS.—

6 (1) IN GENERAL.—Not later than October 1,
7 1996, each State shall submit to the Board the
8 State program in the State.

9 (2) REGIONAL PROGRAMS.—Any State may join
10 with neighboring States to submit to the Board a re-
11 gional program in lieu of a State program, as de-
12 scribed in section 314.

13 (b) REVIEW AND APPROVAL OF PROGRAMS.—The
14 Board shall review programs submitted under subsection
15 (a) and determine whether such programs meet the re-
16 quirements for approval, not later than October 1, 1997.
17 The Board shall not approve such a program unless it
18 finds that the program provides, consistent with the provi-
19 sions of this Act, for—

20 (1) adequate financing of health care services
21 and long-term care services covered under this Act
22 through a designated fund, including the annual
23 submission of the State program budget to the
24 Board,

1 (2) adequate administration, including the des-
2 ignation of a single nonprofit State agency respon-
3 sible for administration of the program, and suffi-
4 cient provisions to ensure against fraud and abuse,

5 (3) the establishment of—

6 (A) an institution reimbursement negotia-
7 tion board to negotiate global operating, capital,
8 and health training budgets with hospitals and
9 other health care and long-term care institu-
10 tions,

11 (B) a practitioner reimbursement negotia-
12 tion board (with membership including State
13 government representatives, consumers, general
14 practice physicians, specialists, and
15 nonphysician practitioners) to negotiate reim-
16 bursement rates for participating providers, and

17 (C) at the State's option, a State advisory
18 board (with broad representation of health pol-
19 icy experts, institutional providers, practition-
20 ers, and consumers) to generally oversee and re-
21 view the performance of the State program,

22 (4) assurances that individuals have the free-
23 dom to choose practitioners and other health care
24 providers for services covered under this Act, and

1 (5) an organized grievance procedure available
2 to consumers through which complaints about the
3 organization and administration of the State pro-
4 gram may be filed, heard, and resolved.

5 (c) OPERATIONAL STATUS.—A State program in a
6 State shall not be considered operational unless it is ap-
7 proved and remains approved under subsection (b).

8 (d) FAILURE TO COMPLY WITH THIS ACT.—When-
9 ever the Board, after reasonable notice and opportunity
10 for hearing to the designated State agency finds that in
11 the administration of the State program there is a failure
12 to comply with any provision of this Act, the Board may—

13 (1) withhold further payments to the State
14 under section 402 and may limit such withholding to
15 specific portions of such program affected by the
16 failure, or

17 (2) place the State program, or specific portions
18 of such program, in receivership under the jurisdic-
19 tion of the Board,
20 until such failure has been corrected.

21 (e) JUDICIAL REVIEW.—

22 (1) IN GENERAL.—If any State is dissatisfied
23 with the Board's action in denying approval of such
24 State's program or finding a failure under sub-
25 section (d) with respect to such program, such State

1 may, within 60 days after notice of such action, file
2 with the United States court of appeals for the cir-
3 cuit in which such State is located a petition for re-
4 view of that action. A copy of the petition shall be
5 forthwith transmitted by the clerk of the court to
6 the Board. The Board thereupon shall file in the
7 court the record of the proceedings upon which the
8 Board's action was based, as provided in section
9 2112 of title 28, United States Code.

10 (2) FINDINGS OF FACT.—The findings of fact
11 by the Board, if supported by substantial evidence,
12 shall be conclusive; but the court, for good cause
13 shown, may remand the case to the Board to take
14 further evidence, and the Board may thereupon
15 make new or modified findings of fact and may mod-
16 ify the Board's previous action, and shall file in the
17 court the record of the further proceedings. Such
18 new or modified findings of fact shall likewise be
19 conclusive if supported by substantial evidence.

20 (3) JURISDICTION OF COURT.—Upon the filing
21 of such petition, the court shall have jurisdiction to
22 affirm the action of the Board or to set it aside, in
23 whole or in part. The judgment of the court shall be
24 subject to review by the Supreme Court of the Unit-

1 ed States upon certiorari or certification as provided
2 in section 1254 of title 28, United States Code.

3 **SEC. 312. USE OF FISCAL INTERMEDIARIES.**

4 (a) IN GENERAL.—Each State program may contract
5 with fiscal intermediaries in a process of competitive bid-
6 ding.

7 (b) ROLE OF FISCAL INTERMEDIARY.—

8 (1) IN GENERAL.—Subject to paragraph (2)
9 and under continuous State oversight, the fiscal
10 intermediary shall process claims and reimburse-
11 ments, distribute the allocation of funds as specified
12 in agreements on global operating budgets, and as-
13 sume general responsibility for the administration of
14 the State program.

15 (2) LIMITATION.—The fiscal intermediary may
16 not participate in, nor administer, the negotiating
17 processes used to establish global operating budgets
18 or practitioner reimbursement rates.

19 (c) TYPE OF ORGANIZATION.—The fiscal
20 intermediary may be any type of entity designated by the
21 State, including nonprofit associations and private compa-
22 nies, as long as the State or regional program provides
23 for public accountability. Such accountability may include
24 review of the operations of the fiscal intermediary by the
25 State advisory board.

1 **SEC. 313. STATE WAIVERS; MANAGED CARE.**

2 (a) STATE WAIVERS.—A State program shall be al-
3 lowed to obtain waivers from the Board—

4 (1) to implement alternative and innovative—

5 (A) methods of reimbursing health care
6 providers,

7 (B) patient cost-sharing arrangements,
8 and

9 (C) administrative structures, and

10 (2) to provide the services covered under this
11 Act through the use of health plans paid through a
12 capitation method in order to allow the freedom of
13 choice of all eligible individuals in the selection of a
14 health plan.

15 In approving any waiver the Board shall assure itself that
16 the State program otherwise complies with the require-
17 ments of this Act that are not inconsistent with the grant-
18 ing of such waiver.

19 (b) MANAGED CARE OPTION.—No provision of this
20 Act shall be construed to prohibit or discourage any State
21 from developing, or contracting with, managed care net-
22 works for the purpose of delivering services covered under
23 this Act of a higher quality and in a more cost-effective
24 manner, as long as such networks otherwise meet the re-
25 quirements of this Act.

1 (c) ORGANIZED APPROACHES TO DELIVERY OF
2 SERVICES.—The Board shall sponsor efforts to encourage
3 States and providers of services to develop and expand or-
4 ganized approaches to the delivery of health care services
5 covered under this Act, including health maintenance or-
6 ganizations, hospital-based and community-oriented team
7 health services, and neighborhood-hospital-home health
8 care plans.

9 **SEC. 314. STATE REGIONAL CONSORTIA.**

10 (a) IN GENERAL.—Any group of States may enter
11 into an agreement to establish a regional consortium for
12 the purposes of implementing a program to be approved
13 by the Board under section 311. Such regional consortium
14 shall have jurisdiction over all States that are parties to
15 such agreement and that shall be subject to the provisions
16 of section 311 as if such consortium were established by
17 a single State.

18 (b) CONSORTIUM AGREEMENT.—Any agreement to
19 establish a State regional consortium shall, in addition to
20 providing for the requirements specified in section 311(b),
21 provide for—

22 (1) a mechanism to resolve any disputes be-
23 tween or among the States that are parties to the
24 agreement, and

1 (2) the collection of data and information con-
2 cerning the operations of the consortium and the
3 submission of such data and information to the
4 Board on an annual basis.

5 (c) CONGRESSIONAL REVIEW.—Any consortium
6 agreement described in this section which has been ap-
7 proved by the Board, shall be submitted to the Congress
8 and shall be considered in effect, unless within 60 days
9 of the submission of the agreement, the Congress enacts
10 a disapproval resolution under the procedures described
11 in section 501.

12 **SEC. 315. GRANTS TO STATES.**

13 (a) IN GENERAL.—The Board shall make grants (in-
14 cluding cooperative agreements) available to States for
15 funding programs and for research designed to prevent or
16 minimize the high costs of health care, to treat illness,
17 disease, or medical conditions created by conditions in the
18 environment or workplace, and to promote health and
19 wellness.

20 (b) SPECIFIC PROGRAM AREAS.—Grants under this
21 section shall be awarded for initiatives in the areas of—

22 (1) environmental health, and

23 (2) health promotion and disease prevention.

1 (c) REQUESTS FOR PROPOSALS.—The Board shall
2 issue periodic requests each year for proposals for grants
3 under this section.

4 **SEC. 316. TECHNICAL ASSISTANCE TO STATES.**

5 (a) GRANTS.—

6 (1) IN GENERAL.—Not later than October 1,
7 1995, the Board shall award a grant to each State
8 or group of States to assist in paying the costs asso-
9 ciated with the establishment and initial operation of
10 the State plan or the State regional consortium
11 agreement.

12 (2) AMOUNTS.—Not less than \$500,000 shall
13 be provided to each State or group of States under
14 a grant awarded under paragraph (1), and any
15 State or group of States shall remit to the Trust
16 Fund any unspent amount of such grant at the end
17 of the 2-year period beginning with the date of the
18 awarding of such grant.

19 (3) PLANNING FUNCTIONS.—Amounts provided
20 under grants awarded under paragraph (1) shall be
21 utilized for planning functions only.

22 (4) STUDY.—Not later than October 1, 1998,
23 the Board shall prepare and submit to the appro-
24 priate committees of Congress, a report that shall
25 contain the results of a study conducted by the

1 Board concerning the use of the grants awarded
2 under paragraph (1), and whether such use was ef-
3 fective preparing State plans and State regional con-
4 sortia agreements and simplifying administrative
5 procedures.

6 (b) TECHNICAL ASSISTANCE.—The Board shall pro-
7 vide technical assistance to States in developing State
8 plans and State regional consortia agreements.

9 (c) AUTHORIZATION OF APPROPRIATIONS.—There
10 are authorized to be appropriated such sums as may be
11 necessary to carry out this section.

12 **TITLE IV—FINANCING**

13 **Subtitle A—Health Budgets**

14 **SEC. 401. NATIONAL HEALTH BUDGET.**

15 (a) IN GENERAL.—

16 (1) ANNUAL BUDGETS.—Except as provided in
17 paragraph (2), the Board shall establish an annual
18 fiscal year budget of expenditures that estimates the
19 total expenditures to be made in such fiscal year by
20 the Federal Government and States for health care
21 services and long-term care services covered under
22 this Act, including the administrative costs associ-
23 ated with such services.

1 (2) BIENNIAL BUDGETS.—The Board may es-
2 tablish biennial fiscal year budgets in lieu of annual
3 budgets.

4 (b) NATIONAL AVERAGE PER CAPITA COSTS.—

5 (1) IN GENERAL.—At least 6 months before the
6 beginning of the first fiscal year of the program
7 under this Act, the Board shall compute the national
8 average per capita cost for each of the services de-
9 scribed in subsection (a) using data the Board
10 deems to be appropriate.

11 (2) ADJUSTMENTS FOR RISK GROUPS.—

12 (A) IN GENERAL.—The Board shall de-
13 velop an adjustment factor to the national aver-
14 age per capita costs computed under paragraph
15 (1) for each risk group (as designated under
16 subparagraph (B)) to reflect the national aver-
17 age per capita costs for that risk group.

18 (B) RISK GROUPS.—The Board shall des-
19 ignate a series of risk groups, determined by
20 age, sex, and other factors that represent dis-
21 tinct patterns of health care services and long-
22 term care services utilization and costs.

23 (3) STATE ADJUSTMENTS TO NATIONAL AVER-
24 AGE PER CAPITA COSTS.—The Board shall develop

1 for each State a factor to adjust the national aver-
2 age per capita costs for each risk group to reflect—

3 (A) average labor and nonlabor costs that
4 are necessary to produce the services described
5 in subsection (a),

6 (B) any special social, environmental, epi-
7 demiological, or other condition affecting health
8 status or the need for health care services and
9 long-term care services,

10 (C) the geographic distribution of the
11 State's population, particularly the proportion
12 of the population residing in rural or medically
13 underserved areas,

14 (D) the quality and availability of the
15 State's existing health care resources needed for
16 delivering health care services and long-term
17 care services, and

18 (E) any other economic, geographic, and
19 sociologic factors.

20 (c) STATE TOTAL EXPENDITURES.—The Board shall
21 compute for each State total projected expenditures in the
22 next fiscal year for each of the services described in sub-
23 section (a), by multiplying—

24 (1) the national average per capita costs of each
25 risk group designated in subsection (b)(2)(B), by

1 (2) the product of the State adjustment factors
2 described in subsection (b)(3) and the number of
3 persons in the State estimated by the Bureau of the
4 Census to be resident members of each risk group
5 at the beginning of the next fiscal year.

6 (d) FEDERAL CONTRIBUTIONS.—

7 (1) IN GENERAL.—The Board shall determine
8 the appropriate Federal contribution for each State,
9 constituting the Federal percentage share of each
10 State's total projected expenditures for the services
11 described in section (a). The Federal share shall be
12 determined by subtracting the State share from 100
13 percent of the total projected expenditures for such
14 State (as described under subsection (c)), but in no
15 event shall such Federal contribution be less than 75
16 percent nor more than 85 percent of such expendi-
17 tures. The Federal share for all States shall equal
18 80 percent of the aggregate of such expenditures for
19 all States.

20 (2) ADJUSTMENTS IN STATE SHARE.—In deter-
21 mining each State share, the Board shall develop a
22 formula that considers a State's—

23 (A) per capita income,

24 (B) total taxable resources,

1 (C) economic performance relative to the
2 national economy as it affects the availability of
3 taxable resources, and

4 (D) other relevant economic and demo-
5 graphic indicators.

6 (e) SUBSEQUENT CALCULATIONS.—For each subse-
7 quent fiscal year, the Board shall recompute under sub-
8 sections (a), (b), (c), and (d) at least 6 months before the
9 beginning of such fiscal year. In making such a recom-
10 putation, the Board shall take into account—

11 (1) changes in medical technology, outcomes re-
12 search evidence concerning the efficacy and safety of
13 health care services and long-term care services,
14 needs for health personnel, professional practice
15 guidelines, and changing health care priorities, after
16 reviewing recommendations of the Advisory Council
17 and the Priorities Council, and

18 (2) changes in the services described in sub-
19 section (a) under regulations promulgated by the
20 Board and accepted by the Congress under section
21 204.

22 (f) EFFECT OF BOARD ACTIONS.—Any determina-
23 tion made by the Board under this section with respect
24 to any fiscal year shall be submitted to the Congress at
25 least 6 months before the beginning of such fiscal year,

1 and shall have the force of law, unless within 60 days of
2 the submission of such determination, the Congress enacts
3 a disapproval resolution under the procedures described
4 in section 501.

5 **SEC. 402. PAYMENTS TO STATES.**

6 (a) IN GENERAL.—For each fiscal year, each State
7 with a State program approved under section 311, is enti-
8 tled to receive (subject to section 311(d)), from amounts
9 in the Trust Fund, a Federal contribution in an amount
10 equal to the product of—

11 (1) the Federal share for such State (computed
12 under section 401(d), and

13 (2) such State’s total projected expenditures
14 (computed under section 401(c)).

15 (b) USE OF DEDICATED FUNDS.—

16 (1) IN GENERAL.—All revenues, including the
17 Federal contribution and State revenues provided to
18 finance a State program under this Act shall be allo-
19 cated to a dedicated fund specified by the State.
20 Payments for health care services and long-term
21 care services covered under this Act shall be made
22 from such fund.

23 (2) SPECIAL ACCOUNTS.—Each State shall es-
24 tablish within its designated fund special accounts,
25 the amount of revenues deposited in each to be de-

1 terminated by the State. The various special accounts
2 shall include the following:

3 (A) An Institutional Global Operating
4 Budget Account shall be used to fund total ex-
5 penditures for the operating costs of hospitals
6 and other health care and long-term care insti-
7 tutions, allocated according to the method spec-
8 ified in section 411(b).

9 (B) An Institutional Capital Account shall
10 be used to fund total expenditures for capital-
11 related items in hospitals and other health care
12 and long-term care institutions, allocated ac-
13 cording to the method specified in section
14 411(c).

15 (C) A Health Training Account shall be
16 used to fund direct and indirect graduate medi-
17 cal education in hospitals and other health care
18 and long-term care institutions to cover excess
19 operating and capital costs associated with
20 teaching and related research activities, allo-
21 cated according to the method specified in sec-
22 tion 411(d).

23 (D) A Practitioner Reimbursement Ac-
24 count shall be used to fund the reimbursement
25 of services provided by health care practitioners,

1 allocated according to the method specified in
2 section 412.

3 **SEC. 403. STATE PROGRAM BUDGETS.**

4 (a) IN GENERAL.—Each State program shall estab-
5 lish an annual fiscal year State program budget which pro-
6 vides for—

7 (1) the total expenditures to be made under the
8 State program in such fiscal year for health care
9 services and long-term care services covered under
10 this Act (including administrative and associated
11 costs), and

12 (2) the revenues to meet such expenditures.

13 (b) COORDINATION.—Each State program budget
14 shall be coordinated, in a manner specified by the Board,
15 with the national health budget established under section
16 401(a).

17 (c) STATE SHARE.—

18 (1) IN GENERAL.—Each State program shall
19 cover the State share of program costs through the
20 use of tax revenues and other financing methods al-
21 lowed under section 424.

22 (2) ADDITIONS TO STATE SHARE.—Each State
23 shall raise the revenues necessary to cover at least
24 the State share specified in the national health
25 budget established by the Board (computed under

1 section 401(d)). Each State is permitted to raise ad-
2 ditional revenues and to increase such State's health
3 program expenditures beyond the amount specified
4 in the State share specified for the national health
5 budget—

6 (A) to cover the costs of benefits for health
7 care services or long-term care services the
8 State program authorizes in addition to the
9 services covered in this Act or as amended by
10 the Board and the Congress,

11 (B) to provide for increased global operat-
12 ing, capital, or health training budgets for hos-
13 pitals and other health care and long-term care
14 institutions,

15 (C) to provide for any unexpected increase
16 in health care costs identified by the State pro-
17 gram, and

18 (D) for other purposes that may be identi-
19 fied by the Board.

20 (d) BARRIERS TO ACCESS PROHIBITED.—No State,
21 either by intention or as an unstated consequence of budg-
22 et allocations, may restrict or cause to be restricted timely
23 access to the medically necessary and appropriate health
24 care services and long-term care services covered under

1 this Act, or permit queues for services to form that have
2 the potential of being life threatening.

3 (e) ANNUAL PUBLICATION.—The State program
4 shall provide for the publication annually of the most re-
5 cent State program budget established under this section.

6 **Subtitle B—Payments to Providers**

7 **SEC. 411. PAYMENTS TO HOSPITALS AND OTHER HEALTH** 8 **CARE AND LONG-TERM CARE INSTITUTIONS.**

9 (a) IN GENERAL.—Each State program shall be re-
10 sponsible for—

11 (1) allocating from the State program budget
12 the aggregate amount of money to be directed to
13 hospitals and other health care and long-term care
14 institutions for the global operating, capital, and
15 health training budgets of such institutions, and

16 (2) devising mechanisms for the allocation from
17 such budget of capital expenditures in non-institu-
18 tional settings.

19 (b) GLOBAL BUDGETS FOR OPERATING EXPENSES
20 FOR HOSPITALS AND OTHER HEALTH CARE AND LONG-
21 TERM CARE INSTITUTIONS.—The following principles
22 shall guide a State institution reimbursement negotiation
23 board in negotiating institutional global operating budg-
24 ets:

1 (1) Each State program budget shall include a
2 separate account for global operating expenses to
3 provide for total State expenditures for the operat-
4 ing expenses of hospitals and other health care and
5 long-term care institutions.

6 (2) Payment shall be based on an annual pro-
7 spective global budget for operating expenses sub-
8 mitted by an institution, in a manner specified by
9 the State program, to the agency designated by the
10 State program.

11 (3) The budgets shall take into account
12 amounts that are reasonable and necessary in the ef-
13 ficient provision of necessary hospital and other in-
14 stitutional services covered under this Act.

15 (4) The operating budgets shall not include
16 capital-related and health training expenses.

17 (5) Adjustments may later be made in the
18 budget to reflect significant changes in the volume
19 or types of services assumed in the approval of the
20 budget.

21 (6) A State should encourage innovation by per-
22 mitting any institution to include in its budget for
23 the immediate year any programs designed to in-
24 crease efficiency in later years, if those improve-

1 ments can be demonstrated to the satisfaction of the
2 designated State agency.

3 (c) CAPITAL BUDGETS FOR HOSPITALS AND OTHER
4 HEALTH CARE AND LONG-TERM CARE INSTITUTIONS.—
5 The following principles shall guide a State institution re-
6 imbursement negotiation board in negotiating institutional
7 capital budgets:

8 (1) Each State program budget shall include a
9 separate account for capital expenses to provide for
10 total State expenditures for the capital-related items
11 in hospitals and other health care and long-term
12 care institutions.

13 (2) Each State program budget shall specify
14 the general manner in which such expenditures for
15 capital-related items are to be distributed among dif-
16 ferent types of institutions and the different areas of
17 the State to take into account the need for capital
18 expenditures throughout the State.

19 (3) Capital expenditures are those authorized
20 by the State for the provision of insured health serv-
21 ices, regardless of whether the source of funds for
22 the capital expenditure is derived from accumulated
23 depreciation charges, operating surpluses or retained
24 earnings, expenditure of accumulated fund balances,
25 issuance of bonds, notes, debentures or other evi-

1 dence of indebtedness, borrowed funds, or any other
2 source including equity capitalization.

3 (4) Unless otherwise provided in this Act re-
4 garding underserved areas, or waived by the des-
5 ignated State agency if necessary to provide equi-
6 table resource allocation and access to quality care,
7 hospitals and other health care and long-term care
8 institutions shall furnish a 15 percent match for
9 funds allocated from the Institutional Capital Ac-
10 count of the budget.

11 (d) HEALTH TRAINING FOR HOSPITALS AND OTHER
12 HEALTH CARE AND LONG-TERM CARE INSTITUTIONS.—
13 The following principles shall guide a State institution re-
14 imbursement negotiation board in negotiating institutional
15 health training budgets:

16 (1) Each State program budget shall include a
17 separate account for direct and indirect graduate
18 medical education-related expenses in hospitals and
19 other health care and long-term care institutions.

20 (2) Each state program budget shall specify the
21 general manner in which such expenditures for di-
22 rect and indirect graduate medical education are to
23 be distributed among different types of institutions
24 and the different areas of the State.

1 (3) The distribution of funds to hospitals and
2 other health care and long-term care institutions
3 from the Health Training Account must conform to
4 the following principles:

5 (A) At least 50 percent of the funding
6 from the Health Training Account is to be di-
7 rected to primary care training programs.

8 (B) For each 5-year period beginning after
9 the date which is 5 years after the date of the
10 enactment of this Act, the Advisory Board will
11 evaluate the required minimum percentage of
12 funds that States must direct to primary care
13 and recommend whether the percentage should
14 be changed to ensure consistency with the goal
15 of encouraging primary care residency training
16 programs.

17 (C) The State is to develop a methodology
18 for funding nonhospital-based residency pro-
19 grams and to establish opportunities for
20 residencies in community-based health care fa-
21 cilities.

22 (D) The distribution of funds from the
23 Health Training Account must take into ac-
24 count the potentially higher costs of placing
25 medical students in rural residency programs.

1 (E) The distribution of funds from the
2 Health Training Account must accommodate
3 the education and training needs of
4 nonphysician practitioners.

5 **SEC. 412. PAYMENTS FOR PRACTITIONERS SERVICES.**

6 The State practitioner reimbursement negotiation
7 board shall negotiate with the State organizations rep-
8 resenting each of the practitioner disciplines in order to
9 derive a relative value scale fee schedule that fulfills each
10 of the following principles:

11 (1) Appropriate levels of payment are provided
12 primary care services, including general, family, and
13 preventive procedures.

14 (2) The same compensation is given for the
15 same procedures even when performed by different
16 types of practitioners licensed to offer those proce-
17 dures.

18 (3) Reimbursement rates for different proce-
19 dures performed by practitioners in different dis-
20 ciplines reflect the relative value of those procedures.

21 (4) Urban and rural practitioners receive the
22 same reimbursement rates for the same services, un-
23 less the State determines that a differential rate is
24 required to increase the access to health care practi-
25 tioners in underserved areas.

1 (5) A process is established that keeps overall
2 reimbursements in line with the amount of funding
3 budgeted for practitioner reimbursements.

4 **SEC. 413. SPECIAL NONPHYSICIAN PRACTITIONER PROVI-**
5 **SIONS.**

6 The following principles shall guide the State practi-
7 tioner reimbursement negotiation board in negotiating re-
8 imbursement rates for nonphysician practitioners:

9 (1) When the same services covered under this
10 Act are provided by practitioners licensed by the
11 State, reimbursement rates for those same services
12 shall be the same regardless of the type of practi-
13 tioner providing such services.

14 (2) For procedures covered under this Act,
15 services provided by all practitioners licensed in the
16 State for those services are to be included in the re-
17 imbursement fee schedule.

18 **SEC. 414. MANDATORY ASSIGNMENT.**

19 (a) IN GENERAL.—Except with respect to patient
20 cost-sharing provisions under section 203 of this Act, no
21 individual shall be liable for payment of any amount for
22 health care services or long-term care services covered
23 under this Act, and payment by a State program shall con-
24 stitute payment in full for such services.

1 (b) ENFORCEMENT.—The State program shall apply
2 appropriate sanctions against the entity if such entity
3 knowingly and willfully charges for an item or service or
4 accepts payment in violation of subsection (a).

5 **Subtitle C—Revenues**

6 **SEC. 421. FEDERAL SOURCES OF REVENUES.**

7 (a) AMERICAN HEALTH SECURITY PLAN PRE-
8 MIUMS.—The Board, in consultation with the Secretary
9 of the Treasury, shall develop a mechanism for determin-
10 ing and collecting a premium from individuals and employ-
11 ers for health care services and long-term care services
12 covered under this Act, to be known as the American
13 Health Security Plan premium.

14 (b) DETERMINATION OF PREMIUM AMOUNT.—The
15 Board shall determine the American Health Security Plan
16 premium for each taxable year beginning after December
17 31, 1996, by estimating the total amount necessary to
18 equal the excess of—

19 (1) expenditures described in section 423(c) for
20 the fiscal year beginning in such taxable year, over

21 (2) receipts described in section 423(b) (other
22 than paragraph (1)) for such fiscal year.

23 (c) COLLECTION OF PREMIUM.—

24 (1) INDIVIDUALS.—The Board shall collect the
25 American Health Security Plan premium from indi-

1 viduals using a mechanism with the following char-
2 acteristics:

3 (A) Income-based (including earned and
4 unearned income).

5 (B) Progressive.

6 (C) Payable in increments during the
7 course of the year.

8 (D) Payable by individuals or by employers
9 on behalf of employees (at the option of the em-
10 ployer), as described in paragraph (2)(C).

11 (E) Subject to the provisions of subtitle F
12 of the Internal Revenue Code of 1986.

13 (2) EMPLOYERS.—The Board shall collect the
14 American Health Security Plan premium from em-
15 ployers using a mechanism with the following char-
16 acteristics:

17 (A) Aggregate employer contributions
18 would equal an amount necessary to prevent an
19 increase in the percentage of 1993 aggregate
20 household health care expenditures.

21 (B) Contribution rate based on each em-
22 ployer's ability to pay as indicated by factors
23 such as the size of the employer's workforce
24 and profitability.

1 (1) AMOUNTS RECEIVED.—Subsection (e) of
2 section 105 of the Internal Revenue Code of 1986
3 (relating to amounts received under accident and
4 health plans) is amended to read as follows:

5 “(e) ACCIDENT OR HEALTH INSURANCE.—For pur-
6 poses of this section, section 104, and section 106, the
7 term ‘accident or health insurance’ means an approved
8 State program under section 311 of the American Health
9 Security Plan Act of 1993.”.

10 (2) EMPLOYER CONTRIBUTIONS.—Section 106
11 of such Code (relating to contributions by employer
12 to accident and health plans) is amended by striking
13 “an accident or health plan” and inserting “accident
14 or health insurance”.

15 (3) CONFORMING AMENDMENT.—Section 105
16 of such Code is amended by striking subsection (h).

17 (b) BUSINESS EXPENSE DEDUCTION FOR HEALTH
18 INSURANCE.—Section 162 of the Internal Revenue Code
19 of 1986 (relating to trade or business expenses) is amend-
20 ed by redesignating subsection (m) as subsection (n) and
21 by inserting after subsection (l) the following new sub-
22 section:

23 “(m) GROUP HEALTH PLANS.—The expenses paid or
24 incurred by an employer for a group health plan shall not
25 be allowed as a deduction under this section unless the

1 plan is an approved State program under section 311 of
2 the American Health Security Plan Act of 1993.”.

3 (c) RULES RELATING TO DEDUCTIONS FOR INDIVID-
4 UALS.—

5 (1) SAME TREATMENT FOR SELF-EMPLOYED
6 INDIVIDUALS AND BUSINESSES.—Section 162(l) of
7 the Internal Revenue Code of 1986 (relating to spe-
8 cial rules for health insurance costs of self-employed
9 individuals) is amended—

10 (A) by striking “25 percent of” in para-
11 graph (1), and

12 (B) by striking paragraph (6).

13 (2) SIMILAR TREATMENT FOR OTHER INDIVID-
14 UALS.—Subsection (d) of section 213 of such Code
15 (relating to medical, dental, etc., expenses) is
16 amended—

17 (A) by striking paragraph (1) and insert-
18 ing the following new paragraph:

19 “(1) MEDICAL CARE.—The term ‘medical care’
20 means American Health Security Plan premiums
21 and cost-sharing amounts paid for coverage under
22 an approved State program under section 311 of the
23 American Health Security Plan Act of 1993.”,

24 (B) by striking paragraphs (2), (6), (7),
25 and (9), and by redesignating paragraphs (3),

1 (4), (5), and (8) as paragraphs (2), (3), (4),
2 and (5), respectively.

3 (d) TERMINATION OF CHILD HEALTH INSURANCE
4 CREDIT.—Clause (i) of section 32(b)(2)(A) of such Code
5 is amended by inserting “(0 percent for taxable years be-
6 ginning after December 31, 1999)” after “6 percent”.

7 (e) EFFECTIVE DATE.—The amendments made by
8 this section shall apply with respect to any taxable year
9 beginning after December 31, 1999.

10 **SEC. 423. FEDERAL HEALTH TRUST FUND.**

11 (a) TRUST FUND ESTABLISHED.—There is hereby
12 created on the books of the Treasury of the United States
13 a trust fund to be known as the “Federal Health Care
14 Trust Fund”. The Trust Fund shall consist of such gifts
15 and bequests as may be made and such amounts as may
16 be deposited in, or appropriated to, such Trust Fund as
17 provided in this Act.

18 (b) RECEIPTS.—

19 (1) TRANSFER OF AMOUNTS EQUIVALENT TO
20 CERTAIN TAXES.—

21 (A) IN GENERAL.—There are hereby ap-
22 propriated to the Trust Fund amounts equiva-
23 lent to 100 percent of the American Health Se-
24 curity Plan premiums received in the Treasury

1 as the result of the mechanism described in sec-
2 tion 421 of this Act.

3 (B) ADDITIONAL REVENUES.—There are
4 appropriated to the Trust Fund amounts equiv-
5 alent to the additional revenues received in the
6 Treasury as the result of the amendments made
7 by section 422 of this Act.

8 (C) TRANSFERS BASED ON ESTIMATES.—
9 The amounts appropriated by subparagraphs
10 (A) and (B) shall be transferred from time to
11 time (not less frequently than monthly) from
12 the general fund in the Treasury to the Trust
13 Fund, such amounts to be determined on the
14 basis of estimates by the Secretary of the
15 Treasury of the taxes and premiums, specified
16 in such subparagraphs, paid to or deposited
17 into the Treasury; and proper adjustments shall
18 be made in amounts subsequently transferred to
19 the extent prior estimates were in excess of or
20 were less than the taxes and premiums specified
21 in such subparagraphs.

22 (2) TRANSFER OF FUNDS.—All amounts, not
23 otherwise obligated, that remain in the Federal Hos-
24 pital Insurance Trust Fund and the Federal Supple-
25 mental Medical Insurance Trust Fund on the first

1 day of the fiscal year 2000 shall be transferred to
2 the Trust Fund.

3 (3) APPROPRIATION OF ADDITIONAL SUMS.—
4 For fiscal years beginning after September 30,
5 1999, there are hereby authorized to be appro-
6 priated, and are appropriated, to the Trust Fund
7 such additional sums as equal the amounts appro-
8 priated with respect to title XIX of the Social Secu-
9 rity Act, section 1079 of title 10, United States
10 Code (CHAMPUS), and chapter 89 of title 5, Unit-
11 ed States Code, as in effect for fiscal year 1999.
12 Such amount shall be adjusted each fiscal year by
13 the increase in the Consumer Price Index (as deter-
14 mined by the Department of Labor) for the previous
15 fiscal year.

16 (4) APPROPRIATION OF SUMS FOR ADMINISTRA-
17 TIVE COSTS.—For fiscal years 1995, 1996, and
18 1997, there are hereby authorized to be appro-
19 priated, and are appropriated, to the Trust Fund
20 such additional sums as may be required to make
21 expenditures referred to in subsection (c)(2).

22 (5) RETURNED GRANT FUNDS.—Any returned
23 grant funds as described in section 316(a)(2) of this
24 Act shall be transferred to the Trust Fund.

25 (c) EXPENDITURES.—

1 (1) TO STATES.—Payments in each fiscal year
2 to each State from the Trust Fund as determined
3 under section 402 are hereby authorized and appro-
4 priated.

5 (2) ADMINISTRATIVE EXPENSES AND
6 GRANTS.—There are hereby authorized and appro-
7 priated such sums as are necessary for the adminis-
8 trative expenses and grants described in sections
9 212(g), 304, 315, 316(c) and 803 of this Act for
10 each fiscal year.

11 (3) CONTINGENCY ACCOUNT.—There are here-
12 by authorized and appropriated such sums as deter-
13 mined necessary by the Board to cover unanticipated
14 events that affect the health care needs of individ-
15 uals described in section 101(a), to be available
16 without fiscal year limitation.

17 (d) INCORPORATION OF TRUST FUND PROVISIONS.—
18 The provisions of subsections (b) through (e) of section
19 1841 of the Social Security Act (42 U.S.C. 1395t), as in
20 effect on the day before the date of the enactment of this
21 Act, shall apply to the Trust Fund in the same manner
22 as such provisions apply to the Federal Supplemental
23 Medical Insurance Trust Fund, except that any reference
24 to the Secretary of Health and Human Services or the

1 Administrator of the Health Care Financing Administra-
2 tion shall be deemed a reference to the Board.

3 (e) TRUST FUND OFF-BUDGET.—The receipts and
4 disbursements of the Trust Fund and the taxes described
5 in subsection (b)(1) shall not be included in the totals of
6 the budget of the United States Government as submitted
7 by the President or of the congressional budget and shall
8 be exempt from any general budget limitation imposed by
9 statute on expenditures and net lending (budget outlays)
10 of the United States Government.

11 **SEC. 424. STATE SOURCES OF REVENUES.**

12 (a) IN GENERAL.—Each State shall be responsible
13 for establishing a financing program for the implementa-
14 tion of the State program in the State. Such financing
15 program may include—

16 (1) funds used to finance the State share of
17 medicaid under title XIX of the Social Security Act
18 as in effect on the day before the date described in
19 section 902(f) of this Act,

20 (2) State and local funding for public hospitals
21 and other indigent care programs, and

22 (3) State funding from general revenues, ear-
23 marked taxes, payroll taxes, sales taxes, and such
24 other measures consistent with this Act as the State
25 may provide.

1 (b) ON-GOING ENTITLEMENT.—Each State with a
2 State program approved by the Commission is entitled to
3 funding from the Commission in the amounts provided
4 under section 402.

5 **TITLE V—CONGRESSIONAL**
6 **CONSIDERATION**

7 **SEC. 501. RULES GOVERNING CONGRESSIONAL CONSIDER-**
8 **ATION.**

9 (a) RULES OF HOUSE OF REPRESENTATIVES AND
10 SENATE.—This section is enacted by the Congress—

11 (1) as an exercise of the rulemaking power of
12 the House of Representatives and the Senate, re-
13 spectively, and as such is deemed a part of the rules
14 of each House, respectively, but applicable only with
15 respect to the procedure to be followed in that
16 House in the case of disapproval resolutions de-
17 scribed in subsection (b), and supersedes other rules
18 only to the extent that such rules are inconsistent
19 therewith; and

20 (2) with full recognition of the constitutional
21 right of either House to change the rules (so far as
22 relating to the procedure of that House) at any time,
23 in the same manner and to the same extent as in
24 the case of any other rule of that House.

1 (b) TERMS OF THE RESOLUTION.—For purposes of
2 this Act, the term “disapproval resolution” means only a
3 joint resolution of the two Houses of the Congress, provid-
4 ing in—

5 (1) the matter after the resolving clause of
6 which is as follows: “That the Congress disapproves
7 the action of the Federal Health Board as submitted
8 by the Board on _____”,
9 the blank space being filled in with the appropriate
10 date; and

11 (2) the title of which is as follows: “Joint Reso-
12 lution disapproving the action of the Federal Health
13 Board”.

14 (c) INTRODUCTION AND REFERRAL.—On the day on
15 which the action of the Board is transmitted to the House
16 of Representatives and the Senate, a disapproval resolu-
17 tion with respect to such action shall be introduced (by
18 request) in the House of Representatives by the Majority
19 Leader of the House, for himself and the Minority Leader
20 of the House, or by Members of the House designated by
21 the Majority Leader of the House, for himself and the Mi-
22 nority Leader of the House, or by Members of the House
23 designated by the Majority Leader and Minority Leader
24 of the House; and shall be introduced (by request) in the
25 Senate by the Majority Leader of the Senate, for himself

1 and the Minority Leader of the Senate, or by Members
2 of the Senate designated by the Majority Leader and Mi-
3 nority Leader of the Senate. If either House is not in ses-
4 sion on the day on which such an action is transmitted,
5 the disapproval resolution with respect to such action shall
6 be introduced in the House, as provided in the preceding
7 sentence, on the first day thereafter on which the House
8 is in session. The disapproval resolution introduced in the
9 House of Representatives and the Senate shall be referred
10 to the appropriate committees of each House.

11 (d) AMENDMENTS PROHIBITED.—No amendment to
12 a disapproval resolution shall be in order in either the
13 House of Representatives or the Senate; and no motion
14 to suspend the application of this subsection shall be in
15 order in either House, nor shall it be in order in either
16 House for the Presiding Officer to entertain a request to
17 suspend the application of this subsection by unanimous
18 consent.

19 (e) PERIOD FOR COMMITTEE AND FLOOR CONSIDER-
20 ATION.—

21 (1) IN GENERAL.—Except as provided in para-
22 graph (2), if the committee or committees of either
23 House to which a disapproval resolution has been re-
24 ferred have not reported it at the close of the 45th
25 day after its introduction, such committee or com-

1 mittees shall be automatically discharged from fur-
2 ther consideration of the disapproval resolution and
3 it shall be placed on the appropriation calendar. A
4 vote on final passage of the disapproval resolution
5 shall be taken in each House on or before the close
6 of the 45th day after the disapproval resolution is
7 reported by the committees or committee of that
8 House to which it was referred, or after such com-
9 mittee or committees have been discharged from fur-
10 ther consideration of the disapproval resolution. If
11 prior to the passage by one House of a disapproval
12 resolution of that House, that House receives the
13 same disapproval resolution from the other House
14 then—

15 (A) the procedure in that House shall be
16 the same as if no disapproval resolution had
17 been received from the other House; but

18 (B) the vote on final passage shall be on
19 the disapproval resolution of the other House.

20 (2) COMPUTATION OF DAYS.—For purposes of
21 paragraph (1), in computing a number of days in ei-
22 ther House, there shall be excluded any day on
23 which the House is not in session.

24 (f) FLOOR CONSIDERATION IN THE HOUSE OF REP-
25 RESENTATIVES.—

1 (1) MOTION TO PROCEED.—A motion in the
2 House of Representatives to proceed to the consider-
3 ation of a disapproval resolution shall be highly priv-
4 ileged and not debatable. An amendment to the mo-
5 tion shall not be in order, nor shall it be in order
6 to move to reconsider the vote by which the motion
7 is agreed to or disagreed to.

8 (2) DEBATE.—Debate in the House of Rep-
9 resentatives on a disapproval resolution shall be lim-
10 ited to not more than 20 hours, which shall be di-
11 vided equally between those favoring and those op-
12 posing the disapproval resolution. A motion further
13 to limit debate shall not be debatable. It shall not
14 be in order to move to recommit a disapproval reso-
15 lution or to move to reconsider the vote by which a
16 disapproval resolution is agreed to or disagreed to.

17 (3) MOTION TO POSTPONE.—Motions to post-
18 pone, made in the House of Representatives with re-
19 spect to the consideration of a disapproval resolu-
20 tion, and motions to proceed to the consideration of
21 other business, shall be decided without debate.

22 (4) APPEALS.—All appeals from the decisions
23 of the Chair relating to the application of the Rules
24 of the House of Representatives to the procedure re-

1 lating to a disapproval resolution shall be decided
2 without debate.

3 (5) GENERAL RULES APPLY.—Except to the ex-
4 tent specifically provided in the preceding provisions
5 of this subsection, consideration of a disapproval res-
6 olution shall be governed by the Rules of the House
7 of Representatives applicable to other bills and reso-
8 lutions in similar circumstances.

9 (g) FLOOR CONSIDERATION IN THE SENATE.—

10 (1) MOTION TO PROCEED.—A motion in the
11 Senate to proceed to the consideration of a dis-
12 approval resolution shall be privileged and not debat-
13 able. An amendment to the motion shall not be in
14 order, nor shall it be in order to move to reconsider
15 the vote by which the motion is agreed to or dis-
16 agreed to.

17 (2) GENERAL DEBATE.—Debate in the Senate
18 on a disapproval resolution, and all debatable mo-
19 tions and appeals in connection therewith, shall be
20 limited to not more than 20 hours. The time shall
21 be equally divided between, and controlled by, the
22 Majority Leader and the Minority Leader or their
23 designees.

24 (3) DEBATE OF MOTIONS AND APPEALS.—De-
25 bate in the Senate on any debatable motion or ap-

1 peal in connection with a disapproval resolution shall
2 be limited to not more than 1 hour, to be equally di-
3 vided between, and controlled by, the mover and the
4 manager of the disapproval resolution, except that in
5 the event the manager of the disapproval resolution
6 is in favor of any such motion or appeal, the time
7 in opposition thereto, shall be controlled by the Mi-
8 nority Leader or his designee. Such leaders, or ei-
9 ther of them, may, from time under their control on
10 the passage of a disapproval resolution, allot addi-
11 tional time to any Senator during the consideration
12 of any debatable motion or appeal.

13 (4) OTHER MOTIONS.—A motion in the Senate
14 to further limit debate is not debatable. A motion to
15 recommit a disapproval resolution is not in order.

16 (h) POINT OF ORDER REQUIRING SUPERMAJORITY
17 FOR MODIFICATIONS TO ACTIONS ONCE APPROVED.—

18 (1) IN GENERAL.—It shall not be in order in
19 the House of Representatives or the Senate to con-
20 sider any amendment to the actions of the Federal
21 Health Board except as provided in paragraph (2).

22 (2) WAIVER.—The point of order described in
23 paragraph (1) may be waived or suspended in the
24 House of Representatives or the Senate only, by the

1 affirmative vote of three-fifths of the Members duly
2 chosen and sworn.

3 **TITLE VI—PRIVATE OPTIONS**

4 **SEC. 601. PRIVATE SUPPLEMENTAL INSURANCE.**

5 Except as provided in section 603, nothing in this Act
6 shall be construed to prohibit the purchase of private in-
7 surance that provides coverage of health care and long-
8 term care services supplementing the services covered
9 under this Act.

10 **SEC. 602. OPTION TO PURCHASE DUPLICATIVE PRIVATE IN-** 11 **SURANCE.**

12 Except as provided in section 603, nothing in this Act
13 shall be construed to prohibit the purchase of private in-
14 surance that provides coverage of health care and long-
15 term care services covered under this Act.

16 **SEC. 603. LIMITS ON PRIVATE INSURANCE.**

17 (a) IN GENERAL.—No insurer may issue a private
18 insurance policy if such policy provides coverage for the
19 cost-sharing requirements for health care services and
20 other non-long-term care services covered under this Act.

21 (b) CERTIFICATION OF NOTIFICATION.—At the time
22 of sale, the issuer of any private insurance policy shall se-
23 cure in writing a certification by the purchaser that the
24 purchaser has been informed of any duplication in cov-
25 erage of the services covered under this Act.

1 (c) REVIEW OF PRACTICES.—No later than 2 years
2 after the full implementation of the provisions of this Act,
3 the Comptroller General of the United States shall review
4 the practices of the private insurance industry and make
5 such recommendations as necessary to the Congress in
6 order to prevent fraud and abuse in the sale of duplicative
7 or supplemental private health insurance and to protect
8 the integrity of the American Health Security Plan.

9 (d) OBLIGATION TO PAY PREMIUM REMAINS.—The
10 purchase of any type of private health insurance policy
11 shall not relieve the purchaser of the payment of the
12 American Health Security Plan premium imposed under
13 section 421.

14 **TITLE VII—EXPANSION OF OUT-**
15 **COMES RESEARCH AND DE-**
16 **LIVERY OF SERVICES IN UN-**
17 **DESERVED AREAS**

18 **SEC. 701. EXPANSION OF OUTCOMES RESEARCH.**

19 Paragraph (1) of section 1142(i) of the Social Secu-
20 rity Act (42 U.S.C. 1320b–12(i)) is amended by striking
21 “and” at the end of subparagraph (D) and by striking
22 (E) and inserting the following:

23 “(E) \$225,000,000 for fiscal year 1994;

24 “(F) \$275,000,000 for fiscal year 1995;

25 and

1 “(G) \$325,000,000 for fiscal year 1996.”.

2 **SEC. 702. NATIONAL HEALTH SERVICE CORPS.**

3 (a) INCREASE IN AUTHORIZATION OF APPROPRIA-
4 TIONS.—There are authorized to be appropriated to carry
5 out subpart II of part D of title III of the Public Health
6 Services Act (42 U.S.C. 254d et seq.) for fiscal year 1994,
7 an amount equal to—

8 (1) the amount appropriated under such sub-
9 part for fiscal year 1993; and

10 (2) an additional amount equal to 40 percent of
11 the amount described in paragraph (1).

12 When making loans under such subpart, priority should
13 be given to students from schools that have primary care
14 programs and that stress underserved practices.

15 (b) COMMUNITY FINANCING PROGRAM.—Subpart II
16 of part D of title III of the Public Health Service Act
17 (42 U.S.C. 254d et seq.) is amended by inserting after
18 section 336A, the following new section:

19 **“SEC. 336B. COMMUNITY FINANCING PROGRAMS.**

20 “(a) ESTABLISHMENT.—The Secretary may award
21 grants under this section to local communities to enable
22 such communities to establish programs to finance the
23 health-related education of residents of such communities.

24 “(b) APPLICATION.—To be eligible to receive a grant
25 under subsection (a), a community shall prepare and sub-

1 mit to the Secretary an application, at such time, in such
2 manner and containing such information as the Secretary
3 may require.

4 “(c) USE.—A community that receives a grant under
5 subsection (a), shall use amounts received under such
6 grant to provide assistance to local residents with respect
7 to the health-related educational expenses of such resi-
8 dents. Such community shall not provide assistance under
9 a grant under this section to a local resident unless such
10 resident agrees to practice in a health-related field in such
11 community for not less than 4 years after graduation. In
12 providing assistance to such residents, the community
13 should give priority to residents attending schools that
14 have primary care programs and that stress underserved
15 practices.

16 “(d) AMOUNTS.—The amount of a grant awarded to
17 a community under this section shall not exceed 75 per-
18 cent of the cost to such community in administering and
19 implementing a community financing program under this
20 section.

21 “(e) AUTHORIZATION OF APPROPRIATIONS.—There
22 are authorized to carry out this section, \$10,000,000 for
23 each of the fiscal year 1994 through 1996.”.

1 **SEC. 703. COMMUNITY AND MIGRANT HEALTH CENTERS.**

2 Subpart I of part D of title III of the Public Health
3 Service Act (42 U.S.C. 254d et seq.) is amended by insert-
4 ing after section 330, the following new section:

5 **“SEC. 330A. NEW COMMUNITY AND MIGRANT HEALTH CEN-**
6 **TERS.**

7 “(a) NEW COMMUNITY AND MIGRANT HEALTH CEN-
8 TERS.—

9 “(1) IN GENERAL.—The Secretary shall award
10 grants to eligible entities to expand the availability
11 of comprehensive primary health services (as defined
12 in section 330(b)(1)) in medically underserved areas.

13 “(2) ELIGIBILITY.—To be eligible to receive a
14 grant under this section an entity shall—

15 “(A) be an entity that—

16 “(i) meets the requirements of section
17 329(a) or 330(a) for being a migrant or
18 community health center, though not a re-
19 cipient of a grant under either section;

20 “(ii) does not meet the requirements
21 of section 329(a) or 330(a) for being a mi-
22 grant or community health center, but that
23 provides assurances satisfactory to the Sec-
24 retary, including subsequent demonstrable
25 evidence, that such entity will meet the re-
26 quirements of either section not later than

1 2 years after receiving a grant under this
2 section;

3 “(iii) is eligible for a planning grant
4 under sections 329(c) or 330(c); or

5 “(iv) is able to provide a subset of the
6 required services, be able to prove that it
7 cannot meet the requirements of section
8 329(a) or 330(a), and demonstrate that it
9 is the most qualified entity in the service
10 area; and

11 “(B) prepare and submit to the Secretary
12 an application at such time, in such manner
13 and containing such information as the Sec-
14 retary may require.

15 “(b) EXPANSION OF CURRENT COMMUNITY AND MI-
16 GRANT HEALTH CENTERS.—

17 “(1) IN GENERAL.— Community and migrant
18 health centers in existence on the date of enactment
19 of this section may utilize any increase in revenue
20 experienced as a result of the increase in the number
21 of insured patients treated for the expansion of the
22 amounts and types of services furnished, to serve ad-
23 ditional patients or areas, or to promote the recruit-
24 ment, training or retention of personnel.

1 “(2) RECOMMENDATIONS.—Not later than 3
2 years after the date of enactment of this section, the
3 Secretary shall prepare and submit to the appro-
4 priate committees of Congress recommendations con-
5 cerning the provision of paragraph (1).

6 “(c) REPORT.—Not later than 3 years after the date
7 of enactment of this section, the Secretary shall prepare
8 and submit to the appropriate committees of Congress a
9 report concerning the need for further migrant and com-
10 munity health center primary care service capacity devel-
11 opment and recommendations concerning the appropriate
12 level of support needed for activities to address such ca-
13 pacity development.

14 “(d) AUTHORIZATIONS OF APPROPRIATIONS.—

15 “(1) IN GENERAL.—There are authorized to be
16 appropriated to carry out this section, \$300,000,000
17 for fiscal years 1994 through 1996.

18 “(2) ADDITIONAL AMOUNTS.—Amounts pro-
19 vided under this section shall be in addition to any
20 amounts appropriated under sections 329 and 330.”.

21 **TITLE VIII—MALPRACTICE**

22 **REFORM**

23 **SEC. 801. GRANTS TO STATES.**

24 (a) IN GENERAL.—The Board shall make grants to
25 States for the development and implementation of medical

1 malpractice reforms, as described in section 802. A State
2 shall use a grant made under this section to develop, im-
3 plement, and evaluate the effectiveness of such reforms.

4 (b) COMPLIANCE WITH FEDERAL STANDARDS.—Be-
5 ginning 2 years after the implementation of the reforms,
6 each State shall annually submit a report to the Board
7 containing such information as the Board may require to
8 determine whether the State is in compliance with the
9 terms of the grant made under this section.

10 **SEC. 802. CRITERIA FOR STATE MALPRACTICE REFORMS.**

11 (a) IN GENERAL.—Each State must demonstrate to
12 the Board that the reforms to the State medical mal-
13 practice system that the State develops or has already
14 adopted or intends to adopt meet the criteria described
15 in subsection (b).

16 (b) CRITERIA.—The criteria for medical malpractice
17 reforms are as follows:

18 (1) COSTS.—Decrease administrative costs and
19 reduce incentives for filing non-meritorious claims.

20 (2) EFFICIENCY.—Reduce the time between the
21 filing of medical malpractice claims and case resolu-
22 tions using procedures which may include the estab-
23 lishment of voluntary alternative dispute resolution
24 mechanisms, such as mediation, arbitration,

1 minitrials, and summary judgments, to facilitate ear-
2 lier case resolutions.

3 (3) ACCESS.—Develop mechanisms to ensure
4 that victims of malpractice or medically injured pa-
5 tients have the meaningful ability to seek compensa-
6 tion, including voluntary alternative dispute resolu-
7 tion mechanisms designed for small claims.

8 (4) QUALITY.—Improve the quality of health
9 care by strengthening mechanisms that reduce the
10 occurrence of medical injury, and detect and sanc-
11 tion health care professionals who commit health
12 care malpractice.

13 (5) EQUITY.—Enhance the fairness of com-
14 pensation provided to injured individuals for both
15 medically and non-medically-related damages, and
16 increase incentives for experience rating of insurance
17 premiums.

18 (c) BOARD STUDY OF CRITERIA.—

19 (1) STUDY.—The Board shall collect data from
20 the States awarded grants under section 801 on the
21 effects of the reforms established to meet the criteria
22 described in subsection (b) on the medical mal-
23 practice systems of such States. The data shall be
24 used to evaluate the effectiveness and appropriate-
25 ness of the criteria described in subsection (b) in ad-

1 dressing the problems of the medical malpractice
2 systems of such States. The Board may modify such
3 criteria based on such study.

4 (2) REPORT.—The Board shall report the re-
5 sults of the study described in paragraph (1) to the
6 Congress on a periodic basis.

7 **SEC. 803. AUTHORIZATION OF APPROPRIATIONS.**

8 There are authorized to be appropriated for grants
9 under this title such sums as may be necessary for fiscal
10 years 1994 through 1997.

11 **TITLE IX—EFFECTIVE DATES;**
12 **TERMINATIONS; TRANSITION;**
13 **RELATION TO ERISA.**

14 **SEC. 901. EFFECTIVE DATES.**

15 (a) FEDERAL ADMINISTRATION.—Not later than Oc-
16 tober 1, 1995, the Board shall promulgate regulations re-
17 garding the health care and long-term care services cov-
18 ered under this Act and the related patient cost-sharing
19 schedules under title II, develop the means for computing
20 the National Health Budget and Federal contributions to
21 the States under subtitle A of title IV, and establish the
22 procedures for reviewing and approving State plans under
23 section 311.

24 (b) PROVISION OF SERVICES.—

1 (1) PREVENTIVE AND PRIMARY CARE SERV-
2 ICES.—The provision of preventive and primary care
3 services under approved State plans, as established
4 under section 201, shall take effect with respect to
5 services furnished on or after October 1, 1997.

6 (2) ACUTE CARE SERVICES.—The provision of
7 acute care services under approved State plans, as
8 established under section 201, shall take effect with
9 respect to services furnished on or after October 1,
10 1998.

11 (3) LONG-TERM CARE SERVICES.—The provi-
12 sion of long-term care services under approved State
13 plans, as established under section 202, shall take
14 effect with respect to services furnished on or after
15 October 1, 1999.

16 (c) MODIFICATION OF TRANSITION PERIOD.—

17 (1) IN GENERAL.—Notwithstanding any other
18 provision of this Act and to the extent the Board de-
19 termines it is appropriate and fiscally responsible,
20 the Board may promulgate regulations to reduce the
21 period between the date of the enactment of this Act
22 and the effective dates otherwise provided in this
23 Act.

24 (2) EFFECT OF BOARD ACTIONS.—Any deter-
25 mination made by the Board under this subsection

1 to change an effective date under this Act shall be
2 submitted to the Congress at least 6 months before
3 the new effective date, and shall have the force of
4 law, unless within 60 days of the submission of such
5 determination, the Congress enacts a disapproval
6 resolution under the procedures described in section
7 501.

8 **SEC. 902. TERMINATION OF OTHER PROGRAMS.**

9 (a) **MEDICARE AND MEDICAID.**—

10 (1) **IN GENERAL.**—Titles XVIII and XIX of the
11 Social Security Act are repealed.

12 (2) **REPEAL OF HOSPITAL INSURANCE TAXES**
13 **UPON FULL IMPLEMENTATION OF PLAN.**—Sections
14 1401(b), 1402(k)(2), 3101(b), 3111(b), 3121(x)(2),
15 3231(e)(2)(B)(i)(II), and 6413(c)(3) of the Internal
16 Revenue Code of 1986 are repealed.

17 (b) **REPEAL OF CHAMPUS PROVISIONS.**—

18 (1) **AMENDMENTS TO CHAPTER 55 OF TITLE**
19 **10.**—Sections 1079 through 1083, 1086, and 1097
20 through 1100 of title 10, United States Code, are
21 repealed.

22 (2) **TABLE OF SECTIONS.**—The table of sections
23 at the beginning of chapter 55 of title 10, United
24 States Code, is amended by striking out the items
25 relating to the sections referred to in paragraph (1).

1 (3) CONFORMING AMENDMENTS.—Chapter 55
2 of title 10, United States Code, is amended as fol-
3 lows:

4 (A) DEFINITION.—Section 1072 is amend-
5 ed by striking out paragraph (4).

6 (B) REIMBURSEMENT OF THE DEPART-
7 MENT OF VETERANS AFFAIRS.—Section
8 1104(b) is amended—

9 (i) in the subsection heading, by strik-
10 ing out “FROM CHAMPUS FUNDS”; and

11 (ii) by striking out “from funds” and
12 all that follows and inserting in lieu thereof
13 “for medical care provided by the Depart-
14 ment of Veterans Affairs pursuant to such
15 agreement.”.

16 (c) REPEAL OF FEDERAL EMPLOYEES HEALTH
17 BENEFITS PROGRAM.—Chapter 89 of title 5, United
18 States Code, is repealed.

19 (d) EFFECTIVE DATE.—The repeals and amend-
20 ments made by this section shall take effect on October
21 1, 1999.

22 **SEC. 903. TRANSITION.**

23 (a) IN GENERAL.—The Board shall issue such regu-
24 lations as are necessary to provide for a transition to the

1 American Health Security Plan established under this Act
 2 from the programs repealed under section 902.

3 (b) RELATION TO OTHER PROGRAMS.—The Board
 4 shall recommend to the Congress appropriate legislative
 5 proposals for the amendment or repeal of any other Fed-
 6 eral program inconsistent with, or duplicative of, the prin-
 7 ciples of the American Health Security Plan established
 8 under this Act.

9 **SEC. 904. RELATION TO ERISA.**

10 The provisions of the Employee Retirement Income
 11 Security Act are superseded to the extent inconsistent
 12 with the requirements of this Act.

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HR 1691 IH—2

HR 1691 IH—3

HR 1691 IH—4

HR 1691 IH—5

HR 1691 IH—6

HR 1691 IH—7