

106TH CONGRESS
1ST SESSION

H. R. 1200

To provide for health care for every American and to control the cost and enhance the quality of the health care system.

IN THE HOUSE OF REPRESENTATIVES

MARCH 18, 1999

Mr. McDERMOTT (for himself, Mr. CONYERS, Mr. SANDERS, Mr. NADLER, Mr. HINCHAY, Mr. SERRANO, Mr. FATTAH, Mr. OLVER, and Mr. COYNE) introduced the following bill; which was referred to the Committee on Commerce, and in addition to the Committees on Ways and Means, Government Reform, and Armed Services, for a period to be subsequently determined by the Speaker, in each case for consideration of such provisions as fall within the jurisdiction of the committee concerned

A BILL

To provide for health care for every American and to control the cost and enhance the quality of the health care system.

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 “American Health Security Act of 1999”.

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

Sec. 1. Short title; table of contents.

TITLE I—ESTABLISHMENT OF A STATE-BASED AMERICAN
HEALTH SECURITY PROGRAM; UNIVERSAL ENTITLEMENT; EN-
ROLLMENT

- Sec. 101. Establishment of a State-based American Health Security Program.
- Sec. 102. Universal entitlement.
- Sec. 103. Enrollment.
- Sec. 104. Portability of benefits.
- Sec. 105. Effective date of benefits.
- Sec. 106. Relationship to existing Federal health programs.

TITLE II—COMPREHENSIVE BENEFITS, INCLUDING PREVENTIVE
BENEFITS AND BENEFITS FOR LONG TERM CARE

- Sec. 201. Comprehensive benefits.
- Sec. 202. Definitions relating to services.
- Sec. 203. Special rules for home and community-based long-term care services.
- Sec. 204. Exclusions and limitations.
- Sec. 205. Certification; quality review; plans of care.

TITLE III—PROVIDER PARTICIPATION

- Sec. 301. Provider participation and standards.
- Sec. 302. Qualifications for providers.
- Sec. 303. Qualifications for comprehensive health service organizations.
- Sec. 304. Limitation on certain physician referrals.

TITLE IV—ADMINISTRATION

Subtitle A—General Administrative Provisions

- Sec. 401. American Health Security Standards Board.
- Sec. 402. American Health Security Advisory Council.
- Sec. 403. Consultation with private entities.
- Sec. 404. State health security programs.
- Sec. 405. Complementary conduct of related health programs.

Subtitle B—Control Over Fraud and Abuse

- Sec. 411. Application of Federal sanctions to all fraud and abuse under American Health Security Program.
- Sec. 412. Requirements for operation of State health care fraud and abuse control units.

TITLE V—QUALITY ASSESSMENT

- Sec. 501. American Health Security Quality Council.
- Sec. 502. Development of certain methodologies, guidelines, and standards.
- Sec. 503. State quality review programs.
- Sec. 504. Elimination of existing utilization review programs; transition.

TITLE VI—NATIONAL HEALTH SECURITY BUDGET; PAYMENTS;
COST CONTAINMENT MEASURES

Subtitle A—Budgeting and Payments to States

- Sec. 601. National health security budget.
- Sec. 602. Computation of individual and State capitation amounts.
- Sec. 603. State health security budgets.

- Sec. 604. Federal payments to States.
- Sec. 605. Account for health professional education expenditures.

Subtitle B—Payments by States to Providers

- Sec. 611. Payments to hospitals and other facility-based services for operating expenses on the basis of approved global budgets.
- Sec. 612. Payments to health care practitioners based on prospective fee schedule.
- Sec. 613. Payments to comprehensive health service organizations.
- Sec. 614. Payments for community-based primary health services.
- Sec. 615. Payments for prescription drugs.
- Sec. 616. Approved devices and equipment.
- Sec. 617. Payments for other items and services.
- Sec. 618. Payment incentives for medically underserved areas.
- Sec. 619. Authority for alternative payment methodologies.

Subtitle C—Mandatory Assignment and Administrative Provisions

- Sec. 621. Mandatory assignment.
- Sec. 622. Procedures for reimbursement; appeals.

TITLE VII—PROMOTION OF PRIMARY HEALTH CARE; DEVELOPMENT OF HEALTH SERVICE CAPACITY; PROGRAMS TO ASSIST THE MEDICALLY UNDERSERVED

Subtitle A—Promotion and Expansion of Primary Care Professional Training

- Sec. 701. Role of Board; establishment of primary care professional output goals.
- Sec. 702. Establishment of Advisory Committee on Health Professional Education.
- Sec. 703. Grants for health professions education, nurse education, and the National Health Service Corps.

Subtitle B—Direct Health Care Delivery

- Sec. 711. Setaside for public health block grants.
- Sec. 712. Setaside for primary health care delivery.
- Sec. 713. Primary care service expansion grants.

Subtitle C—Primary Care and Outcomes Research

- Sec. 721. Set-aside for outcomes research.
- Sec. 722. Office of Primary Care and Prevention Research.

Subtitle D—School-Related Health Services

- Sec. 731. Authorizations of appropriations.
- Sec. 732. Eligibility for development and operation grants.
- Sec. 733. Preferences.
- Sec. 734. Grants for development of projects.
- Sec. 735. Grants for operation of projects.
- Sec. 736. Federal administrative costs.
- Sec. 737. Definitions.

TITLE VIII—FINANCING PROVISIONS; AMERICAN HEALTH SECURITY TRUST FUND

Sec. 800. Amendment of 1986 code; section 15 not to apply.

Subtitle A—American Health Security Trust Fund

Sec. 801. American Health Security Trust Fund.

Subtitle B—Taxes Based on Income and Wages

Sec. 811. Payroll tax on employers.

Sec. 812. Health care income tax.

Subtitle C—Increase in Excise Taxes on Tobacco Products

Sec. 821. Increase in excise taxes on tobacco products.

TITLE IX—CONFORMING AMENDMENTS TO THE EMPLOYEE
RETIREMENT INCOME SECURITY ACT OF 1974

Sec. 901. ERISA inapplicable to health coverage arrangements under State health security programs.

Sec. 902. Exemption of State health security programs from ERISA preemption.

Sec. 903. Prohibition of employee benefits duplicative of benefits under State health security programs; coordination in case of workers' compensation.

Sec. 904. Repeal of continuation coverage requirements under ERISA and certain other requirements relating to group health plans.

Sec. 905. Effective date of title.

TITLE X—ADDITIONAL CONFORMING AMENDMENTS

Sec. 1001. Repeal of certain provisions in Internal Revenue Code of 1986.

Sec. 1002. Repeal of certain provisions in the Employee Retirement Income Security Act of 1974.

Sec. 1003. Repeal of certain provisions in the Public Health Service Act.

Sec. 1004. Effective date of title.

1 **TITLE I—ESTABLISHMENT OF A**
2 **STATE-BASED AMERICAN**
3 **HEALTH SECURITY PRO-**
4 **GRAM; UNIVERSAL ENTITLE-**
5 **MENT; ENROLLMENT**

6 **SEC. 101. ESTABLISHMENT OF A STATE-BASED AMERICAN**
7 **HEALTH SECURITY PROGRAM.**

8 (a) IN GENERAL.—There is hereby established in the
9 United States a State-Based American Health Security
10 Program to be administered by the individual States in

1 accordance with Federal standards specified in, or estab-
2 lished under, this Act.

3 (b) STATE HEALTH SECURITY PROGRAMS.—In order
4 for a State to be eligible to receive payment under section
5 604, a State must establish a State health security pro-
6 gram in accordance with this Act.

7 (c) STATE DEFINED.—

8 (1) IN GENERAL.—In this Act, subject to para-
9 graph (2), the term “State” means each of the fifty
10 States and the District of Columbia.

11 (2) ELECTION.—If the Governor of Puerto
12 Rico, the Virgin Islands, Guam, American Samoa, or
13 the Northern Mariana Islands certifies to the Presi-
14 dent that the legislature of the Commonwealth or
15 territory has enacted legislation desiring that the
16 Commonwealth or territory be included as a State
17 under the provisions of this Act, such Common-
18 wealth or territory shall be included as a “State”
19 under this Act beginning January 1 of the first year
20 beginning ninety days after the President receives
21 the notification.

22 **SEC. 102. UNIVERSAL ENTITLEMENT.**

23 (a) IN GENERAL.—Every individual who is a resident
24 of the United States and is a citizen or national of the
25 United States or lawful resident alien (as defined in sub-

1 section (d) is entitled to benefits for health care services
2 under this Act under the appropriate State health security
3 program. In this section, the term “appropriate State
4 health security program” means, with respect to an indi-
5 vidual, the State health security program for the State in
6 which the individual maintains a primary residence.

7 (b) TREATMENT OF CERTAIN NONIMMIGRANTS.—

8 (1) IN GENERAL.—The American Health Secu-
9 rity Standards Board (in this Act referred to as the
10 “Board”) may make eligible for benefits for health
11 care services under the appropriate State health se-
12 curity program under this Act such classes of aliens
13 admitted to the United States as nonimmigrants as
14 the Board may provide.

15 (2) CONSIDERATION.—In providing for eligi-
16 bility under paragraph (1), the Board shall consider
17 reciprocity in health care services offered to United
18 States citizens who are nonimmigrants in other for-
19 eign states, and such other factors as the Board
20 determines to be appropriate.

21 (c) TREATMENT OF OTHER INDIVIDUALS.—

22 (1) BY BOARD.—The Board also may make eli-
23 gible for benefits for health care services under the
24 appropriate State health security program under this
25 Act other individuals not described in subsection (a)

1 or (b), and regulate the nature of the eligibility of
2 such individuals, in order—

3 (A) to preserve the public health of
4 communities,

5 (B) to compensate States for the addi-
6 tional health care financing burdens created by
7 such individuals, and

8 (C) to prevent adverse financial and med-
9 ical consequences of uncompensated care,
10 while inhibiting travel and immigration to the
11 United States for the sole purpose of obtaining
12 health care services.

13 (2) BY STATES.—Any State health security pro-
14 gram may make individuals described in paragraph
15 (1) eligible for benefits at the expense of the State.

16 (d) LAWFUL RESIDENT ALIEN DEFINED.—For pur-
17 poses of this section, the term “lawful resident alien”
18 means an alien lawfully admitted for permanent residence
19 and any other alien lawfully residing permanently in the
20 United States under color of law, including an alien with
21 lawful temporary resident status under section 210, 210A,
22 or 234A of the Immigration and Nationality Act (8 U.S.C.
23 1160, 1161, or 1255a).

1 **SEC. 103. ENROLLMENT.**

2 (a) IN GENERAL.—Each State health security pro-
3 gram shall provide a mechanism for the enrollment of indi-
4 viduals entitled or eligible for benefits under this Act. The
5 mechanism shall—

6 (1) include a process for the automatic enroll-
7 ment of individuals at the time of birth in the
8 United States and at the time of immigration into
9 the United States or other acquisition of lawful resi-
10 dent status in the United States,

11 (2) provide for the enrollment, as of January 1,
12 2001, of all individuals who are eligible to be en-
13 rolled as of such date, and

14 (3) include a process for the enrollment of indi-
15 viduals made eligible for health care services under
16 subsections (b) and (c) of section 102.

17 (b) AVAILABILITY OF APPLICATIONS.—Each State
18 health security program shall make applications for enroll-
19 ment under the program available—

20 (1) at employment and payroll offices of em-
21 ployers located in the State,

22 (2) at local offices of the Social Security
23 Administration,

24 (3) at social services locations,

25 (4) at out-reach sites (such as provider and
26 practitioner locations), and

1 (5) at other locations (including post offices
2 and schools) accessible to a broad cross-section of
3 individuals eligible to enroll.

4 (c) **ISSUANCE OF HEALTH SECURITY CARDS.**—In
5 conjunction with an individual’s enrollment for benefits
6 under this Act, the State health security program shall
7 provide for the issuance of a health security card which
8 shall be used for purposes of identification and processing
9 of claims for benefits under the program. The State health
10 security program may provide for issuance of such cards
11 by employers for purposes of carrying out enrollment pur-
12 suant to subsection (a)(2).

13 **SEC. 104. PORTABILITY OF BENEFITS.**

14 (a) **IN GENERAL.**—To ensure continuous access to
15 benefits for health care services covered under this Act,
16 each State health security program—

17 (1) shall not impose any minimum period of
18 residence in the State, or waiting period, in excess
19 of three months before residents of the State are
20 entitled to, or eligible for, such benefits under the
21 program;

22 (2) shall provide continuation of payment for
23 covered health care services to individuals who have
24 terminated their residence in the State and estab-
25 lished their residence in another State, for the dura-

1 tion of any waiting period imposed in the State of
2 new residency for establishing entitlement to, or
3 eligibility for, such services; and

4 (3) shall provide for the payment for health
5 care services covered under this Act provided to indi-
6 viduals while temporarily absent from the State
7 based on the following principles:

8 (A) Payment for such health care services
9 is at the rate that is approved by the State
10 health security program in the State in which
11 the services are provided, unless the States con-
12 cerned agree to apportion the cost between
13 them in a different manner.

14 (B) Payment for such health care services
15 provided outside the United States is made on
16 the basis of the amount that would have been
17 paid by the State health security program for
18 similar services rendered in the State, with due
19 regard, in the case of hospital services, to the
20 size of the hospital, standards of service, and
21 other relevant factors.

22 (b) CROSS-BORDER ARRANGEMENTS.—A State
23 health security program for a State may negotiate with
24 such a program in an adjacent State a reciprocal arrange-

1 ment for the coverage under such other program of health
2 care services to enrollees residing in the border region.

3 **SEC. 105. EFFECTIVE DATE OF BENEFITS.**

4 Benefits shall first be available under this Act for
5 items and services furnished on or after January 1, 2001.

6 **SEC. 106. RELATIONSHIP TO EXISTING FEDERAL HEALTH**
7 **PROGRAMS.**

8 (a) MEDICARE AND MEDICAID.—

9 (1) IN GENERAL.—Notwithstanding any other
10 provision of law, subject to paragraph (2)—

11 (A) no benefits shall be available under
12 title XVIII of the Social Security Act for any
13 item or service furnished after December 31,
14 2000,

15 (B) no individual is entitled to medical as-
16 sistance under a State plan approved under
17 title XIX of such Act for any item or service
18 furnished after such date, and

19 (C) no payment shall be made to a State
20 under section 1903(a) of such Act with respect
21 to medical assistance for any item or service
22 furnished after such date.

23 (2) TRANSITION.—In the case of inpatient hos-
24 pital services and extended care services during a
25 continuous period of stay which began before Janu-

1 ary 1, 2001, and which had not ended as of such
2 date, for which benefits are provided under title
3 XVIII, or under a State plan under title XIX, of the
4 Social Security Act, the Secretary of Health and
5 Human Services and each State plan, respectively,
6 shall provide for continuation of benefits under such
7 title or plan until the end of the period of stay.

8 (b) FEDERAL EMPLOYEES HEALTH BENEFITS PRO-
9 GRAM.—No benefits shall be made available under chapter
10 89 of title 5, United States Code, for any part of a cov-
11 erage period occurring after December 31, 2000.

12 (c) CHAMPUS.—No benefits shall be made available
13 under sections 1079 and 1086 of title 10, United States
14 Code, for items or services furnished after December 31,
15 2000.

16 (d) TREATMENT OF BENEFITS FOR VETERANS AND
17 NATIVE AMERICANS.—Nothing in this Act shall affect the
18 eligibility of veterans for the medical benefits and services
19 provided under title 38, United States Code, or of Indians
20 for the medical benefits and services provided by or
21 through the Indian Health Service.

1 **TITLE II—COMPREHENSIVE BEN-**
2 **EFITS, INCLUDING PREVEN-**
3 **TIVE BENEFITS AND BENE-**
4 **FITS FOR LONG-TERM CARE**

5 **SEC. 201. COMPREHENSIVE BENEFITS.**

6 (a) IN GENERAL.—Subject to the succeeding provi-
7 sions of this title, individuals enrolled for benefits under
8 this Act are entitled to have payment made under a State
9 health security program for the following items and serv-
10 ices if medically necessary or appropriate for the mainte-
11 nance of health or for the diagnosis, treatment, or rehabili-
12 tation of a health condition:

13 (1) HOSPITAL SERVICES.—Inpatient and out-
14 patient hospital care, including 24-hour-a-day emer-
15 gency services.

16 (2) PROFESSIONAL SERVICES.—Professional
17 services of health care practitioners authorized to
18 provide health care services under State law, includ-
19 ing patient education and training in self-manage-
20 ment techniques.

21 (3) COMMUNITY-BASED PRIMARY HEALTH
22 SERVICES.—Community-based primary health serv-
23 ices (as defined in section 202(a)).

24 (4) PREVENTIVE SERVICES.—Preventive serv-
25 ices (as defined in section 202(b)).

1 (5) LONG-TERM, ACUTE, AND CHRONIC CARE
2 SERVICES.—

3 (A) Nursing facility services.

4 (B) Home health services.

5 (C) Home and community-based long-term
6 care services (as defined in section 202(c)) for
7 individuals described in section 203(a).

8 (D) Hospice care.

9 (E) Services in intermediate care facilities
10 for individuals with mental retardation.

11 (6) PRESCRIPTION DRUGS, BIOLOGICALS, INSU-
12 LIN, MEDICAL FOODS.—

13 (A) Outpatient prescription drugs and
14 biologicals, as specified by the Board consistent
15 with section 515.

16 (B) Insulin.

17 (C) Medical foods (as defined in section
18 202(e)).

19 (7) DENTAL SERVICES.—Dental services (as de-
20 fined in section 202(h)).

21 (8) MENTAL HEALTH AND SUBSTANCE ABUSE
22 TREATMENT SERVICES.—Mental health and sub-
23 stance abuse treatment services (as defined in sec-
24 tion 202(f)).

25 (9) DIAGNOSTIC TESTS.—Diagnostic tests.

1 (10) OTHER ITEMS AND SERVICES.—

2 (A) OUTPATIENT THERAPY.—Outpatient
3 physical therapy services, outpatient speech pa-
4 thology services, and outpatient occupational
5 therapy services in all settings.

6 (B) DURABLE MEDICAL EQUIPMENT.—Du-
7 rable medical equipment.

8 (C) HOME DIALYSIS.—Home dialysis sup-
9 plies and equipment.

10 (D) AMBULANCE.—Emergency ambulance
11 service.

12 (E) PROSTHETIC DEVICES.—Prosthetic de-
13 vices, including replacements of such devices.

14 (F) ADDITIONAL ITEMS AND SERVICES.—
15 Such other medical or health care items or
16 services as the Board may specify.

17 (b) COST-SHARING.—

18 (1) IN GENERAL.—Except as provided in this
19 subsection, there are no deductibles, coinsurance, or
20 copayments applicable to acute care and preventive
21 benefits provided under this title.

22 (2) COST-SHARING FOR LONG-TERM CARE
23 SERVICES.—

24 (A) IN GENERAL.—

1 (i) payments for home and commu-
2 nity-based long-term care services are sub-
3 ject to coinsurance of 20 percent, and

4 (ii) payments for nursing facility serv-
5 ices are subject to coinsurance of 35 per-
6 cent.

7 (B) EXCEPTION.—With respect to the co-
8 insurance established under subparagraph
9 (A)—

10 (i) such coinsurance shall not apply to
11 an individual with income (as defined by
12 the Secretary) of not more than 100 per-
13 cent of the income official poverty line ap-
14 plicable to a family of the size involved;
15 and

16 (ii) in the case of an individual with
17 such income that exceeds 100 percent, but
18 is less than 200 percent, of such applicable
19 poverty line, the coinsurance shall be re-
20 duced in the same proportion as the pro-
21 portion of such income is less than 200
22 percent of such applicable poverty line.

23 (c) PROHIBITION OF BALANCE BILLING.—As pro-
24 vided in section 531, no person may impose a charge for

1 covered services for which benefits are provided under this
2 Act.

3 (d) NO DUPLICATE HEALTH INSURANCE.—Each
4 State health security program shall prohibit the sale of
5 health insurance in the State if payment under the insur-
6 ance duplicates payment for any items or services for
7 which payment may be made under such a program.

8 (e) STATE PROGRAM MAY PROVIDE ADDITIONAL
9 BENEFITS.—Nothing in this Act shall be construed as
10 limiting the benefits that may be made available under a
11 State health security program to residents of the State
12 at the expense of the State.

13 (f) EMPLOYERS MAY PROVIDE ADDITIONAL BENE-
14 FITS.—Nothing in this Act shall be construed as limiting
15 the additional benefits that an employer may provide to
16 employees or their dependents, or to former employees or
17 their dependents.

18 **SEC. 202. DEFINITIONS RELATING TO SERVICES.**

19 (a) COMMUNITY-BASED PRIMARY HEALTH SERV-
20 ICES.—In this title, the term “community-based primary
21 health services” means ambulatory health services
22 furnished—

23 (1) by a rural health clinic;

24 (2) by a Federally qualified health center (as
25 defined in section 1905(l)(2)(B) of the Social Secu-

1 rity Act), and which, for purposes of this Act, in-
 2 clude services furnished by State and local health
 3 agencies;

4 (3) in a school-based setting;

5 (4) by public educational agencies and other
 6 providers of services to children entitled to assist-
 7 ance under the Individuals with Disabilities Edu-
 8 cation Act for services furnished pursuant to a
 9 written Individualized Family Services Plan or
 10 Individual Education Plan under such Act; and

11 (5) public and private nonprofit entities receiv-
 12 ing Federal assistance under the Public Health
 13 Service Act.

14 (b) PREVENTIVE SERVICES.—

15 (1) IN GENERAL.—In this title, the term “pre-
 16 ventive services” means items and services—

17 (A) which—

18 (i) are specified in paragraph (2), or

19 (ii) the Board determines to be effec-
 20 tive in the maintenance and promotion of
 21 health or minimizing the effect of illness,
 22 disease, or medical condition; and

23 (B) which are provided consistent with the
 24 periodicity schedule established under para-
 25 graph (3).

1 (2) SPECIFIED PREVENTIVE SERVICES.—The
2 services specified in this paragraph are as follows:

3 (A) Basic immunizations.

4 (B) Prenatal and well-baby care (for in-
5 fants under one year of age).

6 (C) Well-child care (including periodic
7 physical examinations, hearing and vision
8 screening, and developmental screening and ex-
9 aminations) for individuals under 18 years of
10 age.

11 (D) Periodic screening mammography, Pap
12 smears, and colorectal examinations and exami-
13 nations for prostate cancer.

14 (E) Physical examinations.

15 (F) Family planning services.

16 (G) Routine eye examinations, eyeglasses,
17 and contact lenses.

18 (H) Hearing aids, but only upon a deter-
19 mination of a certified audiologist or physician
20 that a hearing problem exists and is caused by
21 a condition that can be corrected by use of a
22 hearing aid.

23 (3) SCHEDULE.—The Board shall establish, in
24 consultation with experts in preventive medicine and
25 public health and taking into consideration those

1 preventive services recommended by the Preventive
2 Services Task Force and published as the Guide to
3 Clinical Preventive Services, a periodicity schedule
4 for the coverage of preventive services under para-
5 graph (1). Such schedule shall take into consider-
6 ation the cost-effectiveness of appropriate preventive
7 care and shall be revised not less frequently than
8 once every 5 years, in consultation with experts in
9 preventive medicine and public health.

10 (c) HOME AND COMMUNITY-BASED LONG-TERM
11 CARE SERVICES.—In this title, the term “home and com-
12 munity-based long-term care services” means the following
13 services provided to an individual to enable the individual
14 to remain in such individual’s place of residence within
15 the community:

16 (1) Home health aide services.

17 (2) Adult day health care, social day care or
18 psychiatric day care.

19 (3) Medical social work services.

20 (4) Care coordination services, as defined in
21 subsection (g)(1).

22 (5) Respite care, including training for informal
23 caregivers.

1 (6) Personal assistance services, and home-
2 maker services (including meals) incidental to the
3 provision of personal assistance services.

4 (d) HOME HEALTH SERVICES.—

5 (1) IN GENERAL.—The term “home health
6 services” means items and services described in sec-
7 tion 1861(m) of the Social Security Act and includes
8 home infusion services.

9 (2) HOME INFUSION SERVICES.—The term
10 “home infusion services” includes the nursing, phar-
11 macy, and related services that are necessary to con-
12 duct the home infusion of a drug regimen safely and
13 effectively under a plan established and periodically
14 reviewed by a physician and that are provided in
15 compliance with quality assurance requirements es-
16 tablished by the Secretary.

17 (e) MEDICAL FOODS.—In this title, the term “med-
18 ical foods” means foods which are formulated to be con-
19 sumed or administered enterally under the supervision of
20 a physician and which are intended for the specific dietary
21 management of a disease or condition for which distinctive
22 nutritional requirements, based on recognized scientific
23 principles, are established by medical evaluation.

24 (f) MENTAL HEALTH AND SUBSTANCE ABUSE
25 TREATMENT SERVICES.—

1 (1) SERVICES DESCRIBED.—In this title, the
2 term “mental health and substance abuse treatment
3 services” means the following services related to the
4 prevention, diagnosis, treatment, and rehabilitation
5 of mental illness and promotion of mental health:

6 (A) INPATIENT HOSPITAL SERVICES.—In-
7 patient hospital services furnished primarily for
8 the diagnosis or treatment of mental illness or
9 substance abuse for up to 60 days during a
10 year, reduced by a number of days determined
11 by the Secretary so that the actuarial value of
12 providing such number of days of services
13 under this paragraph to the individual is equal
14 to the actuarial value of the days of inpatient
15 residential services furnished to the individual
16 under subparagraph (B) during the year after
17 such services have been furnished to the indi-
18 vidual for 120 days during the year (rounded to
19 the nearest day), but only if (with respect to
20 services furnished to an individual described in
21 section 204(b)(1)) such services are furnished
22 in conformity with the plan of an organized sys-
23 tem of care for mental health and substance
24 abuse services in accordance with section
25 204(b)(2).

(B) INTENSIVE RESIDENTIAL SERVICES.—

Intensive residential services (as defined in paragraph (2)) furnished to an individual for up to 120 days during any calendar year, except that—

(i) such services may be furnished to the individual for additional days during the year if necessary for the individual to complete a course of treatment to the extent that the number of days of inpatient hospital services described in subparagraph (A) that may be furnished to the individual during the year (as reduced under such subparagraph) is not less than 15; and

(ii) reduced by a number of days determined by the Secretary so that the actuarial value of providing such number of days of services under this paragraph to the individual is equal to the actuarial value of the days of intensive community-based services furnished to the individual under subparagraph (D) during the year after such services have been furnished to the individual for 90 days (or, in the case of services described in subparagraph

1 (D)(ii), for 180 days) during the year
2 (rounded to the nearest day).

3 (C) OUTPATIENT SERVICES.—Outpatient
4 treatment services of mental illness or sub-
5 stance abuse (other than intensive community-
6 based services under subparagraph (D)) for an
7 unlimited number of days during any calendar
8 year furnished in accordance with standards es-
9 tablished by the Secretary for the management
10 of such services, and, in the case of services fur-
11 nished to an individual described in section
12 204(b)(1) who is not an inpatient of a hospital,
13 in conformity with the plan of an organized sys-
14 tem of care for mental health and substance
15 abuse services in accordance with section
16 204(b)(2).

17 (D) INTENSIVE COMMUNITY-BASED SERV-
18 ICES.—Intensive community-based services (as
19 described in paragraph (3))—

20 (i) for an unlimited number of days
21 during any calendar year, in the case of
22 services described in section 1861(ff)(2)(E)
23 that are furnished to an individual who is
24 a seriously mentally ill adult, a seriously
25 emotionally disturbed child, or an adult or

1 child with serious substance abuse disorder
2 (as determined in accordance with criteria
3 established by the Secretary);

4 (ii) in the case of services described in
5 section 1861(ff)(2)(C), for up to 180 days
6 during any calendar year, except that such
7 services may be furnished to the individual
8 for a number of additional days during the
9 year equal to the difference between the
10 total number of days of intensive residen-
11 tial services which the individual may re-
12 ceive during the year under part A (as de-
13 termined under subparagraph (B)) and the
14 number of days of such services which the
15 individual has received during the year, or

16 (iii) in the case of any other such
17 services, for up to 90 days during any cal-
18 endar year, except that such services may
19 be furnished to the individual for the num-
20 ber of additional days during the year de-
21 scribed in clause (ii).

22 (2) INTENSIVE RESIDENTIAL SERVICES DE-
23 FINED.—

24 (A) IN GENERAL.—Subject to subpara-
25 graphs (B) and (C), the term “intensive resi-

1 dential services” means inpatient services pro-
2 vided in any of the following facilities:

3 (i) Residential detoxification centers.

4 (ii) Crisis residential programs or
5 mental illness residential treatment pro-
6 grams.

7 (iii) Therapeutic family or group
8 treatment homes.

9 (iv) Residential centers for substance
10 abuse treatment.

11 (B) REQUIREMENTS FOR FACILITIES.—No
12 service may be treated as an intensive residen-
13 tial service under subparagraph (A) unless the
14 facility at which the service is provided—

15 (i) is legally authorized to provide
16 such service under the law of the State (or
17 under a State regulatory mechanism pro-
18 vided by State law) in which the facility is
19 located or is certified to provide such serv-
20 ice by an appropriate accreditation entity
21 approved by the State in consultation with
22 the Secretary; and

23 (ii) meets such other requirements as
24 the Secretary may impose to assure the

1 quality of the intensive residential services
2 provided.

3 (C) SERVICES FURNISHED TO AT-RISK
4 CHILDREN.—In the case of services furnished
5 to an individual described in section 204(b)(1),
6 no service may be treated as an intensive resi-
7 dential service under this subsection unless the
8 service is furnished in conformity with the plan
9 of an organized system of care for mental
10 health and substance abuse services in accord-
11 ance with section 204(b)(2).

12 (D) MANAGEMENT STANDARDS.—No serv-
13 ice may be treated as an intensive residential
14 service under subparagraph (A) unless the serv-
15 ice is furnished in accordance with standards
16 established by the Secretary for the manage-
17 ment of such services.

18 (3) INTENSIVE COMMUNITY-BASED SERVICES
19 DEFINED.—

20 (A) IN GENERAL.—The term “intensive
21 community-based services” means the items
22 and services described in subparagraph (B) pre-
23 scribed by a physician (or, in the case of serv-
24 ices furnished to an individual described in sec-
25 tion 204(b)(1), by an organized system of care

1 for mental health and substance abuse services
2 in accordance with such section) and provided
3 under a program described in subparagraph
4 (D) under the supervision of a physician (or, to
5 the extent permitted under the law of the State
6 in which the services are furnished, a non-phy-
7 sician mental health professional) pursuant to
8 an individualized, written plan of treatment es-
9 tablished and periodically reviewed by a physi-
10 cian (in consultation with appropriate staff par-
11 ticipating in such program) which sets forth the
12 physician's diagnosis, the type, amount, fre-
13 quency, and duration of the items and services
14 provided under the plan, and the goals for
15 treatment under the plan, but does not include
16 any item or service that is not furnished in ac-
17 cordance with standards established by the Sec-
18 retary for the management of such services.

19 (B) ITEMS AND SERVICES DESCRIBED.—

20 The items and services described in this sub-
21 paragraph are—

22 (i) partial hospitalization services con-
23 sisting of the items and services described
24 in subparagraph (C);

25 (ii) psychiatric rehabilitation services;

1 (iii) day treatment services for indi-
2 viduals under 19 years of age;
3 (iv) in-home services;
4 (v) case management services, includ-
5 ing collateral services designated as such
6 case management services by the Sec-
7 retary;
8 (vi) ambulatory detoxification services;
9 (vii) such other items and services as
10 the Secretary may provide (but in no event
11 to include meals and transportation),
12 that are reasonable and necessary for the diag-
13 nosis or active treatment of the individual's
14 condition, reasonably expected to improve or
15 maintain the individual's condition and func-
16 tional level and to prevent relapse or hos-
17 pitalization, and furnished pursuant to such
18 guidelines relating to frequency and duration of
19 services as the Secretary shall by regulation es-
20 tablish (taking into account accepted norms of
21 medical practice and the reasonable expectation
22 of patient improvement).

23 (C) ITEMS AND SERVICES INCLUDED AS
24 PARTIAL HOSPITALIZATION SERVICES.—For

1 purposes of subparagraph (B)(i), partial hos-
2 pitalization services consist of the following:

3 (i) Individual and group therapy with
4 physicians or psychologists (or other men-
5 tal health professionals to the extent au-
6 thorized under State law).

7 (ii) Occupational therapy requiring
8 the skills of a qualified occupational thera-
9 pist.

10 (iii) Services of social workers, trained
11 psychiatric nurses, behavioral aides, and
12 other staff trained to work with psychiatric
13 patients (to the extent authorized under
14 State law).

15 (iv) Drugs and biologicals furnished
16 for therapeutic purposes (which cannot, as
17 determined in accordance with regulations,
18 be self-administered).

19 (v) Individualized activity therapies
20 that are not primarily recreational or di-
21 versionary.

22 (vi) Family counseling (the primary
23 purpose of which is treatment of the indi-
24 vidual's condition).

1 (vii) Patient training and education
2 (to the extent that training and edu-
3 cational activities are closely and clearly
4 related to the individual's care and treat-
5 ment).

6 (viii) Diagnostic services.

7 (D) PROGRAMS DESCRIBED.—A program
8 described in this subparagraph is a program
9 (whether facility-based or freestanding) which is
10 furnished by an entity—

11 (i) legally authorized to furnish such a
12 program under State law (or the State reg-
13 ulatory mechanism provided by State law)
14 or certified to furnish such a program by
15 an appropriate accreditation entity ap-
16 proved by the State in consultation with
17 the Secretary; and

18 (ii) meeting such other requirements
19 as the Secretary may impose to assure the
20 quality of the intensive community-based
21 services provided.

22 (g) CARE COORDINATION SERVICES.—

23 (1) IN GENERAL.—In this title, the term “care
24 coordination services” means services provided by
25 care coordinators (as defined in paragraph (2)) to

1 individuals described in paragraph (3) for the co-
2 ordination and monitoring of home and community-
3 based long term care services to ensure appropriate,
4 cost-effective utilization of such services in a com-
5 prehensive and continuous manner, and includes—

6 (A) transition management between inpa-
7 tient facilities and community-based services,
8 including assisting patients in identifying and
9 gaining access to appropriate ancillary services;
10 and

11 (B) evaluating and recommending appro-
12 priate treatment services, in cooperation with
13 patients and other providers and in conjunction
14 with any quality review program or plan of care
15 under section 205.

16 (2) CARE COORDINATOR.—

17 (A) IN GENERAL.—In this title, the term
18 “care coordinator” means an individual or non-
19 profit or public agency or organization which
20 the State health security program determines—

21 (i) is capable of performing directly,
22 efficiently, and effectively the duties of a
23 care coordinator described in paragraph
24 (1), and

1 (ii) demonstrates capability in estab-
2 lishing and periodically reviewing and re-
3 vising plans of care, and in arranging for
4 and monitoring the provision and quality
5 of services under any plan.

6 (B) INDEPENDENCE.—State health secu-
7 rity programs shall establish safeguards to as-
8 sure that care coordinators have no financial in-
9 terest in treatment decisions or placements.
10 Care coordination may not be provided through
11 any structure or mechanism through which
12 quality review is performed.

13 (3) ELIGIBLE INDIVIDUALS.—An individual de-
14 scribed in this paragraph is an individual described
15 in section 203 (relating to individuals qualifying for
16 long term and chronic care services).

17 (h) DENTAL SERVICES.—

18 (1) IN GENERAL.—In this title, subject to sub-
19 section (b), the term “dental services” means the
20 following:

21 (A) Emergency dental treatment, including
22 extractions, for bleeding, pain, acute infections,
23 and injuries to the maxillofacial region.

24 (B) Prevention and diagnosis of dental dis-
25 ease, including examinations of the hard and

1 soft tissues of the oral cavity and related struc-
2 tures, radiographs, dental sealants, fluorides,
3 and dental prophylaxis.

4 (C) Treatment of dental disease, including
5 non-cast fillings, periodontal maintenance serv-
6 ices, and endodontic services.

7 (D) Space maintenance procedures to pre-
8 vent orthodontic complications.

9 (E) Orthodontic treatment to prevent se-
10 vere malocclusions.

11 (F) Full dentures.

12 (G) Medically necessary oral health care.

13 (H) Any items and services for special
14 needs patients that are not described in sub-
15 paragraphs (A) through (G) and that—

16 (i) are required to provide such pa-
17 tients the items and services described in
18 subparagraphs (A) through (G);

19 (ii) are required to establish oral func-
20 tion (including general anesthesia for indi-
21 viduals with physical or emotional limita-
22 tions that prevent the provision of dental
23 care without such anesthesia);

24 (iii) consist of orthodontic care for se-
25 vere dentofacial abnormalities; or

1 (iv) consist of prosthetic dental de-
2 vices for genetic or birth defects or fitting
3 for such devices.

4 (I) Any dental care for individuals with a
5 seizure disorder that is not described in sub-
6 paragraphs (A) through (H) and that is re-
7 quired because of an illness, injury, disorder, or
8 other health condition that results from such
9 seizure disorder.

10 (2) LIMITATIONS.—Dental services are subject
11 to the following limitations:

12 (A) PREVENTION AND DIAGNOSIS.—

13 (i) EXAMINATIONS AND PROPHY-
14 LAXIS.—The examinations and prophylaxis
15 described in paragraph (1)(B) are covered
16 only consistent with a periodicity schedule
17 established by the Board, which schedule
18 may provide for special treatment of indi-
19 viduals less than 18 years of age and of
20 special needs patients.

21 (ii) DENTAL SEALANTS.—The dental
22 sealants described in such paragraph are
23 not covered for individuals 18 years of age
24 or older. Such sealants are covered for in-
25 dividuals less than 10 years of age for pro-

tection of the 1st permanent molars. Such sealants are covered for individuals 10 years of age or older for protection of the 2d permanent molars.

(B) TREATMENT OF DENTAL DISEASE.—

Prior to January 1, 2006, the items and services described in paragraph (1)(C) are covered only for individuals less than 18 years of age and special needs patients. On or after such date, such items and services are covered for all individuals enrolled for benefits under this Act, except that endodontic services are not covered for individuals 18 years of age or older.

(C) SPACE MAINTENANCE.—The items and services described in paragraph (1)(D) are covered only for individuals at least 3 years of age, but less than 13 years of age and—

(i) are limited to posterior teeth;

(ii) involve maintenance of a space or spaces for permanent posterior teeth that would otherwise be prevented from normal eruption if the space were not maintained; and

(iii) do not include a space maintainer that is placed within 6 months of the ex-

pected eruption of the permanent posterior tooth concerned.

(D) ORTHODONTIC TREATMENT.—Prior to January 1, 2006, the items and services described in paragraph (1)(E) are covered only for individuals at least 6 years of age, but less than 12 years of age, who have severe dentofacial abnormalities. On or after such date, such items and services are covered only for individuals at least 6 years of age, but less than 12 years of age.

(E) DENTURES.—Prior to January 1, 2006, the dentures described in paragraph (1)(F) are not covered, except for special needs patients. On or after such date, dentures are covered for an individual consistent with a periodicity schedule established by the Board, except that the limitation of periodicity provided in such schedule shall not apply to a special needs patient.

(3) DEFINITIONS.—For purposes of this title:

(A) MEDICALLY NECESSARY ORAL HEALTH CARE.—The term “medically necessary oral health care” means oral health care that is required as a direct result of, or would have a di-

1 rect impact on, an underlying medical condi-
 2 tion. Such term includes oral health care di-
 3 rected toward control or elimination of pain, in-
 4 fection, or reestablishment of oral function.

5 (B) SPECIAL NEEDS PATIENT.—The term
 6 “special needs patient” includes an individual
 7 with a genetic or birth defect, a developmental
 8 disability, or an acquired medical disability.

9 (i) NURSING FACILITY; NURSING FACILITY SERV-
 10 ICES.—Except as may be provided by the Board, the
 11 terms “nursing facility” and “nursing facility services”
 12 have the meanings given such terms in sections 1919(a)
 13 and 1905(f), respectively, of the Social Security Act.

14 (j) SERVICES IN INTERMEDIATE CARE FACILITIES
 15 FOR INDIVIDUALS WITH MENTAL RETARDATION.—Ex-
 16 cept as may be provided by the Board—

17 (1) the term “intermediate care facility for indi-
 18 viduals with mental retardation” has the meaning
 19 specified in section 1905(d) of the Social Security
 20 Act (as in effect before the enactment of this Act);
 21 and

22 (2) the term “services in intermediate care fa-
 23 cilities for individuals with mental retardation”
 24 means services described in section 1905(a)(15) of
 25 such Act (as so in effect) in an intermediate care fa-

1 cility for individuals with mental retardation to an
 2 individual determined to require such services in ac-
 3 cordance with standards specified by the Board and
 4 comparable to the standards described in section
 5 1902(a)(31)(A) of such Act (as so in effect).

6 (k) OTHER TERMS.—Except as may be provided by
 7 the Board, the definitions contained in section 1861 of the
 8 Social Security Act shall apply.

9 **SEC. 203. SPECIAL RULES FOR HOME AND COMMUNITY-**
 10 **BASED LONG-TERM CARE SERVICES.**

11 (a) QUALIFYING INDIVIDUALS.—For purposes of sec-
 12 tion 201(a)(5)(C), individuals described in this subsection
 13 are the following individuals:

14 (1) ADULTS.—Individuals 18 years of age or
 15 older determined (in a manner specified by the
 16 Board)—

17 (A) to be unable to perform, without the
 18 assistance of an individual, at least 2 of the fol-
 19 lowing 5 activities of daily living (or who has a
 20 similar level of disability due to cognitive
 21 impairment)—

22 (i) bathing;

23 (ii) eating;

24 (iii) dressing;

25 (iv) toileting; and

1 (v) transferring in and out of a bed or
2 in and out of a chair;

3 (B) due to cognitive or mental impair-
4 ments, to require supervision because the indi-
5 vidual behaves in a manner that poses health or
6 safety hazards to himself or herself or others;
7 or

8 (C) due to cognitive or mental impair-
9 ments, to require queuing to perform activities
10 of daily living.

11 (2) CHILDREN.—Individuals under 18 years of
12 age determined (in a manner specified by the Board)
13 to meet such alternative standard of disability for
14 children as the Board develops. Such alternative
15 standard shall be comparable to the standard for
16 adults and appropriate for children.

17 (b) LIMIT ON SERVICES.—

18 (1) IN GENERAL.—The aggregate expenditures
19 by a State health security program with respect to
20 home and community-based long-term care services
21 in a period (specified by the Board) may not exceed
22 65 percent (or such alternative ratio as the Board
23 establishes under paragraph (2)) of the average of
24 the amount of payment that would have been made
25 under the program during the period if all the home-

1 based long-term care beneficiaries had been resi-
2 dents of nursing facilities in the same area in which
3 the services were provided.

4 (2) ALTERNATIVE RATIO.—The Board may es-
5 tablish for purposes of paragraph (1) an alternative
6 ratio (of payments for home and community-based
7 long term care services to payments for nursing fa-
8 cility services) as the Board determines to be more
9 consistent with the goal of providing cost-effective
10 long-term care in the most appropriate and least
11 restrictive setting.

12 **SEC. 204. EXCLUSIONS AND LIMITATIONS.**

13 (a) IN GENERAL.—Subject to section 201(e), benefits
14 for service are not available under this Act unless the
15 services meet the standards specified in section 201(a).

16 (b) SPECIAL DELIVERY REQUIREMENTS FOR MEN-
17 TAL HEALTH AND SUBSTANCE ABUSE TREATMENT SERV-
18 ICES PROVIDED TO AT-RISK CHILDREN.—

19 (1) REQUIRING SERVICES TO BE PROVIDED
20 THROUGH ORGANIZED SYSTEMS OF CARE.—A State
21 health security program shall ensure that mental
22 health services and substance abuse treatment serv-
23 ices are furnished through an organized system of
24 care, as described in paragraph (2), if—

1 (A) the services are provided to an indi-
2 vidual less than 22 years of age;

3 (B) the individual has a serious emotional
4 disturbance or a substance abuse disorder; and

5 (C) the individual is, or is at imminent risk
6 of being, subject to the authority of, or in need
7 of the services of, at least 1 public agency that
8 serves the needs of children, including an agen-
9 cy involved with child welfare, special education,
10 juvenile justice, or criminal justice.

11 (2) REQUIREMENTS FOR SYSTEM OF CARE.—In
12 this subsection, an “organized system of care” is a
13 community-based service delivery network, which
14 may consist of public and private providers, that
15 meets the following requirements:

16 (A) The system has established linkages
17 with existing mental health services and sub-
18 stance abuse treatment service delivery pro-
19 grams in the plan service area (or is in the
20 process of developing or operating a system
21 with appropriate public agencies in the area to
22 coordinate the delivery of such services to indi-
23 viduals in the area).

24 (B) The system provides for the participa-
25 tion and coordination of multiple agencies and

1 providers that serve the needs of children in the
2 area, including agencies and providers involved
3 with child welfare, education, juvenile justice,
4 criminal justice, health care, mental health, and
5 substance abuse prevention and treatment.

6 (C) The system provides for the involve-
7 ment of the families of children to whom mental
8 health services and substance abuse treatment
9 services are provided in the planning of treat-
10 ment and the delivery of services.

11 (D) The system provides for the develop-
12 ment and implementation of individualized
13 treatment plans by multidisciplinary and multi-
14 agency teams, which are recognized and fol-
15 lowed by the applicable agencies and providers
16 in the area.

17 (E) The system ensures the delivery and
18 coordination of the range of mental health serv-
19 ices and substance abuse treatment services re-
20 quired by individuals under 22 years of age who
21 have a serious emotion disturbance or a sub-
22 stance abuse disorder.

23 (F) The system provides for the manage-
24 ment of the individualized treatment plans de-
25 scribed in subparagraph (D) and for a flexible

1 response to changes in treatment needs over
2 time.

3 (c) TREATMENT OF EXPERIMENTAL SERVICES.—In
4 applying subsection (a), the Board shall make national
5 coverage determinations with respect to those services that
6 are experimental in nature. Such determinations shall be
7 made consistent with a process that provides for input
8 from representatives of health care professionals and pa-
9 tients and public comment.

10 (d) APPLICATION OF PRACTICE GUIDELINES.—In
11 the case of services for which the American Health Secu-
12 rity Quality Council (established under section 501) has
13 recognized a national practice guideline, the services are
14 considered to meet the standards specified in section
15 201(a) if they have been provided in accordance with such
16 guideline or in accordance with such guidelines as are pro-
17 vided by the State health security program consistent with
18 title V. For purposes of this subsection, a service shall
19 be considered to have been provided in accordance with
20 a practice guideline if the health care provider providing
21 the service exercised appropriate professional discretion to
22 deviate from the guideline in a manner authorized or an-
23 ticipated by the guideline.

24 (e) SPECIFIC LIMITATIONS.—

1 (1) LIMITATIONS ON EYEGLASSES, CONTACT
2 LENSES, HEARING AIDS, AND DURABLE MEDICAL
3 EQUIPMENT.—Subject to section 201(e), the Board
4 may impose such limits relating to the costs and fre-
5 quency of replacement of eyeglasses, contact lenses,
6 hearing aids, and durable medical equipment to
7 which individuals enrolled for benefits under this Act
8 are entitled to have payment made under a State
9 health security program as the Board deems appro-
10 prium.

11 (2) OVERLAP WITH PREVENTIVE SERVICES.—
12 The coverage of services described in section 201(a)
13 (other than paragraph (3)) which also are preventive
14 services are required to be covered only to the extent
15 that they are required to be covered as preventive
16 services.

17 (3) MISCELLANEOUS EXCLUSIONS FROM COV-
18 ERED SERVICES.—Covered services under this Act
19 do not include the following:

20 (A) Surgery and other procedures (such as
21 orthodontia) performed solely for cosmetic pur-
22 poses (as defined in regulations) and hospital or
23 other services incident thereto, unless—

24 (i) required to correct a congenital
25 anomaly;

1 (ii) required to restore or correct a
2 part of the body which has been altered as
3 a result of accidental injury, disease, or
4 surgery; or

5 (iii) otherwise determined to be medi-
6 cally necessary and appropriate under sec-
7 tion 201(a).

8 (B) Personal comfort items or private
9 rooms in inpatient facilities, unless determined
10 to be medically necessary and appropriate
11 under section 201(a).

12 (C) The services of a professional practi-
13 tioner if they are furnished in a hospital or
14 other facility which is not a participating pro-
15 vider.

16 (f) NURSING FACILITY SERVICES AND HOME
17 HEALTH SERVICES.—Nursing facility services and home
18 health services (other than post-hospital services, as de-
19 fined by the Board) furnished to an individual who is not
20 described in section 203(a) are not covered services unless
21 the services are determined to meet the standards speci-
22 fied in section 201(a) and, with respect to nursing facility
23 services, to be provided in the least restrictive and most
24 appropriate setting.

1 **SEC. 205. CERTIFICATION; QUALITY REVIEW; PLANS OF**
2 **CARE.**

3 (a) CERTIFICATIONS.—State health security pro-
4 grams may require, as a condition of payment for institu-
5 tional health care services and other services of the type
6 described in such sections 1814(a) and 1835(a) of the So-
7 cial Security Act, periodic professional certifications of the
8 kind described in such sections.

9 (b) QUALITY REVIEW.—For requirement that each
10 State health security program establish a quality review
11 program that meets the requirements for such a program
12 under title V, see section 404(b)(1)(H).

13 (c) PLAN OF CARE REQUIREMENTS.—A State health
14 security program may require, consistent with standards
15 established by the Board, that payment for services ex-
16 ceeding specified levels or duration be provided only as
17 consistent with a plan of care or treatment formulated by
18 one or more providers of the services or other qualified
19 professionals. Such a plan may include, consistent with
20 subsection (b), case management at specified intervals as
21 a further condition of payment for services.

22 **TITLE III—PROVIDER**
23 **PARTICIPATION**

24 **SEC. 301. PROVIDER PARTICIPATION AND STANDARDS.**

25 (a) IN GENERAL.—An individual or other entity fur-
26 nishing any covered service under a State health security

1 program under this Act is not a qualified provider unless
2 the individual or entity—

3 (1) is a qualified provider of the services under
4 section 302;

5 (2) has filed with the State health security pro-
6 gram a participation agreement described in sub-
7 section (b); and

8 (3) meets such other qualifications and condi-
9 tions as are established by the Board or the State
10 health security program under this Act.

11 (b) REQUIREMENTS IN PARTICIPATION AGREE-
12 MENT.—

13 (1) IN GENERAL.—A participation agreement
14 described in this subsection between a State health
15 security program and a provider shall provide at
16 least for the following:

17 (A) Services to eligible persons will be fur-
18 nished by the provider without discrimination
19 on the ground of race, national origin, income,
20 religion, age, sex or sexual orientation, dis-
21 ability, handicapping condition, or (subject to
22 the professional qualifications of the provider)
23 illness. Nothing in this subparagraph shall be
24 construed as requiring the provision of a type

1 or class of services which services are outside
2 the scope of the provider's normal practice.

3 (B) No charge will be made for any cov-
4 ered services other than for payment authorized
5 by this Act.

6 (C) The provider agrees to furnish such in-
7 formation as may be reasonably required by the
8 Board or a State health security program, in
9 accordance with uniform reporting standards
10 established under section 401(g)(1), for—

11 (i) quality review by designated enti-
12 ties;

13 (ii) the making of payments under
14 this Act (including the examination of
15 records as may be necessary for the
16 verification of information on which pay-
17 ments are based);

18 (iii) statistical or other studies re-
19 quired for the implementation of this Act;
20 and

21 (iv) such other purposes as the Board
22 or State may specify.

23 (D) The provider agrees not to bill the pro-
24 gram for any services for which benefits are not
25 available because of section 204(d).

1 (E) In the case of a provider that is not
2 an individual, the provider agrees not to employ
3 or use for the provision of health services any
4 individual or other provider who or which has
5 had a participation agreement under this sub-
6 section terminated for cause.

7 (F) In the case of a provider paid under a
8 fee-for-service basis under section 612, the pro-
9 vider agrees to submit bills and any required
10 supporting documentation relating to the provi-
11 sion of covered services within 30 days (or such
12 shorter period as a State health security pro-
13 gram may require) after the date of providing
14 such services.

15 (2) TERMINATION OF PARTICIPATION AGREE-
16 MENTS.—

17 (A) IN GENERAL.—Participation agree-
18 ments may be terminated, with appropriate
19 notice—

20 (i) by the Board or a State health se-
21 curity program for failure to meet the
22 requirements of this title, or

23 (ii) by a provider.

24 (B) TERMINATION PROCESS.—Providers
25 shall be provided notice and a reasonable oppor-

1 tunity to correct deficiencies before the Board
2 or a State health security program terminates
3 an agreement unless a more immediate termi-
4 nation is required for public safety or similar
5 reasons.

6 **SEC. 302. QUALIFICATIONS FOR PROVIDERS.**

7 (a) IN GENERAL.—A health care provider is consid-
8 ered to be qualified to provide covered services if the pro-
9 vider is licensed or certified and meets—

10 (1) all the requirements of State law to provide
11 such services,

12 (2) applicable requirements of Federal law to
13 provide such services, and

14 (3) any applicable standards established under
15 subsection (b).

16 (b) MINIMUM PROVIDER STANDARDS.—

17 (1) IN GENERAL.—The Board shall establish,
18 evaluate, and update national minimum standards to
19 assure the quality of services provided under this
20 Act and to monitor efforts by State health security
21 programs to assure the quality of such services. A
22 State health security program may also establish ad-
23 ditional minimum standards which providers must
24 meet.

1 (2) NATIONAL MINIMUM STANDARDS.—The na-
2 tional minimum standards under paragraph (1) shall
3 be established for institutional providers of services,
4 individual health care practitioners, and comprehen-
5 sive health service organizations. Except as the
6 Board may specify in order to carry out this title,
7 a hospital, nursing facility, or other institutional
8 provider of services shall meet standards for such a
9 facility under the medicare program under title
10 XVIII of the Social Security Act. Such standards
11 also may include, where appropriate, elements relat-
12 ing to—

- 13 (A) adequacy and quality of facilities;
14 (B) training and competence of personnel
15 (including continuing education requirements);
16 (C) comprehensiveness of service;
17 (D) continuity of service;
18 (E) patient satisfaction (including waiting
19 time and access to services); and
20 (F) performance standards (including or-
21 ganization, facilities, structure of services, effi-
22 ciency of operation, and outcome in palliation,
23 improvement of health, stabilization, cure, or
24 rehabilitation).

1 (3) TRANSITION IN APPLICATION.—If the
 2 Board provides for additional requirements for pro-
 3 viders under this subsection, any such additional re-
 4 quirement shall be implemented in a manner that
 5 provides for a reasonable period during which a pre-
 6 viously qualified provider is permitted to meet such
 7 an additional requirement.

8 (4) EXCHANGE OF INFORMATION.—The Board
 9 shall provide for an exchange, at least annually,
 10 among State health security programs of informa-
 11 tion with respect to quality assurance and cost
 12 containment.

13 **SEC. 303. QUALIFICATIONS FOR COMPREHENSIVE HEALTH**
 14 **SERVICE ORGANIZATIONS.**

15 (a) IN GENERAL.—For purposes of this Act, a com-
 16 prehensive health service organization (in this section re-
 17 ferred to as a “CHSO”) is a public or private organization
 18 which, in return for a capitated payment amount, under-
 19 takes to furnish, arrange for the provision of, or provide
 20 payment with respect to—

21 (1) a full range of health services (as identified
 22 by the Board), including at least hospital services
 23 and physicians services, and

24 (2) out-of-area coverage in the case of urgently
 25 needed services,

1 to an identified population which is living in or near a
2 specified service area and which enrolls voluntarily in the
3 organization.

4 (b) ENROLLMENT.—

5 (1) IN GENERAL.—All eligible persons living in
6 or near the specified service area of a CHSO are eli-
7 gible to enroll in the organization; except that the
8 number of enrollees may be limited to avoid over-
9 taxing the resources of the organization.

10 (2) MINIMUM ENROLLMENT PERIOD.—Subject
11 to paragraph (3), the minimum period of enrollment
12 with a CHSO shall be twelve months, unless the en-
13 rolled individual becomes ineligible to enroll with the
14 organization.

15 (3) WITHDRAWAL FOR CAUSE.—Each CHSO
16 shall permit an enrolled individual to disenroll from
17 the organization for cause at any time.

18 (c) REQUIREMENTS FOR CHSOs.—

19 (1) ACCESSIBLE SERVICES.—Each CHSO, to
20 the maximum extent feasible, shall make all services
21 readily and promptly accessible to enrollees who live
22 in the specified service area.

23 (2) CONTINUITY OF CARE.—Each CHSO shall
24 furnish services in such manner as to provide con-
25 tinuity of care and (when services are furnished by

1 different providers) shall provide ready referral of
2 patients to such services and at such times as may
3 be medically appropriate.

4 (3) BOARD OF DIRECTORS.—In the case of a
5 CHSO that is a private organization—

6 (A) CONSUMER REPRESENTATION.—At
7 least one-third of the members of the CHSO's
8 board of directors must be consumer members
9 with no direct or indirect, personal or family
10 financial relationship to the organization.

11 (B) PROVIDER REPRESENTATION.—The
12 CHSO's board of directors must include at
13 least one member who represents health care
14 providers.

15 (4) PATIENT GRIEVANCE PROGRAM.—Each
16 CHSO must have in effect a patient grievance pro-
17 gram and must conduct regularly surveys of the sat-
18 isfaction of members with services provided by or
19 through the organization.

20 (5) MEDICAL STANDARDS.—Each CHSO must
21 provide that a committee or committees of health
22 care practitioners associated with the organization
23 will promulgate medical standards, oversee the pro-
24 fessional aspects of the delivery of care, perform the
25 functions of a pharmacy and drug therapeutics com-

1 mittee, and monitor and review the quality of all
2 health services (including drugs, education, and pre-
3 ventive services).

4 (6) PREMIUMS.—Premiums or other charges by
5 a CHSO for any services not paid for under this Act
6 must be reasonable.

7 (7) UTILIZATION AND BONUS INFORMATION.—
8 Each CHSO must—

9 (A) comply with the requirements of sec-
10 tion 1876(i)(8) of the Social Security Act (re-
11 lating to prohibiting physician incentive plans
12 that provide specific inducements to reduce or
13 limit medically necessary services), and

14 (B) make available to its membership utili-
15 zation information and data regarding financial
16 performance, including bonus or incentive pay-
17 ment arrangements to practitioners.

18 (8) PROVISION OF SERVICES TO ENROLLEES AT
19 INSTITUTIONS OPERATING UNDER GLOBAL BUDG-
20 ETS.—The organization shall arrange to reimburse
21 for hospital services and other facility-based services
22 (as identified by the Board) for services provided to
23 members of the organization in accordance with the
24 global operating budget of the hospital or facility ap-
25 proved under section 611.

1 (9) BROAD MARKETING.—Each CHSO must
2 provide for the marketing of its services (including
3 dissemination of marketing materials) to potential
4 enrollees in a manner that is designed to enroll indi-
5 viduals representative of the different population
6 groups and geographic areas included within its
7 service area and meets such requirements as the
8 Board or a State health security program may
9 specify.

10 (10) ADDITIONAL REQUIREMENTS.—Each
11 CHSO must meet—

12 (A) such requirements relating to min-
13 imum enrollment,

14 (B) such requirements relating to financial
15 solvency,

16 (C) such requirements relating to quality
17 and availability of care, and

18 (D) such other requirements,

19 as the Board or a State health security program
20 may specify.

21 (d) PROVISION OF EMERGENCY SERVICES TO NON-
22 ENROLLEES.—A CHSO may furnish emergency services
23 to persons who are not enrolled in the organization. Pay-
24 ment for such services, if they are covered services to eligi-
25 ble persons, shall be made to the organization unless the

1 organization requests that it be made to the individual
 2 provider who furnished the services.

3 **SEC. 304. LIMITATION ON CERTAIN PHYSICIAN REFERRALS.**

4 (a) APPLICATION TO AMERICAN HEALTH SECURITY
 5 PROGRAM.—Section 1877 of the Social Security Act, as
 6 amended by subsections (b) and (c), shall apply under this
 7 Act in the same manner as it applies under title XVIII
 8 of the Social Security Act; except that in applying such
 9 section under this Act any references in such section to
 10 the Secretary or title XVIII of the Social Security Act are
 11 deemed references to the Board and the American Health
 12 Security Program under this Act, respectively.

13 (b) EXPANSION OF PROHIBITION TO CERTAIN ADDI-
 14 TIONAL DESIGNATED SERVICES.—Section 1877(h)(6) of
 15 the Social Security Act (42 U.S.C. 1395nn(h)(6)) is
 16 amended by adding at the end the following:

17 “(L) Ambulance services.

18 “(M) Home infusion therapy services.”.

19 (c) CONFORMING AMENDMENTS.—Section 1877 of
 20 such Act is further amended—

21 (1) in subsection (a)(1)(A), by striking “for
 22 which payment otherwise may be made under this
 23 title” and by inserting “for which a charge is
 24 imposed”;

1 (2) in subsection (a)(1)(B), by striking “under
2 this title”;

3 (3) by amending paragraph (1) of subsection
4 (g) to read as follows:

5 “(1) DENIAL OF PAYMENT.—No payment may
6 be made under a State health security program for
7 a designated health service for which a claim is pre-
8 sented in violation of subsection (a)(1)(B). No indi-
9 vidual, third party payor, or other entity is liable for
10 payment for designated health services for which a
11 claim is presented in violation of such subsection.”;
12 and

13 (4) in subsection (g)(3), by striking “for which
14 payment may not be made under paragraph (1)”
15 and by inserting “for which such a claim may not
16 be presented under subsection (a)(1)”.

17 **TITLE IV—ADMINISTRATION**
18 **Subtitle A—General Administrative**
19 **Provisions**

20 **SEC. 401. AMERICAN HEALTH SECURITY STANDARDS**
21 **BOARD.**

22 (a) ESTABLISHMENT.—There is hereby established
23 an American Health Security Standards Board.

24 (b) APPOINTMENT AND TERMS OF MEMBERS.—

1 (1) IN GENERAL.—The Board shall be com-
2 posed of—

3 (A) the Secretary of Health and Human
4 Services, and

5 (B) 6 other individuals (described in para-
6 graph (2)) appointed by the President with the
7 advice and consent of the Senate.

8 The President shall first nominate individuals under
9 subparagraph (B) on a timely basis so as to provide
10 for the operation of the Board by not later than
11 January 1, 2000.

12 (2) SELECTION OF APPOINTED MEMBERS.—
13 With respect to the individuals appointed under
14 paragraph (1)(B):

15 (A) They shall be chosen on the basis of
16 backgrounds in health policy, health economics,
17 the healing professions, and the administration
18 of health care institutions.

19 (B) They shall provide a balanced point of
20 view with respect to the various health care in-
21 terests and at least two of them shall represent
22 the interests of individual consumers.

23 (C) Not more than three of them shall be
24 from the same political party.

1 (D) To the greatest extent feasible, they
2 shall represent the various geographic regions
3 of the United States and shall reflect the racial,
4 ethnic, and gender composition of the popu-
5 lation of the United States.

6 (3) TERMS OF APPOINTED MEMBERS.—Individ-
7 uals appointed under paragraph (1)(B) shall serve
8 for a term of 6 years, except that the terms of 5 of
9 the individuals initially appointed shall be, as des-
10 ignated by the President at the time of their ap-
11 pointment, for 1, 2, 3, 4, and 5 years. During a
12 term of membership on the Board, no member shall
13 engage in any other business, vocation or employ-
14 ment.

15 (c) VACANCIES.—

16 (1) IN GENERAL.—The President shall fill any
17 vacancy in the membership of the Board in the same
18 manner as the original appointment. The vacancy
19 shall not affect the power of the remaining members
20 to execute the duties of the Board.

21 (2) VACANCY APPOINTMENTS.—Any member
22 appointed to fill a vacancy shall serve for the re-
23 mainder of the term for which the predecessor of the
24 member was appointed.

1 (3) REAPPOINTMENT.—The President may re-
2 appoint an appointed member of the Board for a
3 second term in the same manner as the original ap-
4 pointment. A member who has served for two con-
5 secutive 6-year terms shall not be eligible for re-
6 appointment until two years after the member has
7 ceased to serve.

8 (4) REMOVAL FOR CAUSE.—Upon confirmation,
9 members of the Board may not be removed except
10 by the President for cause.

11 (d) CHAIR.—The President shall designate one of the
12 members of the Board, other than the Secretary, to serve
13 at the will of the President as Chair of the Board.

14 (e) COMPENSATION.—Members of the Board (other
15 than the Secretary) shall be entitled to compensation at
16 a level equivalent to level II of the Executive Schedule,
17 in accordance with section 5313 of title 5, United States
18 Code.

19 (f) GENERAL DUTIES OF THE BOARD.—

20 (1) IN GENERAL.—The Board shall develop
21 policies, procedures, guidelines, and requirements to
22 carry out this Act, including those related to—

23 (A) eligibility;

24 (B) enrollment;

25 (C) benefits;

1 (D) provider participation standards and
2 qualifications, as defined in title III;

3 (E) national and State funding levels;

4 (F) methods for determining amounts of
5 payments to providers of covered services, con-
6 sistent with subtitle B of title VI;

7 (G) the determination of medical necessity
8 and appropriateness with respect to coverage of
9 certain services;

10 (H) assisting State health security pro-
11 grams with planning for capital expenditures
12 and service delivery;

13 (I) planning for health professional edu-
14 cation funding (as specified in title VI);

15 (J) allocating funds provided under title
16 VII; and

17 (K) encouraging States to develop regional
18 planning mechanisms (described in section
19 404(a)(3)).

20 (2) REGULATIONS.—Regulations authorized by
21 this Act shall be issued by the Board in accordance
22 with the provisions of section 553 of title 5, United
23 States Code.

24 (g) UNIFORM REPORTING STANDARDS; ANNUAL RE-
25 PORT; STUDIES.—

1 (1) UNIFORM REPORTING STANDARDS.—

2 (A) IN GENERAL.—The Board shall estab-
3 lish uniform reporting requirements and stand-
4 ards to ensure an adequate national data base
5 regarding health services practitioners, services
6 and finances of State health security programs,
7 approved plans, providers, and the costs of fa-
8 cilities and practitioners providing services.
9 Such standards shall include, to the maximum
10 extent feasible, health outcome measures.

11 (B) REPORTS.—The Board shall analyze
12 regularly information reported to it, and to
13 State health security programs pursuant to
14 such requirements and standards.

15 (2) ANNUAL REPORT.—Beginning January 1,
16 of the second year beginning after the date of the
17 enactment of this Act, the Board shall annually
18 report to Congress on the following:

19 (A) The status of implementation of the
20 Act.

21 (B) Enrollment under this Act.

22 (C) Benefits under this Act.

23 (D) Expenditures and financing under this
24 Act.

1 (E) Cost-containment measures and
2 achievements under this Act.

3 (F) Quality assurance.

4 (G) Health care utilization patterns, in-
5 cluding any changes attributable to the pro-
6 gram.

7 (H) Long-range plans and goals for the de-
8 livery of health services.

9 (I) Differences in the health status of the
10 populations of the different States, including in-
11 come and racial characteristics.

12 (J) Necessary changes in the education of
13 health personnel.

14 (K) Plans for improving service to medi-
15 cally underserved populations.

16 (L) Transition problems as a result of im-
17 plementation of this Act.

18 (M) Opportunities for improvements under
19 this Act.

20 (3) STATISTICAL ANALYSES AND OTHER STUD-
21 IES.—The Board may, either directly or by
22 contract—

23 (A) make statistical and other studies, on
24 a nationwide, regional, state, or local basis, of
25 any aspect of the operation of this Act, includ-

1 ing studies of the effect of the Act upon the
2 health of the people of the United States and
3 the effect of comprehensive health services upon
4 the health of persons receiving such services;

5 (B) develop and test methods of providing
6 through payment for services or otherwise, ad-
7 ditional incentives for adherence by providers to
8 standards of adequacy, access, and quality;
9 methods of consumer and peer review and peer
10 control of the utilization of drugs, of laboratory
11 services, and of other services; and methods of
12 consumer and peer review of the quality of serv-
13 ices;

14 (C) develop and test, for use by the Board,
15 records and information retrieval systems and
16 budget systems for health services administra-
17 tion, and develop and test model systems for
18 use by providers of services;

19 (D) develop and test, for use by providers
20 of services, records and information retrieval
21 systems useful in the furnishing of preventive
22 or diagnostic services;

23 (E) develop, in collaboration with the phar-
24 maceutical profession, and test, improved ad-
25 ministrative practices or improved methods for

1 the reimbursement of independent pharmacies
2 for the cost of furnishing drugs as a covered
3 service; and

4 (F) make such other studies as it may con-
5 sider necessary or promising for the evaluation,
6 or for the improvement, of the operation of this
7 Act.

8 (4) REPORT ON USE OF EXISTING FEDERAL
9 HEALTH CARE FACILITIES.—Not later than one year
10 after the date of the enactment of this Act, the
11 Board shall recommend to the Congress one or more
12 proposals for the treatment of health care facilities
13 of the Federal Government.

14 (h) EXECUTIVE DIRECTOR.—

15 (1) APPOINTMENT.—There is hereby estab-
16 lished the position of Executive Director of the
17 Board. The Director shall be appointed by the
18 Board and shall serve as secretary to the Board and
19 perform such duties in the administration of this
20 title as the Board may assign.

21 (2) DELEGATION.—The Board is authorized to
22 delegate to the Director or to any other officer or
23 employee of the Board or, with the approval of the
24 Secretary of Health and Human Services (and sub-
25 ject to reimbursement of identifiable costs), to any

1 other officer or employee of the Department of
2 Health and Human Services, any of its functions or
3 duties under this Act other than—

4 (A) the issuance of regulations; or

5 (B) the determination of the availability of
6 funds and their allocation to implement this
7 Act.

8 (3) COMPENSATION.—The Executive Director
9 of the Board shall be entitled to compensation at a
10 level equivalent to level III of the Executive Sched-
11 ule, in accordance with section 5314 of title 5,
12 United States Code.

13 (i) INSPECTOR GENERAL.—The Inspector General
14 Act of 1978 (5 U.S.C. App.) is amended—

15 (1) in section 11(1) by inserting after “Cor-
16 poration;” the following: “the Chair of the American
17 Health Security Standards Board;”;

18 (2) in section 11(2) by inserting after “Infor-
19 mation Agency,” the following: “the American
20 Health Security Standards Board;” and

21 (3) by inserting after the second section 8G the
22 following:

1 **“§ 8I. Special provisions concerning American Health**
2 **Security Standards Board**

3 “The Inspector General of the American Health Se-
4 curity Standards Board, in addition to the other authori-
5 ties vested by this Act, shall have the same authority, with
6 respect to the Board and the American Health Security
7 Program under this Act, as the Inspector General for the
8 Department of Health and Human Services has with re-
9 spect to the Secretary of Health and Human Services and
10 the medicare and medicaid programs, respectively.”.

11 (j) STAFF.—The Board shall employ such staff as the
12 Board may deem necessary.

13 (k) ACCESS TO INFORMATION.—The Secretary of
14 Health and Human Services shall make available to the
15 Board all information available from sources within the
16 Department or from other sources, pertaining to the
17 duties of the Board.

18 **SEC. 402. AMERICAN HEALTH SECURITY ADVISORY COUN-**
19 **CIL.**

20 (a) IN GENERAL.—The Board shall provide for an
21 American Health Security Advisory Council (in this sec-
22 tion referred to as the “Council”) to advise the Board on
23 its activities.

24 (b) MEMBERSHIP.—The Council shall be composed
25 of—

1 (1) the Chair of the Board, who shall serve as
2 Chair of the Council, and

3 (2) twenty members, not otherwise in the em-
4 ploy of the United States, appointed by the Board
5 without regard to the provisions of title 5, United
6 States Code, governing appointments in the competi-
7 tive service.

8 The appointed members shall include, in accordance with
9 subsection (e), individuals who are representative of State
10 health security programs, public health professionals, pro-
11 viders of health services, and of individuals (who shall con-
12 stitute a majority of the Council) who are representative
13 of consumers of such services, including a balanced rep-
14 resentation of employers, unions, consumer organizations,
15 and population groups with special health care needs. To
16 the greatest extent feasible, the membership of the Council
17 shall represent the various geographic regions of the
18 United States and shall reflect the racial, ethnic, and gen-
19 der composition of the population of the United States.

20 (c) TERMS OF MEMBERS.—Each appointed member
21 shall hold office for a term of four years, except that—

22 (1) any member appointed to fill a vacancy oc-
23 curring during the term for which the member's
24 predecessor was appointed shall be appointed for the
25 remainder of that term; and

1 (2) the terms of the members first taking office
2 shall expire, as designated by the Board at the time
3 of appointment, five at the end of the first year, five
4 at the end of the second year, five at the end of the
5 third year, and five at the end of the fourth year
6 after the date of enactment of this Act.

7 (d) VACANCIES.—

8 (1) IN GENERAL.—The Board shall fill any va-
9 cancy in the membership of the Council in the same
10 manner as the original appointment. The vacancy
11 shall not affect the power of the remaining members
12 to execute the duties of the Council.

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

17 (3) REAPPOINTMENT.—The Board may re-
18 appoint an appointed member of the Council for a
19 second term in the same manner as the original
20 appointment.

21 (e) QUALIFICATIONS.—

22 (1) PUBLIC HEALTH REPRESENTATIVES.—
23 Members of the Council who are representative of
24 State health security programs and public health
25 professionals shall be individuals who have extensive

1 experience in the financing and delivery of care
2 under public health programs.

3 (2) PROVIDERS.—Members of the Council who
4 are representative of providers of health care shall
5 be individuals who are outstanding in fields related
6 to medical, hospital, or other health activities, or
7 who are representative of organizations or associa-
8 tions of professional health practitioners.

9 (3) CONSUMERS.—Members who are represent-
10 ative of consumers of such care shall be individuals,
11 not engaged in and having no financial interest in
12 the furnishing of health services, who are familiar
13 with the needs of various segments of the population
14 for personal health services and are experienced in
15 dealing with problems associated with the consump-
16 tion of such services.

17 (f) DUTIES.—

18 (1) IN GENERAL.—It shall be the duty of the
19 Council—

20 (A) to advise the Board on matters of gen-
21 eral policy in the administration of this Act, in
22 the formulation of regulations, and in the per-
23 formance of the Board's duties under section
24 401; and

1 (B) to study the operation of this Act and
2 the utilization of health services under it, with
3 a view to recommending any changes in the ad-
4 ministration of the Act or in its provisions
5 which may appear desirable.

6 (2) REPORT.—The Council shall make an an-
7 nual report to the Board on the performance of its
8 functions, including any recommendations it may
9 have with respect thereto, and the Board shall
10 promptly transmit the report to the Congress, to-
11 gether with a report by the Board on any rec-
12 ommendations of the Council that have not been
13 followed.

14 (g) STAFF.—The Council, its members, and any com-
15 mittees of the Council shall be provided with such secre-
16 tarial, clerical, or other assistance as may be authorized
17 by the Board for carrying out their respective functions.

18 (h) MEETINGS.—The Council shall meet as fre-
19 quently as the Board deems necessary, but not less than
20 four times each year. Upon request by seven or more mem-
21 bers it shall be the duty of the Chair to call a meeting
22 of the Council.

23 (i) COMPENSATION.—Members of the Council shall
24 be reimbursed by the Board for travel and per diem in
25 lieu of subsistence expenses during the performance of du-

1 ties of the Board in accordance with subchapter I of chap-
2 ter 57 of title 5, United States Code.

3 (j) FACA NOT APPLICABLE.—The provisions of the
4 Federal Advisory Committee Act shall not apply to the
5 Council.

6 **SEC. 403. CONSULTATION WITH PRIVATE ENTITIES.**

7 The Secretary and the Board shall consult with pri-
8 vate entities, such as professional societies, national asso-
9 ciations, nationally recognized associations of experts,
10 medical schools and academic health centers, consumer
11 groups, and labor and business organizations in the for-
12 mulation of guidelines, regulations, policy initiatives, and
13 information gathering to assure the broadest and most in-
14 formed input in the administration of this Act. Nothing
15 in this Act shall prevent the Secretary from adopting
16 guidelines developed by such a private entity if, in the Sec-
17 retary's and Board's judgment, such guidelines are gen-
18 erally accepted as reasonable and prudent and consistent
19 with this Act.

20 **SEC. 404. STATE HEALTH SECURITY PROGRAMS.**

21 (a) SUBMISSION OF PLANS.—

22 (1) IN GENERAL.—Each State shall submit to
23 the Board a plan for a State health security pro-
24 gram for providing for health care services to the
25 residents of the State in accordance with this Act.

1 (2) REGIONAL PROGRAMS.—A State may join
2 with one or more neighboring States to submit to
3 the Board a plan for a regional health security pro-
4 gram instead of separate State health security
5 programs.

6 (3) REGIONAL PLANNING MECHANISMS.—The
7 Board shall provide incentives for States to develop
8 regional planning mechanisms to promote the ration-
9 al distribution of, adequate access to, and efficient
10 use of, tertiary care facilities, equipment, and
11 services.

12 (b) REVIEW AND APPROVAL OF PLANS.—

13 (1) IN GENERAL.—The Board shall review
14 plans submitted under subsection (a) and determine
15 whether such plans meet the requirements for ap-
16 proval. The Board shall not approve such a plan un-
17 less it finds that the plan (or State law) provides,
18 consistent with the provisions of this Act, for the
19 following:

20 (A) Payment for required health services
21 for eligible individuals in the State in accord-
22 ance with this Act.

23 (B) Adequate administration, including the
24 designation of a single State agency responsible

1 for the administration (or supervision of the
2 administration) of the program.

3 (C) The establishment of a State health
4 security budget.

5 (D) Establishment of payment methodolo-
6 gies (consistent with subtitle B of title VII).

7 (E) Assurances that individuals have the
8 freedom to choose practitioners and other
9 health care providers for services covered under
10 this Act.

11 (F) A procedure for carrying out long-term
12 regional management and planning functions
13 with respect to the delivery and distribution of
14 health care services that—

15 (i) ensures participation of consumers
16 of health services and providers of health
17 services, and

18 (ii) gives priority to the most acute
19 shortages and maldistributions of health
20 personnel and facilities and the most seri-
21 ous deficiencies in the delivery of covered
22 services and to the means for the speedy
23 alleviation of these shortcomings.

24 (G) The licensure and regulation of all
25 health providers and facilities to ensure compli-

1 ance with Federal and State laws and to
2 promote quality of care.

3 (H) Establishment of a quality review sys-
4 tem in accordance with section 503.

5 (I) Establishment of an independent om-
6 budsman for consumers to register complaints
7 about the organization and administration of
8 the State health security program and to help
9 resolve complaints and disputes between con-
10 sumers and providers.

11 (J) Publication of an annual report on the
12 operation of the State health security program,
13 which report shall include information on cost,
14 progress towards achieving full enrollment, pub-
15 lic access to health services, quality review,
16 health outcomes, health professional training,
17 and the needs of medically underserved
18 populations.

19 (K) Provision of a fraud and abuse preven-
20 tion and control unit that the Inspector General
21 determines meets the requirements of section
22 412(a).

23 (L) Prohibit payment in cases of prohib-
24 ited physician referrals under section 304.

1 (2) CONSEQUENCES OF FAILURE TO COMPLY.—

2 If the Board finds that a State plan submitted
3 under paragraph (1) does not meet the requirements
4 for approval under this section or that a State
5 health security program or specific portion of such
6 program, the plan for which was previously ap-
7 proved, no longer meets such requirements, the
8 Board shall provide notice to the State of such fail-
9 ure and that unless corrective action is taken within
10 a period specified by the Board, the Board shall
11 place the State health security program (or specific
12 portions of such program) in receivership under the
13 jurisdiction of the Board.

14 (c) STATE HEALTH SECURITY ADVISORY COUN-
15 CILS.—

16 (1) IN GENERAL.—For each State, the Gov-
17 ernor shall provide for appointment of a State
18 Health Security Advisory Council to advise and
19 make recommendations to the Governor and State
20 with respect to the implementation of the State
21 health security program in the State.

22 (2) MEMBERSHIP.—Each State Health Security
23 Advisory Council shall be composed of at least 11 in-
24 dividuals. The appointed members shall include indi-
25 viduals who are representative of the State health

1 security program, public health professionals, pro-
2 viders of health services, and of individuals (who
3 shall constitute a majority) who are representative of
4 consumers of such services, including a balanced
5 representation of employers, unions and consumer
6 organizations. To the greatest extent feasible, the
7 membership of each State Health Security Advisory
8 Council shall represent the various geographic re-
9 gions of the State and shall reflect the racial, ethnic,
10 and gender composition of the population of the
11 State.

12 (3) DUTIES.—

13 (A) IN GENERAL.—Each State Health Se-
14 curity Advisory Council shall review, and sub-
15 mit comments to the Governor concerning the
16 implementation of the State health security pro-
17 gram in the State.

18 (B) ASSISTANCE.—Each State Health Se-
19 curity Advisory Council shall provide assistance
20 and technical support to community organiza-
21 tions and public and private non-profit agencies
22 submitting applications for funding under ap-
23 propriate State and Federal public health pro-
24 grams, with particular emphasis placed on as-

1 sisting those applicants with broad consumer
2 representation.

3 (d) STATE USE OF FISCAL AGENTS.—

4 (1) IN GENERAL.—Each State health security
5 program, using competitive bidding procedures, may
6 enter into such contracts with qualified entities, such
7 as voluntary associations, as the State determines to
8 be appropriate to process claims and to perform
9 other related functions of fiscal agents under the
10 State health security program.

11 (2) RESTRICTION.—Except as the Board may
12 provide for good cause shown, in no case may more
13 than one contract described in paragraph (1) be
14 entered into under a State health security program.

15 **SEC. 405. COMPLEMENTARY CONDUCT OF RELATED**
16 **HEALTH PROGRAMS.**

17 In performing functions with respect to health per-
18 sonnel education and training, health research, environ-
19 mental health, disability insurance, vocational rehabilita-
20 tion, the regulation of food and drugs, and all other mat-
21 ters pertaining to health, the Secretary of Health and
22 Human Services shall direct all activities of the Depart-
23 ment of Health and Human Services toward contributions
24 to the health of the people complementary to this Act.

1 **Subtitle B—Control Over Fraud**
2 **and Abuse**

3 **SEC. 411. APPLICATION OF FEDERAL SANCTIONS TO ALL**
4 **FRAUD AND ABUSE UNDER AMERICAN**
5 **HEALTH SECURITY PROGRAM.**

6 The following sections of the Social Security Act shall
7 apply to State health security programs in the same man-
8 ner as they apply to State medical assistance plans under
9 title XIX of such Act (except that in applying such provi-
10 sions any reference to the Secretary is deemed a reference
11 to the Board):

12 (1) Section 1128 (relating to exclusion of indi-
13 viduals and entities).

14 (2) Section 1128A (civil monetary penalties).

15 (3) Section 1128B (criminal penalties).

16 (4) Section 1124 (relating to disclosure of own-
17 ership and related information).

18 (5) Section 1126 (relating to disclosure of cer-
19 tain owners).

20 **SEC. 412. REQUIREMENTS FOR OPERATION OF STATE**
21 **HEALTH CARE FRAUD AND ABUSE CONTROL**
22 **UNITS.**

23 (a) REQUIREMENT.—In order to meet the require-
24 ment of section 404(b)(1)(K), each State health security
25 program must establish and maintain a health care fraud

1 and abuse control unit (in this section referred to as a
2 “fraud unit”) that meets requirements of this section and
3 other requirements of the Board. Such a unit may be a
4 State medicaid fraud control unit (described in section
5 1903(q) of the Social Security Act).

6 (b) STRUCTURE OF UNIT.—The fraud unit must—

7 (1) be a single identifiable entity of the State
8 government;

9 (2) be separate and distinct from the State
10 agency with principal responsibility for the adminis-
11 tration of the State health security program; and

12 (3) meet 1 of the following requirements:

13 (A) It must be a unit of the office of the
14 State Attorney General or of another depart-
15 ment of State government which possesses
16 statewide authority to prosecute individuals for
17 criminal violations.

18 (B) If it is in a State the constitution of
19 which does not provide for the criminal prosecu-
20 tion of individuals by a statewide authority and
21 has formal procedures, approved by the Board,
22 that (i) assure its referral of suspected criminal
23 violations relating to the State health insurance
24 plan to the appropriate authority or authorities
25 in the States for prosecution, and (ii) assure its

1 assistance of, and coordination with, such au-
2 thority or authorities in such prosecutions.

3 (C) It must have a formal working rela-
4 tionship with the office of the State Attorney
5 General and have formal procedures (including
6 procedures for its referral of suspected criminal
7 violations to such office) which are approved by
8 the Board and which provide effective coordina-
9 tion of activities between the fraud unit and
10 such office with respect to the detection, inves-
11 tigation, and prosecution of suspected criminal
12 violations relating to the State health insurance
13 plan.

14 (c) FUNCTIONS.—The fraud unit must—

15 (1) have the function of conducting a statewide
16 program for the investigation and prosecution of vio-
17 lations of all applicable State laws regarding any
18 and all aspects of fraud in connection with any as-
19 pect of the provision of health care services and ac-
20 tivities of providers of such services under the State
21 health security program;

22 (2) have procedures for reviewing complaints of
23 the abuse and neglect of patients of providers and
24 facilities that receive payments under the State
25 health security program, and, where appropriate, for

1 acting upon such complaints under the criminal laws
2 of the State or for referring them to other State
3 agencies for action; and

4 (3) provide for the collection, or referral for col-
5 lection to a single State agency, of overpayments
6 that are made under the State health security pro-
7 gram to providers and that are discovered by the
8 fraud unit in carrying out its activities.

9 (d) RESOURCES.—The fraud unit must—

10 (1) employ such auditors, attorneys, investiga-
11 tors, and other necessary personnel,

12 (2) be organized in such a manner, and

13 (3) provide sufficient resources (as specified by
14 the Board), as is necessary to promote the effective
15 and efficient conduct of the unit's activities.

16 (e) COOPERATIVE AGREEMENTS.—The fraud unit
17 must have cooperative agreements (as specified by the
18 Board) with—

19 (1) similar fraud units in other States,

20 (2) the Inspector General, and

21 (3) the Attorney General of the United States.

22 (f) REPORTS.—The fraud unit must submit to the
23 Inspector General an application and annual reports con-
24 taining such information as the Inspector General deter-

1 mines to be necessary to determine whether the unit meets
2 the previous requirements of this section.

3 **TITLE V—QUALITY ASSESSMENT**

4 **SEC. 501. AMERICAN HEALTH SECURITY QUALITY COUNCIL.**

5 (a) ESTABLISHMENT.—There is hereby established
6 an American Health Security Quality Council (in this title
7 referred to as the “Council”).

8 (b) DUTIES OF THE COUNCIL.—The Council shall
9 perform the following duties:

10 (1) PRACTICE GUIDELINES.—The Council shall
11 review and evaluate each practice guideline devel-
12 oped under part B of title IX of the Public Health
13 Service Act. The Council shall determine whether
14 the guideline should be recognized as a national
15 practice guideline to be used under section 204(d)
16 for purposes of determining payments under a State
17 health security program.

18 (2) STANDARDS OF QUALITY, PERFORMANCE
19 MEASURES, AND MEDICAL REVIEW CRITERIA.—The
20 Council shall review and evaluate each standard of
21 quality, performance measure, and medical review
22 criterion developed under part B of title IX of the
23 Public Health Service Act. The Council shall deter-
24 mine whether the standard, measure, or criterion is
25 appropriate for use in assessing or reviewing the

1 quality of services provided by State health security
2 programs, health care institutions, or health care
3 professionals.

4 (3) CRITERIA FOR ENTITIES CONDUCTING
5 QUALITY REVIEWS.—The Council shall develop min-
6 imum criteria for competence for entities that can
7 qualify to conduct ongoing and continuous external
8 quality review for State quality review programs
9 under section 503. Such criteria shall require such
10 an entity to be administratively independent of the
11 individual or board that administers the State health
12 security program and shall ensure that such entities
13 do not provide financial incentives to reviewers to
14 favor one pattern of practice over another. The
15 Council shall ensure coordination and reporting by
16 such entities to assure national consistency in qual-
17 ity standards.

18 (4) REPORTING.—The Council shall report to
19 the Board annually on the conduct of activities
20 under such title and shall report to the Board annu-
21 ally specifically on findings from outcomes research
22 and development of practice guidelines that may af-
23 fect the Board's determination of coverage of serv-
24 ices under section 401(f)(1)(G).

1 (5) OTHER FUNCTIONS.—The Council shall
2 perform the functions of the Council described in
3 section 502.

4 (c) APPOINTMENT AND TERMS OF MEMBERS.—

5 (1) IN GENERAL.—The Council shall be com-
6 posed of 10 members appointed by the President.
7 The President shall first appoint individuals on a
8 timely basis so as to provide for the operation of the
9 Council by not later than January 1, 2000.

10 (2) SELECTION OF MEMBERS.—Each member
11 of the Council shall be a member of a health profes-
12 sion. Five members of the Council shall be physi-
13 cians. Individuals shall be appointed to the Council
14 on the basis of national reputations for clinical and
15 academic excellence. To the greatest extent feasible,
16 the membership of the Council shall represent the
17 various geographic regions of the United States and
18 shall reflect the racial, ethnic, and gender composi-
19 tion of the population of the United States.

20 (3) TERMS OF MEMBERS.—Individuals ap-
21 pointed to the Council shall serve for a term of 5
22 years, except that the terms of 4 of the individuals
23 initially appointed shall be, as designated by the
24 President at the time of their appointment, for 1, 2,
25 3, and 4 years.

1 (d) VACANCIES.—

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

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

11 (3) REAPPOINTMENT.—The President may re-
12 appoint a member of the Council for a second term
13 in the same manner as the original appointment. A
14 member who has served for two consecutive 5-year
15 terms shall not be eligible for reappointment until
16 two years after the member has ceased to serve.

17 (e) CHAIR.—The President shall designate one of the
18 members of the Council to serve at the will of the Presi-
19 dent as Chair of the Council.

20 (f) COMPENSATION.—Members of the Council who
21 are not employees of the Federal Government shall be en-
22 titled to compensation at a level equivalent to level II of
23 the Executive Schedule, in accordance with section 5313
24 of title 5, United States Code.

1 **SEC. 502. DEVELOPMENT OF CERTAIN METHODOLOGIES,**
2 **GUIDELINES, AND STANDARDS.**

3 (a) **PROFILING OF PATTERNS OF PRACTICE; IDENTI-**
4 **FICATION OF OUTLIERS.**—The Council shall adopt meth-
5 odologies for profiling the patterns of practice of health
6 care professionals and for identifying outliers (as defined
7 in subsection (e)).

8 (b) **CENTERS OF EXCELLENCE.**—The Council shall
9 develop guidelines for certain medical procedures des-
10 ignated by the Board to be performed only at tertiary care
11 centers which can meet standards for frequency of proce-
12 dure performance and intensity of support mechanisms
13 that are consistent with the high probability of desired pa-
14 tient outcome. Reimbursement under this Act for such a
15 designated procedure may only be provided if the proce-
16 dure was performed at a center that meets such stand-
17 ards.

18 (c) **REMEDIAL ACTIONS.**—The Council shall develop
19 standards for education and sanctions with respect to
20 outliers so as to assure the quality of health care services
21 provided under this Act. The Council shall develop criteria
22 for referral of providers to the State licensing board if edu-
23 cation proves ineffective in correcting provider practice be-
24 havior.

25 (d) **DISSEMINATION.**—The Council shall disseminate
26 to the State—

1 (1) the methodologies adopted under subsection
2 (a),
3 (2) the guidelines developed under subsection
4 (b), and
5 (3) the standards developed under subsection
6 (c),
7 for use by the States under section 503.

8 (e) OUTLIER DEFINED.—In this title, the term
9 “outlier” means a health care provider whose pattern of
10 practice, relative to applicable practice guidelines, suggests
11 deficiencies in the quality of health care services being pro-
12 vided.

13 **SEC. 503. STATE QUALITY REVIEW PROGRAMS.**

14 (a) REQUIREMENT.—In order to meet the require-
15 ment of section 404(b)(1)(H), each State health security
16 program shall establish one or more qualified entities to
17 conduct quality reviews of persons providing covered serv-
18 ices under the program, in accordance with standards es-
19 tablished under subsection (b)(1) (except as provided in
20 subsection (b)(2)) and subsection (d).

21 (b) FEDERAL STANDARDS.—

22 (1) IN GENERAL.—The Council shall establish
23 standards with respect to—

1 (A) the adoption of practice guidelines
2 (whether developed by the Federal Government
3 or other entities),

4 (B) the identification of outliers (con-
5 sistent with methodologies adopted under sec-
6 tion 502(a)),

7 (C) the development of remedial programs
8 and monitoring for outliers, and

9 (D) the application of sanctions (consistent
10 with the standards developed under section
11 502(c)).

12 (2) STATE DISCRETION.—A State may apply
13 under subsection (a) standards other than those es-
14 tablished under paragraph (1) so long as the State
15 demonstrates to the satisfaction of the Council on an
16 annual basis that the standards applied have been as
17 efficacious in promoting and achieving improved
18 quality of care as the application of the standards
19 established under paragraph (1). Positive improve-
20 ments in quality shall be documented by reductions
21 in the variations of clinical care process and im-
22 provement in patient outcomes.

23 (c) QUALIFICATIONS.—An entity is not qualified to
24 conduct quality reviews under subsection (a) unless the

1 entity satisfies the criteria for competence for such entities
 2 developed by the Council under section 501(b)(3).

3 (d) INTERNAL QUALITY REVIEW.—Nothing in this
 4 section shall preclude an institutional provider from estab-
 5 lishing its own internal quality review and enhancement
 6 programs.

7 **SEC. 504. ELIMINATION OF UTILIZATION REVIEW PRO-**
 8 **GRAMS; TRANSITION.**

9 (a) INTENT.—It is the intention of this title to re-
 10 place by January 1, 2003, random utilization controls with
 11 a systematic review of patterns of practice that com-
 12 promise the quality of care.

13 (b) SUPERSEDING CASE REVIEWS.—

14 (1) IN GENERAL.—Subject to the succeeding
 15 provisions of this subsection, the program of quality
 16 review provided under the previous sections of this
 17 title supersede all existing Federal requirements for
 18 utilization review programs, including requirements
 19 for random case-by-case reviews and programs re-
 20 quiring pre-certification of medical procedures on a
 21 case-by-case basis.

22 (2) TRANSITION.—Before January 1, 2003, the
 23 Board and the States may employ existing utiliza-
 24 tion review standards and mechanisms as may be

1 necessary to effect the transition to pattern of prac-
 2 tice-based reviews.

3 (3) CONSTRUCTION.—Nothing in this sub-
 4 section shall be construed—

5 (A) as precluding the case-by-case review
 6 of the provision of care—

7 (i) in individual incidents where the
 8 quality of care has significantly deviated
 9 from acceptable standards of practice, and

10 (ii) with respect to a provider who has
 11 been determined to be an outlier; or

12 (B) as precluding the case management of
 13 catastrophic, mental health, or substance abuse
 14 cases or long-term care where such manage-
 15 ment is necessary to achieve appropriate, cost-
 16 effective, and beneficial comprehensive medical
 17 care, as provided for in section 204.

18 **TITLE VI—HEALTH SECURITY**
 19 **BUDGET; PAYMENTS; COST**
 20 **CONTAINMENT MEASURES**
 21 **Subtitle A—Budgeting and**
 22 **Payments to States**

23 **SEC. 601. NATIONAL HEALTH SECURITY BUDGET.**

24 (a) NATIONAL HEALTH SECURITY BUDGET.—

1 (1) IN GENERAL.—By not later than September
2 1 before the beginning of each year (beginning with
3 2000), the Board shall establish a national health
4 security budget, which—

5 (A) specifies the total expenditures (includ-
6 ing expenditures for administrative costs) to be
7 made by the Federal Government and the
8 States for covered health care services under
9 this Act, and

10 (B) allocates those expenditures among the
11 States consistent with section 604.

12 Pursuant to subsection (b), such budget for a year
13 shall not exceed the budget for the preceding year
14 increased by the percentage increase in gross domes-
15 tic product.

16 (2) DIVISION OF BUDGET INTO COMPONENTS.—
17 The national health security budget shall consist of
18 at least 4 components:

19 (A) A component for quality assessment
20 activities (described in title V).

21 (B) A component for health professional
22 education expenditures.

23 (C) A component for administrative costs.

24 (D) A component (in this title referred to
25 as the “operating component”) for operating

1 and other expenditures not described in sub-
2 paragraphs (A) through (C), consisting of
3 amounts not included in the other components.
4 A State may provide for the allocation of this
5 component between capital expenditures and
6 other expenditures.

7 (3) ALLOCATION AMONG COMPONENTS.—Tak-
8 ing into account the State health security budgets
9 established and submitted under section 603, the
10 Board shall allocate the national health security
11 budget among the components in a manner that—

12 (A) assures a fair allocation for quality as-
13 sessment activities (consistent with the national
14 health security spending growth limit); and

15 (B) assures that the health professional
16 education expenditure component is sufficient
17 to provide for the amount of health professional
18 education expenditures sufficient to meet the
19 need for covered health care services (consistent
20 with the national health security spending
21 growth limit under subsection (b)(2)).

22 (b) BASIS FOR TOTAL EXPENDITURES.—

23 (1) IN GENERAL.—The total expenditures speci-
24 fied in such budget shall be the sum of the capita-
25 tion amounts computed under section 602(a) and

1 the amount of Federal administrative expenditures
2 needed to carry out this Act.

3 (2) NATIONAL HEALTH SECURITY SPENDING
4 GROWTH LIMIT.—For purposes of this subtitle, the
5 national health security spending growth limit de-
6 scribed in this paragraph for a year is (A) zero, or,
7 if greater, (B) the average annual percentage in-
8 crease in the gross domestic product (in current dol-
9 lars) during the 3-year period beginning with the
10 first quarter of the fourth previous year to the first
11 quarter of the previous year minus the percentage
12 increase (if any) in the number of eligible individuals
13 residing in any State the United States from the
14 first quarter of the second previous year to the first
15 quarter of the previous year.

16 (c) DEFINITIONS.—In this title:

17 (1) CAPITAL EXPENDITURES.—The term “cap-
18 ital expenditures” means expenses for the purchase,
19 lease, construction, or renovation of capital facilities
20 and for equipment and includes return on equity
21 capital.

22 (2) HEALTH PROFESSIONAL EDUCATION EX-
23 PENDITURES.—The term “health professional edu-
24 cation expenditures” means expenditures in hospitals

1 and other health care facilities to cover costs associ-
 2 ated with teaching and related research activities.

3 **SEC. 602. COMPUTATION OF INDIVIDUAL AND STATE CAPI-**
 4 **TATION AMOUNTS.**

5 (a) CAPITATION AMOUNTS.—

6 (1) INDIVIDUAL CAPITATION AMOUNTS.—In es-
 7 tablishing the national health security budget under
 8 section 601(a) and in computing the national aver-
 9 age per capita cost under subsection (b) for each
 10 year, the Board shall establish a method for com-
 11 puting the capitation amount for each eligible indi-
 12 vidual residing in each State. The capitation amount
 13 for an eligible individual in a State classified within
 14 a risk group (established under subsection (d)(2)) is
 15 the product of—

16 (A) a national average per capita cost for
 17 all covered health care services (computed
 18 under subsection (b)),

19 (B) the State adjustment factor (estab-
 20 lished under subsection (c)) for the State, and

21 (C) the risk adjustment factor (established
 22 under subsection (d)) for the risk group.

23 (2) STATE CAPITATION AMOUNT.—

24 (A) IN GENERAL.—For purposes of this
 25 title, the term “State capitation amount”

1 means, for a State for a year, the sum of the
2 capitation amounts computed under paragraph
3 (1) for all the residents of the State in the year,
4 as estimated by the Board before the beginning
5 of the year involved.

6 (B) USE OF STATISTICAL MODEL.—The
7 Board may provide for the computation of
8 State capitation amounts based on statistical
9 models that fairly reflect the elements that com-
10 prise the State capitation amount described in
11 subparagraph (A).

12 (C) POPULATION INFORMATION.—The Bu-
13 reau of the Census shall assist the Board in de-
14 termining the number, place of residence, and
15 risk group classification of eligible individuals.

16 (b) COMPUTATION OF NATIONAL AVERAGE PER CAP-
17 ITA COST.—

18 (1) FOR 1998.—For 2000, the national average
19 per capita cost under this paragraph is equal to—

20 (A) the average per capita health care ex-
21 penditures in the United States in 1998 (as
22 estimated by the Board),

23 (B) increased to 1999 by the Board's esti-
24 mate of the actual amount of such per capita
25 expenditures during 1999, and

1 (C) updated to 2000 by the national health
 2 security spending growth limit specified in sec-
 3 tion 601(b)(2) for 2000.

4 (2) FOR SUCCEEDING YEARS.—For each suc-
 5 ceeding year, the national average per capita cost
 6 under this subsection is equal to the national aver-
 7 age per capita cost computed under this subsection
 8 for the previous year increased by the national
 9 health security spending growth limit (specified in
 10 section 601(b)(2)) for the year involved.

11 (c) STATE ADJUSTMENT FACTORS.—

12 (1) IN GENERAL.—Subject to the succeeding
 13 paragraphs of this subsection, the Board shall de-
 14 velop for each State a factor to adjust the national
 15 average per capita costs to reflect differences
 16 between the State and the United States in—

17 (A) average labor and nonlabor costs that
 18 are necessary to provide covered health services;

19 (B) any social, environmental, or geo-
 20 graphic condition affecting health status or the
 21 need for health care services, to the extent such
 22 a condition is not taken into account in the es-
 23 tablishment of risk groups under subsection (d);

24 (C) the geographic distribution of the
 25 State's population, particularly the proportion

1 of the population residing in medically under-
2 served areas, to the extent such a condition is
3 not taken into account in the establishment of
4 risk groups under subsection (d); and

5 (D) any other factor relating to operating
6 costs required to assure equitable distribution
7 of funds among the States.

8 (2) MODIFICATION OF HEALTH PROFESSIONAL
9 EDUCATION COMPONENT.—With respect to the por-
10 tion of the national health security budget allocated
11 to expenditures for health professional education, the
12 Board shall modify the State adjustment factors so
13 as to take into account—

14 (A) differences among States in health
15 professional education programs in operation as
16 of the date of the enactment of this Act, and

17 (B) differences among States in their rel-
18 ative need for expenditures for health profes-
19 sional education, taking into account the health
20 professional education expenditures proposed in
21 State health security budgets under section
22 603(a).

23 (3) BUDGET NEUTRALITY.—The State adjust-
24 ment factors, as modified under paragraph (2), shall
25 be applied under this subsection in a manner that

1 results in neither an increase nor a decrease in the
2 total amount of the Federal contributions to all
3 State health security programs under subsection (b)
4 as a result of the application of such factors.

5 (4) PHASE-IN.—In applying State adjustment
6 factors under this subsection during the five-year pe-
7 riod beginning with 2000, the Board shall phase-in,
8 over such period, the use of factors described in
9 paragraph (1) in a manner so that the adjustment
10 factor for a State is based on a blend of such factors
11 and a factor that reflects the relative actual average
12 per capita costs of health services of the different
13 States as of the time of enactment of this Act.

14 (5) PERIODIC ADJUSTMENT.—In establishing
15 the national health security budget before the begin-
16 ning of each year, the Board shall provide for appro-
17 priate adjustments in the State adjustment factors
18 under this subsection.

19 (d) ADJUSTMENTS FOR RISK GROUP CLASSIFICA-
20 TION.—

21 (1) IN GENERAL.—The Board shall develop an
22 adjustment factor to the national average per capita
23 costs computed under subsection (b) for individuals
24 classified in each risk group (as designated under
25 paragraph (2)) to reflect the difference between the

1 average national average per capita costs and the
 2 national average per capita cost for individuals clas-
 3 sified in the risk group.

4 (2) RISK GROUPS.—The Board shall designate
 5 a series of risk groups, determined by age, health in-
 6 dicators, and other factors that represent distinct
 7 patterns of health care services utilization and costs.

8 (3) PERIODIC ADJUSTMENT.—In establishing
 9 the national health security budget before the begin-
 10 ning of each year, the Board shall provide for appro-
 11 priate adjustments in the risk adjustment factors
 12 under this subsection.

13 **SEC. 603. STATE HEALTH SECURITY BUDGETS.**

14 (a) ESTABLISHMENT AND SUBMISSION OF BUDG-
 15 ETS.—

16 (1) IN GENERAL.—Each State health security
 17 program shall establish and submit to the Board for
 18 each year a proposed and a final State health secu-
 19 rity budget, which specifies the following:

20 (A) The total expenditures (including ex-
 21 penditures for administrative costs) to be made
 22 under the program in the State for covered
 23 health care services under this Act, consistent
 24 with subsection (b), broken down as follows:

1 (i) By the 4 components (described in
2 section 601(a)(2)), consistent with sub-
3 section (b).

4 (ii) Within the operating component—

5 (I) expenditures for operating
6 costs of hospitals and other facility-
7 based services in the State,

8 (II) expenditures for payment to
9 comprehensive health service organiza-
10 tions,

11 (III) expenditures for payment of
12 services provided by health care prac-
13 titioners, and

14 (IV) expenditures for other cov-
15 ered items and services.

16 Amounts included in the operating compo-
17 nent include amounts that may be used by
18 providers for capital expenditures.

19 (B) The total revenues required to meet
20 the State health security expenditures.

21 (2) PROPOSED BUDGET DEADLINE.—The pro-
22 posed budget for a year shall be submitted under
23 paragraph (1) not later than June 1 before the year.

24 (3) FINAL BUDGET.—The final budget for a
25 year shall—

1 (A) be established and submitted under
 2 paragraph (1) not later than October 1 before
 3 the year, and

4 (B) take into account the amounts estab-
 5 lished under the national health security budget
 6 under section 601 for the year.

7 (4) ADJUSTMENT IN ALLOCATIONS PER-
 8 MITTED.—

9 (A) IN GENERAL.—Subject to subpara-
 10 graphs (B) and (C), in the case of a final
 11 budget, a State may change the allocation of
 12 amounts among components.

13 (B) NOTICE.—No such change may be
 14 made unless the State has provided prior notice
 15 of the change to the Board.

16 (C) DENIAL.—Such a change may not be
 17 made if the Board, within such time period as
 18 the Board specifies, disapproves such change.

19 (b) EXPENDITURE LIMITS.—

20 (1) IN GENERAL.—The total expenditures speci-
 21 fied in each State health security budget under sub-
 22 section (a)(1) shall take into account Federal
 23 contributions made under section 604.

24 (2) LIMIT ON CLAIMS PROCESSING AND BILL-
 25 ING EXPENDITURES.—Each State health security

1 budget shall provide that State administrative ex-
2 penditures, including expenditures for claims proc-
3 essing and billing, shall not exceed 3 percent of the
4 total expenditures under the State health security
5 program, unless the Board determines, on a case-by-
6 case basis, that additional administrative expendi-
7 tures would improve health care quality and cost
8 effectiveness.

9 (3) WORKER ASSISTANCE.—A State health se-
10 curity program may provide that, for budgets for
11 years before 2005, up to 1 percent of the budget
12 may be used for purposes of programs providing as-
13 sistance to workers who are currently performing
14 functions in the administration of the health insur-
15 ance system and who may experience economic dis-
16 location as a result of the implementation of the
17 program.

18 (c) APPROVAL PROCESS FOR CAPITAL EXPENDI-
19 TURES PERMITTED.—Nothing in this title shall be con-
20 strued as preventing a State health security program from
21 providing for a process for the approval of capital expendi-
22 tures based on information derived from regional planning
23 agencies.

1 **SEC. 604. FEDERAL PAYMENTS TO STATES.**

2 (a) IN GENERAL.—Each State with an approved
3 State health security program is entitled to receive, from
4 amounts in the American Health Security Trust Fund, on
5 a monthly basis each year, of an amount equal to one-
6 twelfth of the product of—

7 (1) the State capitation amount (computed
8 under section 602(a)(2)) for the State for the year,
9 and

10 (2) the Federal contribution percentage (estab-
11 lished under subsection (b)).

12 (b) FEDERAL CONTRIBUTION PERCENTAGE.—The
13 Board shall establish a formula for the establishment of
14 a Federal contribution percentage for each State. Such
15 formula shall take into consideration a State's per capita
16 income and revenue capacity and such other relevant eco-
17 nomic indicators as the Board determines to be appro-
18 priate. In addition, during the 5-year period beginning
19 with 2000, the Board may provide for a transition adjust-
20 ment to the formula in order to take into account current
21 expenditures by the State (and local governments thereof)
22 for health services covered under the State health security
23 program. The weighted-average Federal contribution per-
24 centage for all States shall equal 86 percent and in no
25 event shall such percentage be less than 81 percent nor
26 more than 91 percent.

1 (c) USE OF PAYMENTS.—All payments made under
2 this section may only be used to carry out the State health
3 security program.

4 (d) EFFECT OF SPENDING EXCESS OR SURPLUS.—

5 (1) SPENDING EXCESS.—If a State exceeds its
6 budget in a given year, the State shall continue to
7 fund covered health services from its own revenues.

8 (2) SURPLUS.—If a State provides all covered
9 health services for less than the budgeted amount
10 for a year, it may retain its Federal payment for
11 that year for uses consistent with this Act.

12 **SEC. 605. ACCOUNT FOR HEALTH PROFESSIONAL EDU-**
13 **CATION EXPENDITURES.**

14 (a) SEPARATE ACCOUNT.—Each State health secu-
15 rity program shall—

16 (1) include a separate account for health pro-
17 fessional education expenditures, and

18 (2) specify the general manner, consistent with
19 subsection (b), in which such expenditures are to be
20 distributed among different types of institutions and
21 the different areas of the State.

22 (b) DISTRIBUTION RULES.—The distribution of
23 funds to hospitals and other health care facilities from the
24 account must conform to the following principles:

1 (1) The disbursement of funds must be con-
 2 sistent with achievement of the national and pro-
 3 gram goals (specified in section 701(b)) within the
 4 State health security program and the distribution
 5 of funds from the account must be conditioned upon
 6 the receipt of such reports as the Board may require
 7 in order to monitor compliance with such goals.

8 (2) The distribution of funds from the account
 9 must take into account the potentially higher costs
 10 of placing health professional students in clinical
 11 education programs in health professional shortage
 12 areas.

13 **Subtitle B—Payments by States to** 14 **Providers**

15 **SEC. 611. PAYMENTS TO HOSPITALS AND OTHER FACILITY-** 16 **BASED SERVICES FOR OPERATING EXPENSES** 17 **ON THE BASIS OF APPROVED GLOBAL** 18 **BUDGETS.**

19 (a) DIRECT PAYMENT UNDER GLOBAL BUDGET.—
 20 Payment for operating expenses for institutional and facil-
 21 ity-based care, including hospital services and nursing fa-
 22 cility services, under State health security programs shall
 23 be made directly to each institution or facility by each
 24 State health security program under an annual prospec-
 25 tive global budget approved under the program. Such a

1 budget shall include payment for outpatient care and non-
 2 facility-based care that is furnished by or through the fa-
 3 cility. In the case of a hospital that is wholly owned (or
 4 controlled) by a comprehensive health service organization
 5 that is paid under section 614 on the basis of a global
 6 budget, the global budget of the organization shall include
 7 the budget for the hospital.

8 (b) ANNUAL NEGOTIATIONS; BUDGET APPROVAL.—

9 (1) IN GENERAL.—The prospective global budg-
 10 et for an institution or facility shall—

11 (A) be developed through annual negotia-
 12 tions between (i) a panel of individuals who are
 13 appointed by the Governor of the State and who
 14 represent consumers, labor, business, and the
 15 State government, and (ii) the institution or fa-
 16 cility, and

17 (B) be based on a nationally uniform sys-
 18 tem of cost accounting established under stand-
 19 ards of the Board.

20 (2) CONSIDERATIONS.—In developing a budget
 21 through negotiations, there shall be taken into
 22 account at least the following:

23 (A) With respect to inpatient hospital serv-
 24 ices, the number, and classification by diag-
 25 nosis-related group, of discharges.

1 (B) An institution's or facility's past ex-
2 penditures.

3 (C) The extent to which debt service for
4 capital expenditures has been included in the
5 proposed operating budget.

6 (D) The extent to which capital expendi-
7 tures are financed directly or indirectly through
8 reductions in direct care to patients, including
9 (but not limited to) reductions in registered
10 nursing staffing patterns or changes in emer-
11 gency room or primary care services or avail-
12 ability.

13 (E) Change in the consumer price index
14 and other price indices.

15 (F) The cost of reasonable compensation
16 to health care practitioners.

17 (G) The compensation level of the institu-
18 tion's or facility's work force.

19 (H) The extent to which the institution or
20 facility is providing health care services to meet
21 the needs of residents in the area served by the
22 institution or facility, including the institution's
23 or facility's occupancy level.

24 (I) The institution's or facility's previous
25 financial and clinical performance, based on uti-

1 lization and outcomes data provided under this
2 Act.

3 (J) The type of institution or facility, in-
4 cluding whether the institution or facility is
5 part of a clinical education program or serves
6 a health professional education, research or
7 other training purpose.

8 (K) Technological advances or changes.

9 (L) Costs of the institution or facility asso-
10 ciated with meeting Federal and State regula-
11 tions.

12 (M) The costs associated with necessary
13 public outreach activities.

14 (N) In the case of a for-profit facility, a
15 reasonable rate of return on equity capital,
16 independent of those operating expenses nec-
17 essary to fulfill the objectives of this Act.

18 (O) Incentives to facilities that maintain
19 costs below previous reasonable budgeted levels
20 without reducing the care provided.

21 (P) With respect to facilities that provide
22 mental health services and substance abuse
23 treatment services, any additional costs involved
24 in the treatment of dually diagnosed individ-
25 uals.

1 The portion of such a budget that relates to expendi-
2 tures for health professional education shall be con-
3 sistent with the State health security budget for
4 such expenditures.

5 (3) PROVISION OF REQUIRED INFORMATION; DI-
6 AGNOSIS-RELATED GROUP.—No budget for an insti-
7 tution or facility for a year may be approved unless
8 the institution or facility has submitted on a timely
9 basis to the State health security program such in-
10 formation as the program or the Board shall specify,
11 including in the case of hospitals information on dis-
12 charges classified by diagnosis-related group.

13 (c) ADJUSTMENTS IN APPROVED BUDGETS.—

14 (1) ADJUSTMENTS TO GLOBAL BUDGETS THAT
15 CONTRACT WITH COMPREHENSIVE HEALTH SERVICE
16 ORGANIZATIONS.—Each State health security pro-
17 gram shall develop an administrative mechanism for
18 reducing operating funds to institutions or facilities
19 in proportion to payments made to such institutions
20 or facilities for services contracted for by a com-
21 prehensive health service organization.

22 (2) AMENDMENTS.—In accordance with stand-
23 ards established by the Board, an operating and
24 capital budget approved under this section for a year
25 may be amended before, during, or after the year if

1 there is a substantial change in any of the factors
2 relevant to budget approval.

3 (d) DONATIONS PERMISSIBLE.—The States health
4 security programs may permit institutions and facilities
5 to raise funds from private sources to pay for newly con-
6 structed facilities, major renovations, and equipment. The
7 expenditure of such funds, whether for operating or cap-
8 ital expenditures, does not obligate the State health secu-
9 rity program to provide for continued support for such ex-
10 penditures unless included in an approved global budget.

11 **SEC. 612. PAYMENTS TO HEALTH CARE PRACTITIONERS**
12 **BASED ON PROSPECTIVE FEE SCHEDULE.**

13 (a) FEE FOR SERVICE.—

14 (1) IN GENERAL.—Every independent health
15 care practitioner is entitled to be paid, for the provi-
16 sion of covered health services under the State
17 health security program, a fee for each billable cov-
18 ered service.

19 (2) GLOBAL FEE PAYMENT METHODOLOGIES.—
20 The Board shall establish models and encourage
21 State health security programs to implement alter-
22 native payment methodologies that incorporate glob-
23 al fees for related services (such as all outpatient
24 procedures for treatment of a condition) or for a
25 basic group of services (such as primary care serv-

1 ices) furnished to an individual over a period of
2 time, in order to encourage continuity and efficiency
3 in the provision of services. Such methodologies shall
4 be designed to ensure a high quality of care.

5 (3) BILLING DEADLINES; ELECTRONIC BILL-
6 ING.—A State health security program may deny
7 payment for any service of an independent health
8 care practitioner for which it did not receive a bill
9 and appropriate supporting documentation (which
10 had been previously specified) within 30 days after
11 the date the service was provided. Such a program
12 may require that bills for services for which payment
13 may be made under this section, or for any class of
14 such services, be submitted electronically.

15 (b) PAYMENT RATES BASED ON NEGOTIATED PRO-
16 SPECTIVE FEE SCHEDULES.—With respect to any pay-
17 ment method for a class of services of practitioners, the
18 State health security program shall establish, on a pro-
19 spective basis, a payment schedule. The State health secu-
20 rity program may establish such a schedule after negotia-
21 tions with organizations representing the practitioners in-
22 volved. Such fee schedules shall be designed to provide in-
23 centives for practitioners to choose primary care medicine,
24 including general internal medicine and pediatrics, over
25 medical specialization. Nothing in this section shall be con-

1 strued as preventing a State from adjusting the payment
 2 schedule amounts on a quarterly or other periodic basis
 3 depending on whether expenditures under the schedule will
 4 exceed the budgeted amount with respect to such expendi-
 5 tures.

6 (c) BILLABLE COVERED SERVICE DEFINED.—In this
 7 section, the term “billable covered service” means a service
 8 covered under section 201 for which a practitioner is enti-
 9 tled to compensation by payment of a fee determined
 10 under this section.

11 **SEC. 613. PAYMENTS TO COMPREHENSIVE HEALTH SERV-**
 12 **ICE ORGANIZATIONS.**

13 (a) IN GENERAL.—Payment under a State health se-
 14 curity program to a comprehensive health service organi-
 15 zation to its enrollees shall be determined by the State—

16 (1) based on a global budget described in sec-
 17 tion 611, or

18 (2) based on the basic capitation amount de-
 19 scribed in subsection (b) for each of its enrollees.

20 (b) BASIC CAPITATION AMOUNT.—

21 (1) IN GENERAL.—The basic capitation amount
 22 described in this subsection for an enrollee shall be
 23 determined by the State health security program on
 24 the basis of the average amount of expenditures that
 25 is estimated would be made under the State health

1 security program for covered health care services for
 2 an enrollee, based on actuarial characteristics (as de-
 3 fined by the State health security program).

4 (2) ADJUSTMENT FOR SPECIAL HEALTH
 5 NEEDS.—The State health security program shall
 6 adjust such average amounts to take into account
 7 the special health needs, including a disproportionate
 8 number of medically underserved individuals, of pop-
 9 ulations served by the organization.

10 (3) ADJUSTMENT FOR SERVICES NOT PRO-
 11 VIDED.—The State health security program shall ad-
 12 just such average amounts to take into account the
 13 cost of covered health care services that are not pro-
 14 vided by the comprehensive health service organiza-
 15 tion under section 303(a).

16 **SEC. 614. PAYMENTS FOR COMMUNITY-BASED PRIMARY**
 17 **HEALTH SERVICES.**

18 (a) IN GENERAL.—In the case of community-based
 19 primary health services, subject to subsection (b), pay-
 20 ments under a State health security program shall—

21 (1) be based on a global budget described in
 22 section 611,

23 (2) be based on the basic primary care capita-
 24 tion amount described in subsection (c) for each in-

1 dividual enrolled with the provider of such services,
2 or

3 (3) be made on a fee-for-service basis under
4 section 612.

5 (b) PAYMENT ADJUSTMENT.—Payments under sub-
6 section (a) may include, consistent with the budgets devel-
7 oped under this title—

8 (1) an additional amount, as set by the State
9 health security program, to cover the costs incurred
10 by a provider which serves persons not covered by
11 this Act whose health care is essential to overall
12 community health and the control of communicable
13 disease, and for whom the cost of such care is other-
14 wise uncompensated,

15 (2) an additional amount, as set by the State
16 health security program, to cover the reasonable
17 costs incurred by a provider that furnishes case
18 management services (as defined in section
19 1915(g)(2) of the Social Security Act), transpor-
20 tation services, and translation services, and

21 (3) an additional amount, as set by the State
22 health security program, to cover the costs incurred
23 by a provider in conducting health professional edu-
24 cation programs in connection with the provision of
25 such services.

1 (c) BASIC PRIMARY CARE CAPITATION AMOUNT.—

2 (1) IN GENERAL.—The basic primary care capi-
3 tation amount described in this subsection for an en-
4 rollee with a provider of community-based primary
5 health services shall be determined by the State
6 health security program on the basis of the average
7 amount of expenditures that is estimated would be
8 made under the State health security program for
9 such an enrollee, based on actuarial characteristics
10 (as defined by the State health security program).

11 (2) ADJUSTMENT FOR SPECIAL HEALTH
12 NEEDS.—The State health security program shall
13 adjust such average amounts to take into account
14 the special health needs, including a disproportionate
15 number of medically underserved individuals, of pop-
16 ulations served by the provider.

17 (3) ADJUSTMENT FOR SERVICES NOT PRO-
18 VIDED.—The State health security program shall ad-
19 just such average amounts to take into account the
20 cost of community-based primary health services
21 that are not provided by the provider.

22 (d) COMMUNITY-BASED PRIMARY HEALTH SERVICES
23 DEFINED.—In this section, the term “community-based
24 primary health services” has the meaning given such term
25 in section 202(a).

1 **SEC. 615. PAYMENTS FOR PRESCRIPTION DRUGS.**

2 (a) ESTABLISHMENT OF LIST.—

3 (1) IN GENERAL.—The Board shall establish a
4 list of approved prescription drugs and biologicals
5 that the Board determines are necessary for the
6 maintenance or restoration of health or of employ-
7 ability or self-management and eligible for coverage
8 under this Act.

9 (2) EXCLUSIONS.—The Board may exclude re-
10 imbursement under this Act for ineffective, unsafe,
11 or over-priced products where better alternatives are
12 determined to be available.

13 (b) PRICES.—For each such listed prescription drug
14 or biological covered under this Act, for insulin, and for
15 medical foods, the Board shall from time to time deter-
16 mine a product price or prices which shall constitute the
17 maximum to be recognized under this Act as the cost of
18 a drug to a provider thereof. The Board may conduct ne-
19 gotiations, on behalf of State health security programs,
20 with product manufacturers and distributors in deter-
21 mining the applicable product price or prices.

22 (c) CHARGES BY INDEPENDENT PHARMACIES.—
23 Each State health security program shall provide for pay-
24 ment for a prescription drug or biological or insulin fur-
25 nished by an independent pharmacy based on the drug's
26 cost to the pharmacy (not in excess of the applicable prod-

1 uct price established under subsection (b)) plus a dis-
2 pensing fee. In accordance with standards established by
3 the Board, each State health security program, after con-
4 sultation with representatives of the pharmaceutical pro-
5 fession, shall establish schedules of dispensing fees, de-
6 signed to afford reasonable compensation to independent
7 pharmacies after taking into account variations in their
8 cost of operation resulting from regional differences, dif-
9 ferences in the volume of prescription drugs dispensed, dif-
10 ferences in services provided, the need to maintain expend-
11 itures within the budgets established under this title,
12 and other relevant factors.

13 **SEC. 616. PAYMENTS FOR APPROVED DEVICES AND EQUIP-**
14 **MENT.**

15 (a) ESTABLISHMENT OF LIST.—The Board shall es-
16 tablish a list of approved durable medical equipment and
17 therapeutic devices and equipment (including eyeglasses,
18 hearing aids, and prosthetic appliances), that the Board
19 determines are necessary for the maintenance or restora-
20 tion of health or of employability or self-management and
21 eligible for coverage under this Act.

22 (b) CONSIDERATIONS AND CONDITIONS.—In estab-
23 lishing the list under subsection (a), the Board shall take
24 into consideration the efficacy, safety, and cost of each
25 item contained on such list, and shall attach to any item

1 such conditions as the Board determines appropriate with
2 respect to the circumstances under which, or the frequency
3 with which, the item may be prescribed.

4 (c) PRICES.—For each such listed item covered under
5 this Act, the Board shall from time to time determine a
6 product price or prices which shall constitute the max-
7 imum to be recognized under this Act as the cost of the
8 item to a provider thereof. The Board may conduct nego-
9 tiations, on behalf of State health security programs, with
10 equipment and device manufacturers and distributors in
11 determining the applicable product price or prices.

12 (d) EXCLUSIONS.—The Board may exclude from cov-
13 erage under this Act ineffective, unsafe, or overpriced
14 products where better alternatives are determined to be
15 available.

16 **SEC. 617. PAYMENTS FOR OTHER ITEMS AND SERVICES.**

17 In the case of payment for other covered health serv-
18 ices, the amount of payment under a State health security
19 program shall be established by the program—

20 (1) in accordance with payment methodologies
21 which are specified by the Board, after consultation
22 with the American Health Security Advisory Coun-
23 cil, or methodologies established by the State under
24 section 620, and

1 (2) consistent with the State health security
2 budget.

3 **SEC. 618. PAYMENT INCENTIVES FOR MEDICALLY UNDER-**
4 **SERVED AREAS.**

5 (a) MODEL PAYMENT METHODOLOGIES.—In addi-
6 tion to the payment amounts otherwise provided in this
7 title, the Board shall establish model payment methodolo-
8 gies and other incentives that promote the provision of
9 covered health care services in medically underserved
10 areas, particularly in rural and inner-city underserved
11 areas.

12 (b) CONSTRUCTION.—Nothing in this title shall be
13 construed as limiting the authority of State health security
14 programs to increase payment amounts or otherwise pro-
15 vide additional incentives, consistent with the State health
16 security budget, to encourage the provision of medically
17 necessary and appropriate services in underserved areas.

18 **SEC. 619. AUTHORITY FOR ALTERNATIVE PAYMENT METH-**
19 **ODOLOGIES.**

20 A State health security program, as part of its plan
21 under section 404(a), may use a payment methodology
22 other than a methodology required under this subtitle so
23 long as—

24 (1) such payment methodology does not affect
25 the entitlement of individuals to coverage, the

1 weighting of fee schedules to encourage an increase
2 in the number of primary care providers, the ability
3 of individuals to choose among qualified providers,
4 the benefits covered under the program, or the com-
5 pliance of the program with the State health security
6 budget under subtitle A, and

7 (2) the program submits periodic reports to the
8 Board showing the operation and effectiveness of the
9 alternative methodology, in order for the Board to
10 evaluate the appropriateness of applying the alter-
11 native methodology to other States.

12 **Subtitle C—Mandatory Assignment** 13 **and Administrative Provisions**

14 **SEC. 631. MANDATORY ASSIGNMENT.**

15 (a) NO BALANCE BILLING.—Payments for benefits
16 under this Act shall constitute payment in full for such
17 benefits and the entity furnishing an item or service for
18 which payment is made under this Act shall accept such
19 payment as payment in full for the item or service and
20 may not accept any payment or impose any charge for
21 any such item or service other than accepting payment
22 from the State health security program in accordance with
23 this Act.

24 (b) ENFORCEMENT.—If an entity knowingly and will-
25 fully bills for an item or service or accepts payment in

1 violation of subsection (a), the Board may apply sanctions
2 against the entity in the same manner as sanctions could
3 have been imposed under section 1842(j)(2) of the Social
4 Security Act for a violation of section 1842(j)(1) of such
5 Act. Such sanctions are in addition to any sanctions that
6 a State may impose under its State health security
7 program.

8 **SEC. 632. PROCEDURES FOR REIMBURSEMENT; APPEALS.**

9 (a) PROCEDURES FOR REIMBURSEMENT.—In accord-
10 ance with standards issued by the Board, a State health
11 security program shall establish a timely and administra-
12 tively simple procedure to assure payment within 60 days
13 of the date of submission of clean claims by providers
14 under this Act.

15 (b) APPEALS PROCESS.—Each State health security
16 program shall establish an appeals process to handle all
17 grievances pertaining to payment to providers under this
18 title.

1 **TITLE VII—PROMOTION OF PRI-**
2 **MARY HEALTH CARE; DEVEL-**
3 **OPMENT OF HEALTH SERV-**
4 **ICE CAPACITY; PROGRAMS TO**
5 **ASSIST THE MEDICALLY UN-**
6 **DERSERVED**

7 **Subtitle A—Promotion and Expan-**
8 **sion of Primary Care Profes-**
9 **sional Training**

10 **SEC. 701. ROLE OF BOARD; ESTABLISHMENT OF PRIMARY**
11 **CARE PROFESSIONAL OUTPUT GOALS.**

12 (a) IN GENERAL.—The Board is responsible for—

13 (1) coordinating health professional education
14 policies and goals, in consultation with the Secretary
15 of Health and Human Services (in this title referred
16 to as the “Secretary”), to achieve the national goals
17 specified in subsection (b);

18 (2) overseeing the health professional education
19 expenditures of the State health security programs
20 from the account established under section 602(c);

21 (3) developing and maintaining, in cooperation
22 with the Secretary, a system to monitor the number
23 and specialties of individuals through their health
24 professional education, any postgraduate training,
25 and professional practice; and

1 (4) developing, coordinating, and promoting
2 other policies that expand the number of primary
3 care practitioners.

4 (b) NATIONAL GOALS.—The national goals specified
5 in this subsection are as follows:

6 (1) GRADUATE MEDICAL EDUCATION.—By not
7 later than 5 years after the date of the enactment
8 of this Act, at least 50 percent of the residents in
9 medical residency education programs (as defined in
10 subsection (e)(1)) are primary care residents (as
11 defined in subsection (e)(3)).

12 (2) MIDDLELEVEL PRIMARY CARE PRACTI-
13 TIONERS.—To assure an adequate supply of primary
14 care practitioners, there shall be a number, specified
15 by the Board, of midlevel primary care practitioners
16 (as defined in subsection (e)(2)) employed in the
17 health care system as of January 1, 2005.

18 (c) METHOD FOR ATTAINMENT OF NATIONAL GOAL
19 FOR GRADUATE MEDICAL EDUCATION; PROGRAM
20 GOALS.—

21 (1) IN GENERAL.—The Board shall establish a
22 method of applying the national goal in subsection
23 (b)(1) to program goals for each medical residency
24 education program or to medical residency education
25 consortia.

1 (2) CONSIDERATION.—The program goals
2 under paragraph (1) shall be based on the distribu-
3 tion of medical schools and other teaching facilities
4 within each State health security program, and the
5 number of positions for graduate medical education.

6 (3) MEDICAL RESIDENCY EDUCATION CONSOR-
7 TIUM.—In this subsection, the term “medical resi-
8 dency education consortium” means a consortium of
9 medical residency education programs in a contig-
10 uous geographic area (which may be an interstate
11 area) if the consortium—

12 (A) includes at least one medical school
13 with a teaching hospital and related teaching
14 settings, and

15 (B) has an affiliation with qualified com-
16 munity-based primary health service providers
17 described in section 202(a) and with at least
18 one comprehensive health service organization
19 established under section 303.

20 (4) ENFORCEMENT THROUGH STATE HEALTH
21 SECURITY BUDGETS.—The Board shall develop a
22 formula for reducing payments to State health secu-
23 rity programs (that provide for payments to a med-
24 ical residency education program) that failed to meet

1 the goal for the program established under this sub-
2 section.

3 (d) METHOD FOR ATTAINMENT OF NATIONAL GOAL
4 FOR MIDDLELEVEL PRIMARY CARE PRACTITIONERS.—To as-
5 sist in attaining the national goal identified in subsection
6 (b)(2), the Board shall—

7 (1) advise the Public Health Service on alloca-
8 tions of funding under titles VII and VIII of the
9 Public Health Service Act, the National Health
10 Service Corps, and other programs in order to in-
11 crease the supply of midlevel primary care practi-
12 tioners, and

13 (2) commission a study of the potential benefits
14 and disadvantages of expanding the scope of practice
15 authorized under State laws for any class of midlevel
16 primary care practitioners.

17 (e) DEFINITIONS.—In this title:

18 (1) MEDICAL RESIDENCY EDUCATION PRO-
19 GRAM.—The term “medical residency education pro-
20 gram” means a program that provides education
21 and training to graduates of medical schools in order
22 to meet requirements for licensing and certification
23 as a physician, and includes the medical school su-
24 pervising the program and includes the hospital or
25 other facility in which the program is operated.

1 (2) MIDDLELEVEL PRIMARY CARE PRACTI-
 2 TIONER.—The term “midlevel primary care practi-
 3 tioner” means a clinical nurse practitioner, certified
 4 nurse midwife, physician assistance, or other non-
 5 physician practitioner, specified by the Board, as au-
 6 thorized to practice under State law.

7 (3) PRIMARY CARE RESIDENT.—The term “pri-
 8 mary care resident” means (in accordance with cri-
 9 teria established by the Board) a resident being
 10 trained in a distinct program of family practice med-
 11 icine, general practice, general internal medicine, or
 12 general pediatrics.

13 **SEC. 702. ESTABLISHMENT OF ADVISORY COMMITTEE ON**
 14 **HEALTH PROFESSIONAL EDUCATION.**

15 (a) IN GENERAL.—The Board shall provide for an
 16 Advisory Committee on Health Professional Education (in
 17 this section referred to as the “Committee”) to advise the
 18 Board on its activities under section 701.

19 (b) MEMBERSHIP.—The Committee shall be com-
 20 posed of—

21 (1) the Chair of the Board, who shall serve as
 22 Chair of the Committee, and

23 (2) 12 members, not otherwise in the employ of
 24 the United States, appointed by the Board without
 25 regard to the provisions of title 5, United States

1 Code, governing appointments in the competitive
2 service.

3 The appointed members shall provide a balanced point of
4 view with respect to health professional education, primary
5 care disciplines, and health care policy and shall include
6 individuals who are representative of medical schools,
7 other health professional schools, residency programs, pri-
8 mary care practitioners, teaching hospitals, professional
9 associations, public health organizations, State health
10 security programs, and consumers.

11 (c) TERMS OF MEMBERS.—Each appointed member
12 shall hold office for a term of five years, except that—

13 (1) any member appointed to fill a vacancy oc-
14 ccurring during the term for which the member's
15 predecessor was appointed shall be appointed for the
16 remainder of that term; and

17 (2) the terms of the members first taking office
18 shall expire, as designated by the Board at the time
19 of appointment, two at the end of the second year,
20 two at the end of the third year, two at the end of
21 the fourth year, and three at the end of the fifth
22 year after the date of enactment of this Act.

23 (d) VACANCIES.—

24 (1) IN GENERAL.—The Board shall fill any va-
25 cancy in the membership of the Committee in the

1 same manner as the original appointment. The va-
2 cancy shall not affect the power of the remaining
3 members to execute the duties of the Committee.

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

8 (3) REAPPOINTMENT.—The Board may re-
9 appoint an appointed member of the Committee for
10 a second term in the same manner as the original
11 appointment.

12 (e) DUTIES.—It shall be the duty of the Committee
13 to advise the Board concerning graduate medical edu-
14 cation policies under this title.

15 (f) STAFF.—The Committee, its members, and any
16 committees of the Committee shall be provided with such
17 secretarial, clerical, or other assistance as may be author-
18 ized by the Board for carrying out their respective
19 functions.

20 (g) MEETINGS.—The Committee shall meet as fre-
21 quently as the Board deems necessary, but not less than
22 4 times each year. Upon request by four or more members
23 it shall be the duty of the Chair to call a meeting of the
24 Committee.

1 (h) COMPENSATION.—Members of the Committee
 2 shall be reimbursed by the Board for travel and per diem
 3 in lieu of subsistence expenses during the performance of
 4 duties of the Board in accordance with subchapter I of
 5 chapter 57 of title 5, United States Code.

6 (i) FACA NOT APPLICABLE.—The provisions of the
 7 Federal Advisory Committee Act shall not apply to the
 8 Committee.

9 **SEC. 703. GRANTS FOR HEALTH PROFESSIONS EDUCATION,**
 10 **NURSE EDUCATION, AND THE NATIONAL**
 11 **HEALTH SERVICE CORPS.**

12 (a) TRANSFERS TO PUBLIC HEALTH SERVICE.—
 13 From the amounts provided under subsection (c), the
 14 Board shall make transfers from the American Health Se-
 15 curity Trust Fund to the Public Health Service under sub-
 16 part II of part D of title III, title VII, and title VIII of
 17 the Public Health Service Act for the support of the Na-
 18 tional Health Service Corps, health professions education,
 19 and nursing education, including education of clinical
 20 nurse practitioners, certified registered nurse anesthetists,
 21 certified nurse midwives, and physician assistants. Of the
 22 amounts so transferred in each year, not less than 50 per-
 23 cent shall be expended for the support of the National
 24 Health Service Corps.

1 (b) RANGE OF FUNDS.—The amount of transfers
 2 under subsection (a) for any fiscal year shall be an amount
 3 (specified by the Board each year) not less than $\frac{4}{100}$ per-
 4 cent and not to exceed $\frac{6}{100}$ percent of the amounts the
 5 Board estimates will be expended from the Trust Fund
 6 in the fiscal year.

7 (c) FUNDS SUPPLEMENTAL TO OTHER FUNDS.—The
 8 funds provided under this section with respect to provision
 9 of services are in addition to, and not in replacement of,
 10 funds made available under the provisions referred to in
 11 subsection (a) and shall be administered in accordance
 12 with the terms of such provisions. The Board shall make
 13 no transfer of funds under this section for any fiscal year
 14 for which the total appropriations for the programs au-
 15 thorized by such provisions are less than the total amount
 16 appropriated for such programs in fiscal year 1998.

17 **Subtitle B—Direct Health Care** 18 **Delivery**

19 **SEC. 711. SETASIDE FOR PUBLIC HEALTH.**

20 (a) TRANSFERS TO PUBLIC HEALTH SERVICE.—
 21 From the amounts provided under subsection (c), the
 22 Board shall make transfers from the American Health Se-
 23 curity Trust Fund to the Public Health Service for the
 24 following purposes (other than payment for services cov-
 25 ered under title II):

1 (1) For payments to States under the maternal
2 and child health block grants under title V of the
3 Social Security Act.

4 (2) For prevention and treatment of tuber-
5 culosis under section 317 of the Public Health Serv-
6 ice Act.

7 (3) For the prevention and treatment of sexu-
8 ally transmitted diseases under section 318 of the
9 Public Health Service Act.

10 (4) Preventive health block grants under part A
11 of title XIX of the Public Health Service Act.

12 (5) Grants to States for community mental
13 health services under subpart I of part B of title
14 XIX of the Public Health Service Act.

15 (6) Grants to States for prevention and treat-
16 ment of substance abuse under subpart II of part B
17 of title XIX of the Public Health Service Act.

18 (7) Grants for HIV health care services under
19 parts A, B, and C of title XXVI of the Public
20 Health Service Act.

21 (8) Public health formula grants described in
22 subsection (d).

23 (b) RANGE OF FUNDS.—The amount of transfers
24 under subsection (a) for any fiscal year shall be an amount
25 (specified by the Board each year) not less than $\frac{1}{10}$ per-

1 cent and not to exceed $14/100$ percent of the amounts the
2 Board estimates will be expended from the Trust Fund
3 in the fiscal year.

4 (c) FUNDS SUPPLEMENTAL TO OTHER FUNDS.—The
5 funds provided under this section with respect to provision
6 of services are in addition to, and not in replacement of,
7 funds made available under the programs referred to in
8 subsection (a) and shall be administered in accordance
9 with the terms of such programs.

10 (d) REQUIRED REPORTS ON HEALTH STATUS.—The
11 Secretary shall require each State receiving funds under
12 this section to submit annual reports to the Secretary on
13 the health status of the population and measurable objec-
14 tives for improving the health of the public in the State.
15 Such reports shall include the following:

16 (1) A comparison of the measures of the State
17 and local public health system compared to relevant
18 objectives set forth in “Health People 2000” or sub-
19 sequent national objectives set by the Secretary.

20 (2) A description of health status measures to
21 be improved within the State (at the State and local
22 levels) through expanded public health functions and
23 health promotion and disease prevention programs.

1 (3) Measurable outcomes and process objectives
2 for improving health status, and a report on out-
3 comes from the previous year.

4 (4) Information regarding how Federal funding
5 has improved population-based prevention activities
6 and programs.

7 (5) A description of the core public health func-
8 tions to be carried out at the local level.

9 (6) A description of the relationship between
10 the State's public health system, community-based
11 health promotion and disease prevention providers,
12 and the State health security program.

13 (e) LIMITATION ON FUND TRANSFERS.—The Board
14 shall make no transfer of funds under this section for any
15 fiscal year for which the total appropriations for such pro-
16 grams are less than the total amount appropriated for
17 such programs in fiscal year 1998.

18 (f) PUBLIC HEALTH FORMULA GRANTS.—The Sec-
19 retary shall provide stable funds to States through for-
20 mula grants for the purpose of carrying out core public
21 health functions to monitor and protect the health of com-
22 munities from communicable diseases and exposure to
23 toxic environmental pollutants, occupational hazards,
24 harmful products, and poor health outcomes. Such func-
25 tions include the following:

1 (1) Data collection, analysis, and assessment of
2 public health data, vital statistics, and personal
3 health data to assess community health status and
4 outcomes reporting. This function includes the ac-
5 quisition and installation of hardware and software,
6 and personnel training and technical assistance to
7 operate and support automated and integrated infor-
8 mation systems.

9 (2) Activities to protect the environment and to
10 assure the safety of housing, workplaces, food, and
11 water.

12 (3) Investigation and control of adverse health
13 conditions, and threats to the health status of indi-
14 viduals and the community. This function includes
15 the identification and control of outbreaks of infec-
16 tious disease, patterns of chronic disease and injury,
17 and cooperative activities to reduce the levels of vio-
18 lence.

19 (4) Health promotion and disease prevention
20 activities for which there is a significant need and a
21 high priority of the Public Health Service.

22 (5) The provision of public health laboratory
23 services to complement private clinical laboratory
24 services, including—

1 (A) screening tests for metabolic diseases
2 in newborns,

3 (B) toxicology assessments of blood lead
4 levels and other environmental toxins,

5 (C) tuberculosis and other disease requir-
6 ing partner notification, and

7 (D) testing for infectious and food-borne
8 diseases.

9 (6) Training and education for the public
10 health professions.

11 (7) Research on effective and cost-effective pub-
12 lic health practices. This function includes the devel-
13 opment, testing, evaluation, and publication of re-
14 sults of new prevention and public health control
15 interventions.

16 (8) Integration and coordination of the preven-
17 tion programs and services of community-based pro-
18 viders, local and State health departments, and
19 other sectors of State and local government that af-
20 fect health.

21 **SEC. 712. SETASIDE FOR PRIMARY HEALTH CARE DELIV-**
22 **ERY.**

23 (a) TRANSFERS TO PUBLIC HEALTH SERVICE.—
24 From the amounts provided under subsection (c), the
25 Board shall make transfers from the American Health Se-

1 curity Trust Fund to the Public Health Service for the
2 program of primary care service expansion grants under
3 subpart V of part D of title III of the Public Health
4 Service Act (as added by section 713 of this Act).

5 (b) RANGE OF FUNDS.—The amount of transfers
6 under subsection (a) for any fiscal year shall be an amount
7 (specified by the Board each year) not less than $\frac{6}{100}$ per-
8 cent and not to exceed $\frac{1}{10}$ percent of the amounts the
9 Board estimates will be expended from the Trust Fund
10 in the fiscal year.

11 (c) FUNDS SUPPLEMENTAL TO OTHER FUNDS.—The
12 funds provided under this section with respect to provision
13 of services are in addition to, and not in replacement of,
14 funds made available under the sections 329, 330, 340,
15 340A, 1001, and 2655 of the Public Health Service Act.
16 The Board shall make no transfer of funds under this sec-
17 tion for any fiscal year for which the total appropriations
18 for such sections are less than the total amount appro-
19 priated under such sections in fiscal year 1998.

20 **SEC. 713. PRIMARY CARE SERVICE EXPANSION GRANTS.**

21 Part D of title III of the Public Health Service Act
22 (42 U.S.C. 254b et seq.) is amended by adding at the end
23 thereof the following new subpart:

1 “Subpart IX—Primary Care Expansion

2 **“SEC. 340E. EXPANDING PRIMARY CARE DELIVERY CAPAC-**
3 **ITY IN URBAN AND RURAL AREAS.**

4 “(a) GRANTS FOR PRIMARY CARE CENTERS.—From
5 the amounts described in subsection (c), the American
6 Health Security Standards Board shall make grants to
7 public and nonprofit private entities for projects to plan
8 and develop primary care centers which will serve medi-
9 cally underserved populations (as defined in section
10 330(b)(3)) in urban and rural areas and to deliver primary
11 care services to such populations in such areas. The funds
12 provided under such a grant may be used for the same
13 purposes for which a grant may be made under subsection
14 (c), (e), (f), (g), (h), or (i) of section 330.

15 “(b) PROCESS OF AWARDING GRANTS.—The provi-
16 sions of subsection (j)(1) of section 330 shall apply to a
17 grant under this section in the same manner as they apply
18 to a grant under the corresponding subsection of such sec-
19 tion. The provisions of subsection (l)(2)(A) of such section
20 shall apply to grants for projects to plan and develop pri-
21 mary care centers under this section in the same manner
22 as they apply to grants under such section.

23 “(c) FUNDING AS SET-ASIDE FROM TRUST FUND.—
24 Funding to carry out this section is provided from the

1 American Health Security Trust Fund in accordance with
 2 section 912 of the American Health Security Act.

3 “(d) PRIMARY CARE CENTER DEFINED.—In this sec-
 4 tion, the term ‘primary care center’ means—

5 “(1) a health center (as defined in section
 6 330(1)),

7 “(2) an entity qualified to receive a grant under
 8 section 330, 1001 or 2655, or

9 “(3) a Federally-qualified health center (as de-
 10 fined in section 1905(l)(2)(B) of the Social Security
 11 Act).”.

12 **Subtitle C—Primary Care and** 13 **Outcomes Research**

14 **SEC. 721. SET-ASIDE FOR OUTCOMES RESEARCH.**

15 (a) GRANTS FOR OUTCOMES RESEARCH.—The
 16 Board shall make transfers from the American Health Se-
 17 curity Trust Fund to the Agency for Health Care Policy
 18 and Research under title IX of the Public Health Service
 19 Act for the purpose of carrying out activities under such
 20 title. The Secretary shall assure that there is a special em-
 21 phasis placed on pediatric outcomes research.

22 (b) RANGE OF FUNDS.—The amount of transfers
 23 under subsection (a) for any fiscal year shall be an amount
 24 (specified by the Board each year) not less than $\frac{1}{100}$ per-
 25 cent and not to exceed $\frac{2}{100}$ percent of the amounts the

1 Board estimates will be expended from the Trust Fund
2 in the fiscal year.

3 (c) FUNDS SUPPLEMENTAL TO OTHER FUNDS.—The
4 funds provided under this section with respect to provision
5 of services are in addition to, and not in replacement of,
6 funds made available to the Agency for Health Care Policy
7 and Research under section 926 of the Public Health
8 Service Act. The Board shall make no transfer of funds
9 under this section for any fiscal year for which the total
10 appropriations under such section are less than the total
11 amount appropriated under such section and title in fiscal
12 year 1998.

13 (d) CONFORMING AMENDMENT.—Section 926(a) of
14 the Public Health Service Act (42 U.S.C. 299c–5(a)) is
15 amended by striking “\$115,000,000” and all that follows
16 and inserting “for each fiscal year (beginning with fiscal
17 year 2000) such sums as may be necessary.”.

18 **SEC. 722. OFFICE OF PRIMARY CARE AND PREVENTION RE-**
19 **SEARCH.**

20 (a) IN GENERAL.—Title IV of the Public Health
21 Service Act is amended—

22 (1) by redesignating parts G through I as parts
23 H through J, respectively; and

24 (2) by inserting after part F the following new
25 part:

5 “(a) ESTABLISHMENT.—There is established within
6 the Office of the Director of NIH an office to be known
7 as the Office of Primary Care and Prevention Research
8 (in this part referred to as the ‘Office’). The Office shall
9 be headed by a director, who shall be appointed by the
10 Director of NIH.

“(1) identify projects of research on primary
care and prevention, for children as well as adults,
that should be conducted or supported by the na-
tional research institutes, with particular emphasis
on—

19 “(B) diagnostic effectiveness,

21 “(D) health and family planning services,

24 “(F) the use of multidisciplinary teams of
25 health care practitioners.

1 “(2) identify multidisciplinary research related
2 to primary care and prevention that should be so
3 conducted;

4 “(3) promote coordination and collaboration
5 among entities conducting research identified under
6 any of paragraphs (1) and (2);

7 “(4) encourage the conduct of such research by
8 entities receiving funds from the national research
9 institutes;

10 “(5) recommend an agenda for conducting and
11 supporting such research;

12 “(6) promote the sufficient allocation of the re-
13 sources of the national research institutes for con-
14 ducting and supporting such research; and

15 “(7) prepare the report required in section
16 486G.

17 “(c) PRIMARY CARE AND PREVENTION RESEARCH
18 DEFINED.—For purposes of this part, the term ‘primary
19 care and prevention research’ means research on improve-
20 ment of the practice of family medicine, general internal
21 medicine, and general pediatrics, and includes research
22 relating to—

23 “(1) obstetrics and gynecology, dentistry, or
24 mental health or substance abuse treatment when

1 provided by a primary care physician or other
2 primary care practitioner, and
3 “(2) primary care provided by multidisciplinary
4 teams.

5 **“SEC. 486F. NATIONAL DATA SYSTEM AND CLEARINGHOUSE**
6 **ON PRIMARY CARE AND PREVENTION RE-**
7 **SEARCH.**

8 “(a) DATA SYSTEM.—The Director of NIH, in con-
9 sultation with the Director of the Office, shall establish
10 a data system for the collection, storage, analysis, re-
11 trieval, and dissemination of information regarding pri-
12 mary care and prevention research that is conducted or
13 supported by the national research institutes. Information
14 from the data system shall be available through informa-
15 tion systems available to health care professionals and pro-
16 viders, researchers, and members of the public.

17 “(b) CLEARINGHOUSE.—The Director of NIH, in
18 consultation with the Director of the Office and with the
19 National Library of Medicine, shall establish, maintain,
20 and operate a program to provide, and encourage the use
21 of, information on research and prevention activities of the
22 national research institutes that relate to primary care
23 and prevention research.

1 **“SEC. 486G. BIENNIAL REPORT.**

2 “(a) IN GENERAL.—With respect to primary care
3 and prevention research, the Director of the Office shall,
4 not later than one year after the date of the enactment
5 of this part, and biennially thereafter, prepare a report—

6 “(1) describing and evaluating the progress
7 made during the preceding two fiscal years in re-
8 search and treatment conducted or supported by the
9 National Institutes of Health;

10 “(2) summarizing and analyzing expenditures
11 made by the agencies of such Institutes (and by
12 such Office) during the preceding two fiscal years;
13 and

14 “(3) making such recommendations for legisla-
15 tive and administrative initiatives as the Director of
16 the Office determines to be appropriate.

17 “(b) INCLUSION IN BIENNIAL REPORT OF DIRECTOR
18 OF NIH.—The Director of the Office shall submit each
19 report prepared under subsection (a) to the Director of
20 NIH for inclusion in the report submitted to the President
21 and the Congress under section 403.

22 **“SEC. 486H. AUTHORIZATION OF APPROPRIATIONS.**

23 “For the Office of Primary Care and Prevention Re-
24 search, there are authorized to be appropriated
25 \$150,000,000 for fiscal year 2000, \$180,000,000 for fis-
26 cal year 2001, and \$216,000,000 for fiscal year 2002.”.

1 (b) REQUIREMENT OF SUFFICIENT ALLOCATION OF
 2 RESOURCES OF INSTITUTES.—Section 402(b) of the Pub-
 3 lic Health Service Act (42 U.S.C. 282(b)) is amended—

4 (1) in paragraph (13), by striking “and” after
 5 the semicolon at the end;

6 (2) in paragraph (14), by striking the period at
 7 the end and inserting “; and”; and

8 (3) by inserting after paragraph (14) the fol-
 9 lowing new paragraph:

10 “(15) after consultation with the Director of
 11 the Office of Primary Care and Prevention Re-
 12 search, shall ensure that resources of the National
 13 Institutes of Health are sufficiently allocated for
 14 projects on primary care and prevention research
 15 that are identified under section 486E(b).”.

16 **Subtitle D—School-Related Health** 17 **Services**

18 **SEC. 731. AUTHORIZATIONS OF APPROPRIATIONS.**

19 (a) FUNDING FOR SCHOOL-RELATED HEALTH SERV-
 20 ICES.—For the purpose of carrying out this subtitle, there
 21 are authorized to be appropriated \$100,000,000 for fiscal
 22 year 2002, \$275,000,000 for fiscal year 2003,
 23 \$350,000,000 for fiscal year 2004, and \$400,000,000 for
 24 each of the fiscal years 2005 and 2006.

1 (b) RELATION TO OTHER FUNDS.—The authoriza-
2 tions of appropriations established in subsection (a) are
3 in addition to any other authorizations of appropriations
4 that are available for the purpose described in such sub-
5 section.

6 **SEC. 732. ELIGIBILITY FOR DEVELOPMENT AND OPER-**
7 **ATION GRANTS.**

8 (a) IN GENERAL.—Entities eligible to apply for and
9 receive grants under section 734 or 735 are the following:

10 (1) State health agencies that apply on behalf
11 of local community partnerships and other commu-
12 nities in need of health services for school-aged chil-
13 dren within the State.

14 (2) Local community partnerships in States in
15 which health agencies have not applied.

16 (b) LOCAL COMMUNITY PARTNERSHIPS.—

17 (1) IN GENERAL.—A local community partner-
18 ship under subsection (a)(2) is an entity that, at a
19 minimum, includes—

20 (A) a local health care provider with expe-
21 rience in delivering services to school-aged chil-
22 dren;

23 (B) one or more local public schools; and

24 (C) at least one community based organi-
25 zation located in the community to be served

1 that has a history of providing services to
2 school-aged children in the community who are
3 at-risk.

4 (2) PARTICIPATION.—A partnership described
5 in paragraph (1) shall, to the maximum extent fea-
6 sible, involve broad based community participation
7 from parents and adolescent children to be served,
8 health and social service providers, teachers and
9 other public school and school board personnel, de-
10 velopment and service organizations for adolescent
11 children, and interested business leaders. Such par-
12 ticipation may be evidenced through an expanded
13 partnership, or an advisory board to such partner-
14 ship.

15 (c) DEFINITIONS REGARDING CHILDREN.—For pur-
16 poses of this subtitle:

17 (1) The term “adolescent children” means
18 school-aged children who are adolescents.

19 (2) The term “school-aged children” means in-
20 dividuals who are between the ages of 4 and 19 (in-
21 clusive).

22 **SEC. 733. PREFERENCES.**

23 (a) IN GENERAL.—In making grants under sections
24 734 and 735, the Secretary shall give preference to appli-
25 cants whose communities to be served show the most sub-

1 stantial level of need for such services among school-aged
2 children, as measured by indicators of community health
3 including the following:

4 (1) High levels of poverty.

5 (2) The presence of a medically underserved
6 population.

7 (3) The presence of a health professional short-
8 age area.

9 (4) High rates of indicators of health risk
10 among school-aged children, including a high propor-
11 tion of such children receiving services through the
12 Individuals with Disabilities Education Act, adoles-
13 cent pregnancy, sexually transmitted disease (includ-
14 ing infection with the human immunodeficiency
15 virus), preventable disease, communicable disease,
16 intentional and unintentional injuries, community
17 and gang violence, unemployment among adolescent
18 children, juvenile justice involvement, and high rates
19 of drug and alcohol exposure.

20 (b) LINKAGE TO COMMUNITY HEALTH CENTERS.—

21 In making grants under sections 734 and 735, the Sec-
22 retary shall give preference to applicants that demonstrate
23 a linkage to community health centers.

1 **SEC. 734. GRANTS FOR DEVELOPMENT OF PROJECTS.**

2 (a) IN GENERAL.—The Secretary may make grants
3 to State health agencies or to local community partner-
4 ships to develop school health service sites.

5 (b) USE OF FUNDS.—A project for which a grant
6 may be made under subsection (a) may include but not
7 be limited to the cost of the following:

8 (1) Planning for the provision of school health
9 services.

10 (2) Recruitment, compensation, and training of
11 health and administrative staff.

12 (3) The development of agreements, and the ac-
13 quisition and development of equipment and infor-
14 mation services, necessary to support information
15 exchange between school health service sites and
16 health plans, health providers, and other entities au-
17 thorized to collect information under this Act.

18 (4) Other activities necessary to assume oper-
19 ational status.

20 (c) APPLICATION FOR GRANT.—

21 (1) IN GENERAL.—Applicants shall submit ap-
22 plications in a form and manner prescribed by the
23 Secretary.

24 (2) APPLICATIONS BY STATE HEALTH AGEN-
25 CIES.—

1 (A) In the case of applicants that are State
2 health agencies, the application shall contain
3 assurances that the State health agency is ap-
4 plying for funds—

5 (i) on behalf of at least one local com-
6 munity partnership; and

7 (ii) on behalf of at least one other
8 community identified by the State as in
9 need of the services funded under this sub-
10 title but without a local community part-
11 nership.

12 (B) In the case of the communities identi-
13 fied in applications submitted by State health
14 agencies that do not yet have local community
15 partnerships (including the community identi-
16 fied under subparagraph (A)(ii)), the State
17 shall describe the steps that will be taken to aid
18 the communities in developing a local commu-
19 nity partnership.

20 (C) A State applying on behalf of local
21 community partnerships and other communities
22 may retain not more than 10 percent of grants
23 awarded under this subtitle for administrative
24 costs.

1 (d) CONTENTS OF APPLICATION.—In order to receive
2 a grant under this section, an applicant must include in
3 the application the following information:

4 (1) An assessment of the need for school health
5 services in the communities to be served, using the
6 latest available health data and health goals and ob-
7 jectives established by the Secretary.

8 (2) A description of how the applicant will de-
9 sign the proposed school health services to reach the
10 maximum number of school-aged children who are
11 at risk.

12 (3) An explanation of how the applicant will in-
13 tegrate its services with those of other health and
14 social service programs within the community.

15 (4) A description of a quality assurance pro-
16 gram which complies with standards that the Sec-
17 retary may prescribe.

18 (e) NUMBER OF GRANTS.—Not more than one plan-
19 ning grant may be made to a single applicant. A planning
20 grant may not exceed two years in duration.

21 **SEC. 735. GRANTS FOR OPERATION OF PROJECTS.**

22 (a) IN GENERAL.—The Secretary may make grants
23 to State health agencies or to local community partner-
24 ships for the cost of operating school health service sites.

1 (b) USE OF GRANT.—The costs for which a grant
2 may be made under this section include but are not limited
3 to the following:

4 (1) The cost of furnishing health services that
5 are not otherwise covered under this Act or by any
6 other public or private insurer.

7 (2) The cost of furnishing services whose pur-
8 pose is to increase the capacity of individuals to uti-
9 lize available health services, including transpor-
10 tation, community and patient outreach, patient
11 education, translation services, and such other serv-
12 ices as the Secretary determines to be appropriate in
13 carrying out such purpose.

14 (3) Training, recruitment and compensation of
15 health professionals and other staff.

16 (4) Outreach services to school-aged children
17 who are at risk and to the parents of such children.

18 (5) Linkage of individuals to health plans, com-
19 munity health services and social services.

20 (6) Other activities deemed necessary by the
21 Secretary.

22 (c) APPLICATION FOR GRANT.—Applicants shall sub-
23 mit applications in a form and manner prescribed by the
24 Secretary. In order to receive a grant under this section,

1 an applicant must include in the application the following
2 information:

3 (1) A description of the services to be furnished
4 by the applicant.

5 (2) The amounts and sources of funding that
6 the applicant will expend, including estimates of the
7 amount of payments the applicant will receive from
8 sources other than the grant.

9 (3) Such other information as the Secretary de-
10 termines to be appropriate.

11 (d) ADDITIONAL CONTENTS OF APPLICATION.—In
12 order to receive a grant under this section, an applicant
13 must meet the following conditions:

14 (1) The applicant furnishes the following serv-
15 ices:

16 (A) Diagnosis and treatment of simple ill-
17 nesses and minor injuries.

18 (B) Preventive health services, including
19 health screenings.

20 (C) Services provided for the purpose de-
21 scribed in subsection (b)(2).

22 (D) Referrals and followups in situations
23 involving illness or injury.

24 (E) Health and social services, counseling
25 services, and necessary referrals, including re-

1 ferrals regarding mental health and substance
2 abuse.

3 (F) Such other services as the Secretary
4 determines to be appropriate.

5 (2) The applicant is a participating provider in
6 the State's program for medical assistance under
7 title XIX of the Social Security Act.

8 (3) The applicant does not impose charges on
9 students or their families for services (including col-
10 lection of any cost-sharing for services under the
11 comprehensive benefit package that otherwise would
12 be required).

13 (4) The applicant has reviewed and will periodi-
14 cally review the needs of the population served by
15 the applicant in order to ensure that its services are
16 accessible to the maximum number of school-aged
17 children in the area, and that, to the maximum ex-
18 tent possible, barriers to access to services of the ap-
19 plicant are removed (including barriers resulting
20 from the area's physical characteristics, its eco-
21 nomic, social and cultural grouping, the health care
22 utilization patterns of such children, and available
23 transportation).

24 (5) In the case of an applicant which serves a
25 population that includes a substantial proportion of

1 individuals of limited English speaking ability, the
2 applicant has developed a plan to meet the needs of
3 such population to the extent practicable in the lan-
4 guage and cultural context most appropriate to such
5 individuals.

6 (6) The applicant will provide non-Federal con-
7 tributions toward the cost of the project in an
8 amount determined by the Secretary.

9 (7) The applicant will operate a quality assur-
10 ance program consistent with section 734(d).

11 (e) DURATION OF GRANT.—A grant under this sec-
12 tion shall be for a period determined by the Secretary.

13 (f) REPORTS.—A recipient of funding under this sec-
14 tion shall provide such reports and information as are re-
15 quired in regulations of the Secretary.

16 **SEC. 736. FEDERAL ADMINISTRATIVE COSTS.**

17 Of the amounts made available under section 731, the
18 Secretary may reserve not more than 5 percent for admin-
19 istrative expenses regarding this subtitle.

20 **SEC. 737. DEFINITIONS.**

21 For purposes of this subtitle:

22 (1) The term “adolescent children” has the
23 meaning given such term in section 732(c).

24 (2) The term “at risk” means at-risk with re-
25 spect to health.

1 (3) The term “community health center” has
2 the meaning given such term in section 330 of the
3 Public Health Service Act.

4 (4) The term “health professional shortage
5 area” means a health professional shortage area des-
6 ignated under section 332 of the Public Health Serv-
7 ice Act.

8 (5) The term “medically underserved popu-
9 lation” has the meaning given such term in section
10 330 of the Public Health Service Act.

11 (6) The term “school-aged children” has the
12 meaning given such term in section 732(c).

13 **TITLE VIII—FINANCING PROVI-**
14 **SIONS; AMERICAN HEALTH**
15 **SECURITY TRUST FUND**

16 **SEC. 800. AMENDMENT OF 1986 CODE; SECTION 15 NOT TO**
17 **APPLY.**

18 (a) AMENDMENT OF 1986 CODE.—Except as other-
19 wise expressly provided, whenever in this title an amend-
20 ment or repeal is expressed in terms of an amendment
21 to, or repeal of, a section or other provision, the reference
22 shall be considered to be made to a section or other provi-
23 sion of the Internal Revenue Code of 1986.

24 (b) SECTION 15 NOT TO APPLY.—The amendments
25 made by subtitle B shall not be treated as a change in

1 a rate of tax for purposes of section 15 of the Internal
2 Revenue Code of 1986.

3 **Subtitle A—American Health**
4 **Security Trust Fund**

5 **SEC. 801. AMERICAN HEALTH SECURITY TRUST FUND.**

6 (a) IN GENERAL.—There is hereby created on the
7 books of the Treasury of the United States a trust fund
8 to be known as the American Health Security Trust Fund
9 (in this section referred to as the “Trust Fund”). The
10 Trust Fund shall consist of such gifts and bequests as
11 may be made and such amounts as may be deposited in,
12 or appropriated to, such Trust Fund as provided in this
13 Act.

14 (b) APPROPRIATIONS INTO TRUST FUND.—

15 (1) TAXES.—There are hereby appropriated to
16 the Trust Fund for each fiscal year (beginning with
17 fiscal year 2000), out of any moneys in the Treasury
18 not otherwise appropriated, amounts equivalent to
19 100 percent of the aggregate increase in tax liabil-
20 ities under the Internal Revenue Code of 1986 which
21 is attributable to the application of the amendments
22 made by this title. The amounts appropriated by the
23 preceding sentence shall be transferred from time to
24 time (but not less frequently than monthly) from the
25 general fund in the Treasury to the Trust Fund,

1 such amounts to be determined on the basis of esti-
2 mates by the Secretary of the Treasury of the taxes
3 paid to or deposited into the Treasury; and proper
4 adjustments shall be made in amounts subsequently
5 transferred to the extent prior estimates were in ex-
6 cess of or were less than the amounts that should
7 have been so transferred.

8 (2) CURRENT PROGRAM RECEIPTS.—Notwith-
9 standing any other provision of law, there are hereby
10 appropriated to the Trust Fund for each fiscal year
11 (beginning with fiscal year 2000) the amounts that
12 would otherwise have been appropriated to carry out
13 the following programs:

14 (A) The medicare program, under parts A
15 and B of title XVIII of the Social Security Act
16 (other than amounts attributable to any pre-
17 miums under such parts).

18 (B) The medicaid program, under State
19 plans approved under title XIX of such Act.

20 (C) The Federal employees health benefit
21 program, under chapter 89 of title 5, United
22 States Code.

23 (D) The CHAMPUS program, under chap-
24 ter 55 of title 10, United States Code.

1 (E) The maternal and child health pro-
2 gram (under title V of the Social Security Act),
3 vocational rehabilitation programs, programs
4 for drug abuse and mental health services
5 under the Public Health Service Act, programs
6 providing general hospital or medical assistance,
7 and any other Federal program identified by
8 the Board, in consultation with the Secretary of
9 the Treasury, to the extent the programs pro-
10 vide for payment for health services the pay-
11 ment of which may be made under this Act.

12 (c) INCORPORATION OF PROVISIONS.—The provisions
13 of subsections (b) through (i) of section 1817 of the Social
14 Security Act shall apply to the Trust Fund under this Act
15 in the same manner as they applied to the Federal Hos-
16 pital Insurance Trust Fund under part A of title XVIII
17 of such Act, except that the American Health Security
18 Standards Board shall constitute the Board of Trustees
19 of the Trust Fund.

20 (d) TRANSFER OF FUNDS.—Any amounts remaining
21 in the Federal Hospital Insurance Trust Fund or the Fed-
22 eral Supplementary Medical Insurance Trust Fund after
23 the settlement of claims for payments under title XVIII
24 have been completed, shall be transferred into the Amer-
25 ican Health Security Trust Fund.

1 **Subtitle B—Taxes Based on Income**
2 **and Wages**

3 **SEC. 811. PAYROLL TAX ON EMPLOYERS.**

4 (a) IN GENERAL.—Section 3111 (relating to tax on
5 employers) is amended by redesignating subsection (c) as
6 subsection (d) and by inserting after subsection (b) the
7 following new subsection:

8 “(c) HEALTH CARE.—In addition to other taxes,
9 there is hereby imposed on every employer an excise tax,
10 with respect to having individuals in his employ, equal to
11 8.7 percent of the wages (as defined in section 3121(a))
12 paid by him with respect to employment (as defined in
13 section 3121(b)).”

14 (b) SELF-EMPLOYMENT INCOME.—Section 1401 (re-
15 lating to rate of tax on self-employment income) is amend-
16 ed by redesignating subsection (c) as subsection (d) and
17 by inserting after subsection (b) the following new sub-
18 section:

19 “(c) HEALTH CARE.—In addition to other taxes,
20 there shall be imposed for each taxable year, on the self-
21 employment income of every individual, a tax equal to 8.7
22 percent of the amount of the self-employment income for
23 such taxable year.”

24 (c) COMPARABLE TAXES FOR RAILROAD SERV-
25 ICES.—

1 (1) TAX ON EMPLOYERS.—Section 3221 is
2 amended by redesignating subsections (c), (d), and
3 (e) as subsections (d), (e), and (f), respectively, and
4 by inserting after subsection (b) the following new
5 subsection:

6 “(c) HEALTH CARE.—In addition to other taxes,
7 there is hereby imposed on every employer an excise tax,
8 with respect to having individuals in his employ, equal to
9 8.7 percent of the compensation paid by such employer
10 for services rendered to such employer.”

11 (2) TAX ON EMPLOYEE REPRESENTATIVES.—
12 Subsection (a) of section 3211 (relating to tax on
13 employee representatives) is amended by redesign-
14 ating paragraph (3) as paragraph (4) and by in-
15 serting after paragraph (2) the following new para-
16 graph:

17 “(3) HEALTH CARE.—In addition to other
18 taxes, there is hereby imposed on the income of each
19 employee representative a tax equal to 8.7 percent of
20 the compensation received during the calendar year
21 by such employee representative for services ren-
22 dered by such employee representative.

23 (3) NO APPLICABLE BASE.—Subparagraph (A)
24 of section 3231(e)(2) is amended by adding at the
25 end thereof the following new clause:

1 “(iv) HEALTH CARE TAXES.—Clause
 2 (i) shall not apply to the taxes imposed by
 3 sections 3221(c) and 3211(a)(3).”

4 (4) TECHNICAL AMENDMENTS.—

5 (A) Paragraph (4) of section 3211(a), as
 6 redesignated by paragraph (2), is amended by
 7 striking “and (2)” and inserting “, (2), and
 8 (3)”.

9 (B) Subsection (f) of section 3221, as re-
 10 designated by paragraph (1), is amended by
 11 striking “and (b)” and inserting “, (b), and
 12 (c)”.

13 (d) EFFECTIVE DATE.—The amendments made by
 14 this section shall apply to remuneration paid after Decem-
 15 ber 31, 2000.

16 **SEC. 812. HEALTH CARE INCOME TAX.**

17 (a) GENERAL RULE.—Subchapter A of chapter 1 (re-
 18 lating to determination of tax liability) is amended by add-
 19 ing at the end thereof the following new part:

20 **“PART VIII—HEALTH CARE INCOME TAX ON** 21 **INDIVIDUALS**

“Sec. 59B. Health care income tax.

22 **“SEC. 59B. HEALTH CARE INCOME TAX.**

23 “(a) IMPOSITION OF TAX.—In the case of an indi-
 24 vidual, there is hereby imposed a tax (in addition to any

1 other tax imposed by this subtitle) equal to 2.2 percent
 2 of the taxable income of the taxpayer for the taxable year.

3 “(b) NO CREDITS AGAINST TAX; NO EFFECT ON
 4 MINIMUM TAX.—The tax imposed by this section shall not
 5 be treated as a tax imposed by this chapter for purposes
 6 of determining—

7 “(1) the amount of any credit allowable under
 8 this chapter, or

9 “(2) the amount of the minimum tax imposed
 10 by section 55.

11 “(c) SPECIAL RULES.—

12 “(1) TAX TO BE WITHHELD, ETC.—For pur-
 13 poses of this title, the tax imposed by this section
 14 shall be treated as imposed by section 1.

15 “(2) REIMBURSEMENT OF TAX BY EMPLOYER
 16 NOT INCLUDIBLE IN GROSS INCOME.—The gross in-
 17 come of an employee shall not include any payment
 18 by his employer to reimburse the employee for the
 19 tax paid by the employee under this section.

20 “(3) OTHER RULES.—The rules of section
 21 59A(d) shall apply to the tax imposed by this sec-
 22 tion.”

23 (b) CLERICAL AMENDMENT.—The table of parts for
 24 subchapter A of chapter 1 is amended by adding at the
 25 end the following new item:

“Part VIII. Health care income tax on individuals.”

1 (c) EFFECTIVE DATE.—The amendments made by
2 this section shall apply to taxable years beginning after
3 December 31, 2000.

4 **Subtitle C—Increase in Excise**
5 **Taxes on Tobacco Products**

6 **SEC. 821. INCREASE IN EXCISE TAXES ON TOBACCO PROD-**
7 **UCTS.**

8 (a) CIGARETTES.—Subsection (b) of section 5701 is
9 amended—

10 (1) by striking “\$19.50 per thousand (\$17 per
11 thousand on cigarettes removed during 2000 or
12 2001)” in paragraph (1) and inserting “\$22.50 per
13 thousand”, and

14 (2) by striking “\$40.95 per thousand (\$35.70
15 per thousand on cigarettes removed during 2000 or
16 2001)” in paragraph (2) and inserting “\$47.25 per
17 thousand”.

18 (b) CIGARS.—Subsection (a) of section 5701 is
19 amended—

20 (1) by striking “\$1.828 cents per thousand
21 (\$1.594 cents per thousand on cigars removed dur-
22 ing 2000 or 2001)” in paragraph (1) and inserting
23 “\$2.11 per thousand”, and

24 (2) by striking “equal to” and all that follows
25 in paragraph (2) and inserting “equal to 23.91 per-

1 cent of the price for which sold but not more than
2 \$56.25 per thousand.”

3 (c) CIGARETTE PAPERS.—Subsection (c) of section
4 5701 is amended by striking “1.22 cents (1.06 cents on
5 cigarette papers removed during 2000 or 2001)” and in-
6 serting “1.41 cents”.

7 (d) CIGARETTE TUBES.—Subsection (d) of section
8 5701 is amended by striking “2.44 cents (2.13 cents on
9 cigarette tubes removed during 2000 or 2001)” and in-
10 serting “2.81 cents”.

11 (e) SMOKELESS TOBACCO.—Subsection (e) of section
12 5701 is amended—

13 (1) by striking “58.5 cents (51 cents on snuff
14 removed during 2000 or 2001)” in paragraph (1)
15 and inserting “67.5 cents”, and

16 (2) by striking “19.5 cents (17 cents on chew-
17 ing tobacco removed during 2000 or 2001)” in para-
18 graph (2) and inserting “22.5 cents”.

19 (f) PIPE TOBACCO.—Subsection (f) of section 5701
20 is amended by striking “\$1.0969 cents (95.67 cents on
21 pipe tobacco removed during 2000 or 2001)” and insert-
22 ing “\$1.27”.

23 (g) EFFECTIVE DATE.—The amendments made by
24 this section shall apply to articles removed (as defined in

1 section 5702(k) of the Internal Revenue Code of 1986)
2 after December 31, 2000.

3 (h) FLOOR STOCKS TAXES.—

4 (1) IMPOSITION OF TAX.—On tobacco products
5 and cigarette papers and tubes manufactured in or
6 imported into the United States which are removed
7 before January 1, 2001, and held on such date for
8 sale by any person, there is hereby imposed a tax in
9 an amount equal to the excess of—

10 (A) the tax which would be imposed under
11 section 5701 of the Internal Revenue Code of
12 1986 on the article if the article had been re-
13 moved on such date, over

14 (B) the prior tax (if any) imposed under
15 section 5701 or 7652 of such Code on such ar-
16 ticle.

17 (2) AUTHORITY TO EXEMPT CIGARETTES HELD
18 IN VENDING MACHINES.—To the extent provided in
19 regulations prescribed by the Secretary, no tax shall
20 be imposed by paragraph (1) on cigarettes held for
21 retail sale on January 1, 2001, by any person in any
22 vending machine. If the Secretary provides such a
23 benefit with respect to any person, the Secretary
24 may reduce the \$500 amount in paragraph (3) with
25 respect to such person.

1 (3) CREDIT AGAINST TAX.—Each person shall
2 be allowed as a credit against the taxes imposed by
3 paragraph (1) an amount equal to \$500. Such credit
4 shall not exceed the amount of taxes imposed by
5 paragraph (1) for which such person is liable.

6 (4) LIABILITY FOR TAX AND METHOD OF PAY-
7 MENT.—

8 (A) LIABILITY FOR TAX.—A person hold-
9 ing any article on January 1, 2001, to which
10 any tax imposed by paragraph (1) applies shall
11 be liable for such tax.

12 (B) METHOD OF PAYMENT.—The tax im-
13 posed by paragraph (1) shall be paid in such
14 manner as the Secretary shall prescribe by reg-
15 ulations.

16 (C) TIME FOR PAYMENT.—The tax im-
17 posed by paragraph (1) shall be paid on or be-
18 fore July 31, 2001.

19 (5) ARTICLES IN FOREIGN TRADE ZONES.—
20 Notwithstanding the Act of June 18, 1934 (48 Stat.
21 998, 19 U.S.C. 81a) and any other provision of law,
22 any article which is located in a foreign trade zone
23 on January 1, 2001, shall be subject to the tax im-
24 posed by paragraph (1) if—

1 (A) internal revenue taxes have been deter-
2 mined, or customs duties liquidated, with re-
3 spect to such article before such date pursuant
4 to a request made under the 1st proviso of sec-
5 tion 3(a) of such Act, or

6 (B) such article is held on such date under
7 the supervision of a customs officer pursuant to
8 the 2d proviso of such section 3(a).

9 (6) DEFINITIONS.—For purposes of this
10 subsection—

11 (A) IN GENERAL.—Terms used in this sub-
12 section which are also used in section 5702 of
13 the Internal Revenue Code of 1986 shall have
14 the respective meanings such terms have in
15 such section.

16 (B) SECRETARY.—The term “Secretary”
17 means the Secretary of the Treasury or his del-
18 egate.

19 (7) CONTROLLED GROUPS.—Rules similar to
20 the rules of section 5061(e)(3) of such Code shall
21 apply for purposes of this subsection.

22 (8) OTHER LAWS APPLICABLE.—All provisions
23 of law, including penalties, applicable with respect to
24 the taxes imposed by section 5701 of such Code
25 shall, insofar as applicable and not inconsistent with

1 the provisions of this subsection, apply to the floor
 2 stocks taxes imposed by paragraph (1), to the same
 3 extent as if such taxes were imposed by such section
 4 5701. The Secretary may treat any person who bore
 5 the ultimate burden of the tax imposed by para-
 6 graph (1) as the person to whom a credit or refund
 7 under such provisions may be allowed or made.

8 **TITLE IX—CONFORMING AMEND-**
 9 **MENTS TO THE EMPLOYEE**
 10 **RETIREMENT INCOME SECU-**
 11 **RITY ACT OF 1974**

12 **SEC. 901. ERISA INAPPLICABLE TO HEALTH COVERAGE AR-**
 13 **RANGEMENTS UNDER STATE HEALTH SECU-**
 14 **RITY PROGRAMS.**

15 Section 4 of the Employee Retirement Income Secu-
 16 rity Act of 1974 (29 U.S.C. 1003) is amended—

17 (1) in subsection (a), by striking “subsection
 18 (b)” and inserting “subsections (b) and (c)”; and

19 (2) by adding at the end the following new sub-
 20 section:

21 “(c) The provisions of this title shall not apply to any
 22 arrangement forming a part of a State health security pro-
 23 gram established pursuant to section 101(b) of the Amer-
 24 ican Health Security Act of 1999.”.

1 **SEC. 902. EXEMPTION OF STATE HEALTH SECURITY PRO-**
2 **GRAMS FROM ERISA PREEMPTION.**

3 Section 514(b) of the Employee Retirement Income
4 Security Act of 1974 (29 U.S.C. 1144(b)) is amended by
5 adding at the end the following new paragraph:

6 “(10) Subsection (a) of this section shall not apply
7 to State health security programs established pursuant to
8 section 101(b) of the American Health Security Act of
9 1999.”.

10 **SEC. 903. PROHIBITION OF EMPLOYEE BENEFITS DUPLICA-**
11 **TIVE OF BENEFITS UNDER STATE HEALTH**
12 **SECURITY PROGRAMS; COORDINATION IN**
13 **CASE OF WORKERS’ COMPENSATION.**

14 (a) IN GENERAL.—Part 5 of subtitle B of title I of
15 the Employee Retirement Income Security Act of 1974 is
16 amended by adding at the end the following new section:

17 “PROHIBITION OF EMPLOYEE BENEFITS DUPLICATIVE OF
18 STATE HEALTH SECURITY PROGRAM BENEFITS; CO-
19 ORDINATION IN CASE OF WORKERS’ COMPENSATION

20 “SEC. 518. (a) Subject to subsection (b), no employee
21 benefit plan may provide benefits which duplicate payment
22 for any items or services for which payment may be made
23 under a State health security program established pursu-
24 ant to section 101(b) of the American Health Security Act
25 of 1999.

1 “(b)(1) Each workers compensation carrier that is
2 liable (or would be liable but for the enactment of the
3 American Health Security Act) for payment for workers
4 compensation services furnished in a State shall reimburse
5 the State health security plan for the State in which the
6 services are furnished for the cost of such services.

7 “(2) In this subsection:

8 “(A) The term ‘workers compensation carrier’
9 means an insurance company that underwrites work-
10 ers compensation medical benefits with respect to
11 one or more employers and includes an employer or
12 fund that is financially at risk for the provision of
13 workers compensation medical benefits.

14 “(B) The term ‘workers compensation medical
15 benefits’ means, with respect to an enrollee who is
16 an employee subject to the workers compensation
17 laws of a State, the comprehensive medical benefits
18 for work-related injuries and illnesses provided for
19 under such laws with respect to such an employee.

20 “(C) The term ‘workers compensation services’
21 means items and services included in workers com-
22 pensation medical benefits and includes items and
23 services (including rehabilitation services and long-
24 term-care services) commonly used for treatment of
25 work-related injuries and illnesses.”.

1 (b) CLERICAL AMENDMENT.—The table of contents
 2 in section 1 of such Act is amended by inserting after the
 3 item relating to section 517 the following new items:

“Sec. 518. Prohibition of employee benefits duplicative of state health security
 program benefits; coordination in case of workers’ compensa-
 tion.”.

4 **SEC. 904. REPEAL OF CONTINUATION COVERAGE REQUIRE-**
 5 **MENTS UNDER ERISA AND CERTAIN OTHER**
 6 **REQUIREMENTS RELATING TO GROUP**
 7 **HEALTH PLANS.**

8 (a) IN GENERAL.—Part 6 of subtitle B of title I of
 9 the Employee Retirement Income Security Act of 1974
 10 (29 U.S.C. 1161 et seq.) is repealed.

11 (b) CONFORMING AMENDMENTS.—

12 (1) Section 502(a) of such Act (29 U.S.C.
 13 1132(a)) is amended—

14 (A) by striking paragraph (7); and

15 (B) by redesignating paragraph (8) as
 16 paragraph (7).

17 (2) Section 502(c)(1) of such Act (29 U.S.C.
 18 1132(c)(1)) is amended by striking “paragraph (1)
 19 or (4) of section 606 or”.

20 (3) Section 4301(c)(4) of the Omnibus Budget
 21 Reconciliation Act of 1993 (Public Law 103–66; 107
 22 Stat. 377) and the amendments made thereby are
 23 repealed.

1 (4) The table of contents in section 1 of the
 2 Employee Retirement Income Security Act of 1974
 3 is amended by striking the items relating to part 6
 4 of subtitle B of title I of such Act.

5 **SEC. 905. EFFECTIVE DATE OF TITLE.**

6 The amendments made by this title shall take effect
 7 January 1, 2001.

8 **TITLE X—ADDITIONAL**
 9 **CONFORMING AMENDMENTS**

10 **SEC. 1001. REPEAL OF CERTAIN PROVISIONS IN INTERNAL**
 11 **REVENUE CODE OF 1986.**

12 The provisions of titles III and IV of the Health In-
 13 surance Portability and Accountability Act, other than
 14 subtitles D and H and section 342, are repealed and the
 15 provisions of law that were amended or repealed by such
 16 provisions are hereby restored as if such provisions had
 17 not been enacted.

18 (c) RELATED AMENDMENTS.—Strike subsections (l)
 19 and (m) of section 401 of the Health Insurance Portability
 20 and Accountability Act of 1996.

21 **SEC. 1002. REPEAL OF CERTAIN PROVISIONS IN THE EM-**
 22 **PLOYEE RETIREMENT INCOME SECURITY**
 23 **ACT OF 1974.**

24 (a) IN GENERAL.—Part 7 of subtitle B of title I of
 25 the Employee Retirement Income Security Act of 1974 is

1 repealed and the items relating to such part in the table
2 of contents in section 1 of such Act are repealed.

3 (b) ADDITIONAL AMENDMENTS.—Section 514(b) of
4 such Act (29 U.S.C. 1144(b)) is amended by striking
5 paragraph (9).

6 **SEC. 1003. REPEAL OF CERTAIN PROVISIONS IN THE PUB-**
7 **LIC HEALTH SERVICE ACT AND RELATED**
8 **PROVISIONS.**

9 (a) IN GENERAL.—Titles XXII and XXVII of the
10 Public Health Service Act are repealed.

11 (b) ADDITIONAL AMENDMENTS.—(1) Section
12 1301(b) of such Act (42 U.S.C. 300e(b)) is amended by
13 striking paragraph (6).

14 (2) Sections 104 and 191 of the Health Insurance
15 Portability and Accountability Act of 1996 are repealed.

16 **SEC. 1004. EFFECTIVE DATE OF TITLE.**

17 The amendments made by this title shall take effect
18 January 1, 2001.

