I

108TH CONGRESS
2D SESSION

H. R. 4325

To guarantee for all Americans quality, affordable, and comprehensive health insurance coverage.

IN THE HOUSE OF REPRESENTATIVES

MAY 11, 2004

Ms. BALDWIN (for herself, Mr. TIERNEY, Mr. MCDERMOTT, Ms. SCHAKOWSKY, Mr. GRIJALVA, Mr. CONYERS, Ms. LEE, Ms. JACKSON-LEE of Texas, and Mr. OBEY) introduced the following bill; which was referred to the Committee on Energy and Commerce, and in addition to the Committee on Ways and Means, 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

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A BILL

To guarantee for all Americans quality, affordable, and comprehensive health insurance coverage.

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

SECTION 1. SHORT TITLE; TABLE OF CONTENTS.

(a) SHORT TITLE.—This Act may be cited as the ''Health Security for All Americans Act''.

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

SEC. 2. FINDINGS.

Congress makes the following findings:

(1) The health of the American people is the foundation of American strength, productivity, and wealth.

(2) The guarantee of health care coverage and access to quality medical care to all Americans is a fundamental right and is essential to the general welfare.

(3) 43,600,000 Americans, more than 8,500,000 of whom are children, have no health insurance.

(4) Health insurance coverage is unstable; less than ½ of all adults have been in their current health plan for 3 years.

(5) The average American will hold at least 7 jobs during their life, risking lack of health coverage every time they change or are between jobs.

(6) Annual health care expenditures in the United States total $1.55 trillion.

(7) In the United States, personal health care spending grows 2.5 percent faster than the gross domestic product.

(8) Although the United States spends considerably more in health care per person than any other nation, it ranks only fifteenth among countries worldwide on an overall index designed to measure a range of health goals according to the World Health Organization.

(9) One of 4 adults, about 40,000,000 people, say they have gone without needed medical care because they couldn't afford it.

(10) Nearly 31,000,000 Americans face collection agencies annually because they owe money for medical bills.

(11) The average American worker is paying twice as much for family coverage than 10 years ago.

(12) Because many individuals do not have health insurance coverage, they may incur health care costs which they do not fully reimburse, resulting in cost-shifting to others.

(13) As a consequence of the piecemeal health care system in the United States, administrative overhead costs approximately $1,059 per person an-

nually, while other Western industrialized nations with universal health care systems spend approximately $200 per person annually for administrative overhead.

(14) The United States should adopt national goals of universal, affordable, comprehensive health insurance coverage and should provide generous matching grants to the States to achieve those goals within 5 years of the date of enactment of this Act.

TITLE I—HEALTH SECURITY FOR ALL AMERICANS—EXPANSION PHASE (PHASE I)

SEC. 101. EXPANSION PHASE (PHASE I) VOLUNTARY STATE UNIVERSAL HEALTH INSURANCE COVERAGE PLANS.

The Social Security Act (42 U.S.C. 301 et seq.) is amended by adding at the end the following:

"TITLE XXII—HEALTH SECURITY FOR ALL AMERICANS

"PART A—EXPANSION PHASE (PHASE I) PLANS

"SEC. 2201. PURPOSE; VOLUNTARY STATE PLANS.

''(a) PURPOSE.—The purpose of this part is to provide funds to participating States to enable those States to ensure universal health insurance coverage by establishing State administered systems targeted to State resi-

dents with a family income that does not exceed 300 percent of the poverty line.

''(b) EXPANSION PHASE (PHASE I) PLAN REQUIRED.—A State is not eligible for a payment under section 2205(a) unless the State has submitted to the Secretary a plan that—

''(1) sets forth how the State intends to use the funds provided under this part to ensure universal, affordable, and comprehensive health insurance coverage to eligible residents of the State consistent with the provisions of this part; and

''(2) has been approved under section 2202(d).

''SEC. 2202. PLAN REQUIREMENTS.

''(a) IN GENERAL.—Every expansion phase (phase I) plan shall include provisions for the following:

''(1) INFORMATION ON THE LEVEL OF HEALTH INSURANCE COVERAGE.—

''(A) The level of health insurance coverage within the State as determined under subsection (b).

''(B) The base coverage gap for the year involved as determined under subsection (b)(4).

''(C) State efforts to provide or obtain health insurance coverage for uncovered residents of the State, including the steps the State

is taking to identify and enroll all uncovered residents of the State who are eligible to participate in public or private health insurance programs.

''(2) DETAILS OF, AND TIMELINES FOR, EXPANSION PHASE (PHASE I) PLAN.—

''(A) USE OF FUNDS; COORDINATION.—The activities that the State intends to carry out using funds received under this part, including how the State will coordinate efforts under this part with existing State efforts to increase the health insurance coverage of individuals.

''(B) TIMELINES.—Consistent with subsection (c), the manner in which the State will reduce the base coverage gap for the year involved, including a timetable with specified targets for reducing the base coverage gap by—

''(i) 50 percent within 2 years after the date of approval of the expansion phase (phase I) plan; and

''(ii) 100 percent within 4 years after such date.

''(3) MAINTENANCE OF EFFORT.—The manner in which the State will ensure that—

''(A) employers within the State will continue to provide not less than the level of financial support toward the health insurance premiums required for coverage of their employees as such employers provided as of the date of enactment of this title; and

''(B) the State will continue to provide not less than the level of State expenditures incurred for State-funded health programs as of such date.

For purposes of this paragraph, any population or service that was covered under the medicaid program under title XIX under a waiver under section 1115 or section 1902(r)(2) shall be treated as if such State expenditures had been based on the enhanced FMAP formula used under the State children's health insurance program under title XXI.

''(4) STATE OUTREACH PROGRAMS; ACCESS.—The manner in which, and a timetable for when, the State will—

''(A) institute outreach programs; and

''(B) ensure that all eligible residents of the State have access to the health insurance coverage provided under this part.

''(5) ASSURANCE OF COVERAGE OF ESSENTIAL SERVICES.—An assurance that the State program established under this part will comply with the requirements of section 1867 (commonly referred to as the 'Emergency Medical Treatment and Active Labor Act').

''(6) REPRESENTATION ON BOARDS AND COMMISSIONS.—The manner in which the State will ensure that all Boards and Commissions that the State establishes to administer the plan will include, among others, representatives of providers, consumers, employers, and health worker unions.

''(7) DISCLOSURE OF INFORMATION TO THE PUBLIC.—The manner in which the State will ensure that, with respect to entities and individuals that provide services for which reimbursement is provided under this part—

''(A) financial arrangements between insurers and providers and between providers and medical equipment suppliers are disclosed to the public; and

''(B) ownership interests and health care worker qualifications and credentials are disclosed to the public.

''(8) CONSUMER PROTECTIONS.—The manner in which the State will ensure compliance with sections 2221, 2222, 2223, and 2224.

''(9) PUBLIC REVIEW.—The manner in which the State will provide for the public review of institutional changes in services provided, markets and regions covered, withdrawal or movement of services, closures or downsizing, and other actions that affect the provision of health insurance under the plan.

''(10) SERVICES IN RURAL AND UNDERSERVED AREAS; CULTURAL COMPETENCY.—The manner in which the State will ensure—

''(A) coverage in rural and underserved areas; and

''(B) that the needs of culturally diverse populations are met.

''(11) MECHANISMS TO MINIMIZE ADVERSE RISK SELECTION.—The manner in which the State will encourage mechanisms to minimize adverse risk selection that provide choice of health plans and control costs.

''(12) LIMITATION ON ADMINISTRATIVE EXPENDITURES.—The manner in which the State will ensure that all qualified plans in the State expend at least 90 percent (or, during the first 2 years of

the plan, 85 percent) of total income received from premiums on the provision of covered health care benefits (excluding all costs for marketing, advertising, health plan administration, profits, or capital accumulation) to individuals.

''(13) SELF-EMPLOYED AND MULTIEMPLOYED.—The manner in which the State will address self-employed individuals and multiwage earner families.

''(14) REQUIREMENT TO MAINTAIN MEDICAID BENEFITS.—The manner in which the State will ensure that individuals who are eligible for medical assistance under title XIX and who receive benefits under the expansion phase (phase I) plan shall receive any items or services that are not available under the expansion phase (phase I) plan but that are available under the State medicaid program under title XIX through 'wraparound coverage' under such program.

''(15) COST CONTAINMENT; RISK SELECTION.—What cost containment strategies the State will employ and how the State will reduce adverse risk selection.

''(16) OTHER MATTERS.—Any other matter determined appropriate by the Secretary.

''(b) CURRENT LEVEL OF COVERAGE.—

''(1) IN GENERAL.—The Secretary shall develop a standardized survey approach that provides timely and up-to-date data to determine the percentage of the population of each State that is currently covered by a health insurance plan or program that provides coverage that meets the requirements of section 2203(a).

''(2) BIANNUAL SURVEY.—The Secretary shall provide for the conduct of the survey developed under paragraph (1) not less than biannually to make coverage determinations for purposes of paragraph (1).

''(3) USE OF ALTERNATIVE SYSTEM.—The Secretary shall permit a State to utilize an alternative population-based monitoring system to make determinations with respect to coverage in the State for purposes of paragraph (1) if the Secretary determines that such system meets or exceeds the methodological standards utilized in the survey developed under paragraph (1).

''(4) BASE COVERAGE GAP.—For purposes of subsection (a)(1)(A), the base coverage gap for a State shall be equal to 100 percent of the eligible individuals and families in the State for the year in-

volved, less the current level of coverage for those individuals and families for such year as determined under paragraph (1) or (3).

''(c) REDUCING THE LEVEL OF UNINSURED INDIVIDUALS.—

''(1) IN GENERAL.—To be eligible to receive funds under this part, a State shall agree to administer an expansion phase (phase I) plan with a goal of providing health insurance coverage for 100 percent of the eligible residents of the State by not later than 4 years after the date of approval of the State's expansion phase (phase I) plan.

''(2) PERMISSIBLE ACTIVITIES.—A State may use amounts provided under this part for any activities consistent with this part that are appropriate to enroll individuals in health plans and health programs to meet the targets contained in the State plan under subsection (a)(2)(B), including through the use of direct payments to health plans or, in the case of a single State plan, directly to providers of services.

''(d) PROCESS FOR SUBMISSION, APPROVAL, AND AMENDMENT OF EXPANSION PHASE (PHASE I) PLAN.—The provisions of section 2106 apply to an expansion phase (phase I) plan under this part in the same manner

as they apply to a State plan under title XXI, except that no expansion phase (phase I) plan may be effective earlier than January 1, 2004, and all expansion phase (phase I) plans must be submitted for approval by not later than December 31, 2005.

"SEC. 2203. COVERAGE REQUIREMENTS FOR EXPANSION PHASE (PHASE I) PLANS.

''(a) REQUIRED SCOPE OF HEALTH INSURANCE COVERAGE.—Health insurance coverage provided under this part shall consist of at least the benefits provided under the Federal Employees Health Benefits Program standard Blue Cross/Blue Shield preferred provider option service benefit plan, described in and offered under section 8903(1) of part 5, United States Code, plus mental health and substance abuse treatment benefits parity for all individuals, and benefits for early and periodic screening and diagnosis services (EPSDT) under section 1905(a)(4)(B) for all individuals under 21 years of age.

''(b) LIMITATIONS ON PREMIUMS AND COST-SHARING.—

''(1) DESCRIPTION; GENERAL CONDITIONS.—An expansion phase (phase I) plan shall include a description, consistent with this subsection, of the amount (if any) of premiums, cost-sharing, or other

similar charges imposed. Any such charges shall be imposed pursuant to a public schedule.

''(2) LIMITATIONS ON PREMIUMS AND COST-SHARING.—

''(A) INDIVIDUALS AND FAMILIES WITH INCOME BELOW 150 PERCENT OF POVERTY LINE.—In the case of an individual or family whose income is at or below 150 percent of the poverty line—

''(i) the State plan may not impose a premium; and

''(ii) the total annual aggregate amount of cost-sharing imposed by a State with respect to all individuals in a family may not exceed 0.5 percent of the family's income for the year involved.

''(B) INDIVIDUALS AND FAMILIES WITH INCOME BETWEEN 150 AND 300 PERCENT OF POVERTY LINE.—In the case of an individual or family whose income exceeds 150 percent but does not exceed 300 percent of the poverty line—

''(i) the State plan may not impose a premium that exceeds an amount that is equal to—

"(I) 20 percent of the average cost of providing benefits to an individual (or a family) under this part in the year involved; or

"(II) 3 percent of the family's income for the year involved; and

"(ii) the total annual aggregate amount of premiums and cost-sharing (combined) imposed by a State with respect to all individuals in a family may not exceed 5 percent of the family's income for the year involved.

"(C) INDIVIDUALS AND FAMILIES WITH INCOME ABOVE 300 PERCENT OF POVERTY LINE.—In the case of an individual or family whose income exceeds 300 percent of the poverty line—

"(i) the State plan may not impose a premium that exceeds 20 percent of the average cost of providing benefits to an individual (or a family of the size involved) under this part in the year involved; and

"(ii) the total annual aggregate amount of premiums and cost-sharing (combined) imposed by a State with re-

spect to all individuals in a family may not exceed 7 percent of the family's income for the year involved.

''(D) SELF-EMPLOYED INDIVIDUALS.—The State shall establish rules for self-employed individuals based on individual and family income.

''(3) COLLECTION.—The State shall establish procedures for collecting any premiums, cost-sharing, or other similar charges imposed under this part. Such procedures shall provide for annual reconciliations and adjustments.

''(c) APPLICATION OF CERTAIN REQUIREMENTS.—

''(1) RESTRICTION ON APPLICATION OF PREEXISTING CONDITION EXCLUSIONS.—The expansion phase (phase I) plan shall not permit the imposition of any preexisting condition exclusion for covered benefits under the plan.

''(2) CHOICE OF PLANS.—

''(A) IN GENERAL.—Except as provided in subparagraph (B), the expansion phase (phase I) plan shall offer eligible individuals and families a choice of qualified plans from which to receive benefits under this part. At least 1 plan shall be a preferred provider option plan.

''(B) WAIVER.—The Secretary—

''(i) may waive the requirement under subparagraph (A) if determined appropriate; and

''(ii) shall waive such requirement in the case of a State that establishes a single State plan.

''SEC. 2204. ALLOTMENTS.

''(a) STATE ALLOTMENTS.—

''(1) IN GENERAL.—With respect to a fiscal year, the Secretary shall allot to each State with an expansion phase (phase I) plan approved under this part the amount determined under paragraph (2) for such State for such fiscal year.

''(2) DETERMINATION OF COST OF COVERAGE.—The amount determined under this paragraph is the amount equal to—

''(A) the product of—

''(i) the Federal participation rate for the State as determined under subsection (b) or, if applicable, the enhanced Federal participation rate for the State, as determined under subsection (c);

''(ii) the estimated cost for the minimum benefits package required to comply

under section 2203, not to exceed the sum of—

"(I) the total annual Government and employee contributions required for individual or self and family health benefits coverage under the Federal Employees Health Benefits Program standard Blue Cross/Blue Shield preferred provider option service benefit plan, described in and offered under section 8903(1) of title 5, United States Code (adjusted for age and other factors, as the Secretary determines appropriate); and

"(II) the estimated average cost-sharing expense for an individual or family; and

"(iii) the estimated number of residents to be enrolled in the expansion phase (phase I) plan; less

"(B) the sum of—

"(i) the individual or family health insurance contribution and cost-sharing payments to be made in accordance with section 2203(b); and

''(ii) any applicable employer contribution to such payments.

''(b) FEDERAL PARTICIPATION RATE.—For purposes of subsection (a)(2)(A)(i), the Federal participation rate for a State shall be equal to the enhanced FMAP determined for the State under section 2105(b).

''(c) ENHANCED FEDERAL PARTICIPATION RATE.—

''(1) IN GENERAL.—For purposes of subsection (a)(2)(A)(i), the enhanced Federal participation rate for a State shall be equal to the Federal participation rate for such State under subsection (b), as adjusted by the Secretary based on the decrease in the base coverage gap in the State.

''(2) AMOUNT OF ADJUSTMENT AND APPLICATION.—

''(A) AMOUNT OF ADJUSTMENT.—The Federal participation rate under subsection (b) with respect to a State shall be increased by—

''(i) 1 percentage point if the base coverage gap of the State has decreased by at least 50 percent within 2 years after the date of approval of the expansion phase (phase I) plan, as determined by the Secretary; and

"(ii) 3 percentage points if the base coverage gap of the State has decreased by 100 percent within 4 years after the date of approval of the expansion phase (phase I) plan, as determined by the Secretary.

"(B) APPLICATION.—The increase described in—

"(i) subparagraph (A)(i) shall only apply to a State for the period beginning with the month of the determination under such subparagraph and ending with the month preceding the month of the determination under subparagraph (A)(ii) (if any), but in no event for more than 24 months; and

"(ii) subparagraph (A)(ii) shall apply to a State for any year (or portion thereof) beginning with the month of the determination under such subparagraph.

"(3) FULL COVERAGE.—For purposes of this part, a State shall be deemed to have decreased its base coverage gap by 100 percent if the Secretary determines that—

"(A) 98 percent of all eligible residents of the State are provided health insurance cov-

erage under the expansion phase (phase I) plan; and

''(B) the remaining 2 percent of such residents are served by alternative health care delivery systems as demonstrated by the State.

''(d) GRANTS TO INDIAN TRIBES, NATIVE HAWAIIAN ORGANIZATIONS, AND ALASKA NATIVE ORGANIZATIONS.—

''(1) IN GENERAL.—Out of funds appropriated under subsection (e), the Secretary shall reserve an amount, not to exceed 1 percent of the total allotments determined under subsection (a) for a fiscal year, to make grants to Indian tribes, Native Hawaiian organizations, and Alaska Native organizations for development and implementation of universal health insurance coverage plans for members of such tribes and organizations.

''(2) PLAN.—To be eligible to receive a grant under paragraph (1), an Indian tribe, Native Hawaiian organization, or Alaska Native organization shall submit a universal health insurance coverage plan to the Secretary at such time, in such manner, and containing such information, as the Secretary may require.

''(3) REGULATIONS.—The Secretary shall issue regulations specifying the requirements of this part that apply to Indian tribes, Native Hawaiian organizations, and Alaska Native organizations receiving grants under paragraph (1).

''(e) APPROPRIATION.—

''(1) IN GENERAL.—Out of any funds in the Treasury not otherwise appropriated, there is appropriated to carry out this title such sums as may be necessary for fiscal year 2004 and each fiscal year thereafter.

''(2) BUDGET AUTHORITY.—Paragraph (1) constitutes budget authority in advance of appropriations Acts and represents the obligation of the Federal Government to provide States, Indian tribes, Native Hawaiian organizations, and Alaska Native organizations with the allotments determined under this section and the grants for administrative and outreach activities under section 2205.

''SEC. 2205. ADMINISTRATION.

''(a) PAYMENTS.—

''(1) IN GENERAL.—

''(A) QUARTERLY.—Subject to subparagraph (B) and subsection (b), the Secretary shall make quarterly payments to each State

with an expansion phase (phase I) plan approved under this part, from its allotment under section 2204.

"(B) FUNDING FOR ADMINISTRATION AND OUTREACH.—

"(i) AUTHORITY TO MAKE GRANTS.—In addition to the allotments determined under section 2204, the Secretary may make grants to States, Indian tribes, Native Hawaiian organizations, and Alaska Native organizations for expenditures for administrative and outreach activities.

"(ii) AMOUNTS.—

"(I) IN GENERAL.—A grant awarded under this subparagraph shall not exceed the applicable percentage (as determined under subclause (II)) of the total amount allotted to the State, Indian tribe, Native Hawaiian organization, or Alaska Native organization under section 2204.

"(II) APPLICABLE PERCENTAGE.—For purposes of subclause (I), the applicable percentage is—

"(aa) 10 percent for 2005 through 2009; and

"(bb) 3 percent for 2010 and each year thereafter.

"(2) ADVANCE PAYMENT; RETROSPECTIVE ADJUSTMENT.—The Secretary may make payments under this part for each quarter on the basis of advance estimates by the State and such other investigation as the Secretary may find necessary, and may reduce or increase the payments as necessary to adjust for any overpayment or underpayment for prior quarters.

"(3) FLEXIBILITY IN SUBMITTAL OF CLAIMS.—Nothing in this subsection shall be construed as preventing a State from claiming as expenditures in the quarter expenditures that were incurred in a previous quarter.

"(b) AUTHORITY FOR BLENDED RATE FOR HEALTH SECURITY, MEDICAID, AND SCHIP FUNDS.—The Secretary shall establish procedures for blending the payments that a State is entitled to receive under this title, title XIX, and title XXI into 1 payment rate if—

"(1) the State requests such a blended payment; and

''(2) the Secretary finds that the State meets maintenance of effort requirements established by the Secretary.

''(c) LIMITATIONS ON FEDERAL PAYMENTS BASED ON COST CONTAINMENT.—

''(1) DETERMINATION OF BASELINE.—Each year (beginning with 2004), the Secretary shall establish a baseline projection for the national rate of growth in private health insurance premiums for such year.

''(2) REQUIREMENT.—Beginning with fiscal year 2005 and each fiscal year thereafter, any payment made to a State under section 2204 shall not exceed the amount paid to the State under such section for the preceding fiscal year, adjusted for changes in enrollment and a premium inflation adjustment that is 0.5 percent below the baseline projection determined under paragraph (1) for the year, unless the State adopts (and the Secretary approves) cost containment strategy that will reduce the rate of growth of spending.

''(d) OTHER LIMITATIONS ON USE OF FUNDS.—

''(1) IN GENERAL.—A State participating under part A, and, effective January 1, 2008, all States under part B, shall ensure that any payments re-

ceived by the State under section 2205 or 2116(a) are not used by any individual or entity, including providers or health plans that contract to provide services herein, to finance directly or indirectly, or to otherwise facilitate expenditures to influence health care workers of such individual or entity with respect to issues related to unionization.

''(2) CONSTRUCTION.—Nothing in this subsection shall be construed to limit expenditures made for the purpose of good faith collective bargaining or pursuant to the terms of a bona fide collective bargaining agreement.

''(e) WAIVER OF FEDERAL REQUIREMENTS.—A State may request (and the Secretary may grant) a waiver of any provision of Federal law that the State determines is necessary in order to carry out an approved expansion phase (phase I) plan under this part.

''(f) REPORT.—Not later than January 1, 2005, and each January 1 thereafter, the Secretary, in consultation with the General Accounting Office and the Congressional Budget Office, shall prepare and submit to the appropriate committees of Congress a report on the number of States receiving payments under this part for the year for which the report is being prepared as well as the level of insurance coverage attained by each such State.

"SEC. 2206. DEFINITIONS.

"In this title:

"(1) COST-SHARING.—The term 'cost-sharing' has the meaning given such term under the Federal Employees Health Benefits Program standard Blue Cross/Blue Shield preferred provider option service benefit plan described in and offered under section 8903(1) of part 5, United States Code, and includes deductibles, copayments, coinsurance, as such terms are defined for purposes of such plan.

"(2) ELIGIBLE RESIDENTS OF A STATE.—

"(A) IN GENERAL.—The term 'eligible residents of a State' means an individual or family who—

"(i) is (or consists of) a resident of the State involved;

"(ii) except as provided in subparagraph (B), has a family income that does not exceed 300 percent of the poverty line;

"(iii) is (or consists of) a citizen of the United States, a legal resident alien, or an individual otherwise residing in the United States under the authority of Federal law; and

"(iv) in the case of an individual, is not eligible for benefits under the medicare

program under title XVIII or for medical assistance under the medicaid program under title XIX (other than under the application of section 1902(a)(10)(A)(ii)(XIV)).

''(B) OPTION TO PROVIDE COVERAGE FOR INDIVIDUALS AND FAMILIES WITH HIGHER INCOME.—If approved by the Secretary, a State may increase the percentage described in subparagraph (A)(ii), or eliminate all income eligibility criteria in order to provide coverage under this part to more individuals and families.

''(3) EXPANSION PHASE (PHASE I) PLAN.—The term 'expansion phase (phase I) plan' means the State universal health insurance coverage plan submitted under section 2201(b).

''(4) HEALTH CARE SERVICES.—The term 'health care services' includes medical, surgical, mental health, and substance abuse services, whether provided on an inpatient or outpatient basis.

''(5) HEALTH CARE WORKER.—The term 'health care worker' means an individual employed by an employer that provides—

''(A) health care services; or

''(B) necessary related services, including administrative, food service, janitorial, or maintenance service to an entity that provides such health care services.

''(6) HEALTH PLAN.—The term 'health plan' includes health insurance coverage, as defined in section 2791(b)(1) of the Public Health Service Act (42 U.S.C. 300gg–91(b)(1)) and group health plans, as defined in section 2791(a) of such Act (42 U.S.C. 300gg91(b)(1)).

''(7) MENTAL HEALTH AND SUBSTANCE ABUSE TREATMENT BENEFITS PARITY.—

''(A) IN GENERAL.—The term 'mental health and substance abuse treatment benefits parity' means, with respect to health coverage, that the coverage does not impose treatment limitations or financial requirements on the coverage of mental health benefits if similar requirements are not imposed on coverage of medical and surgical benefits in comparable settings (including inpatient and outpatient settings).

''(B) TREATMENT LIMITATIONS.—The term 'treatment limitations' means limits on the frequency of treatment, number of visits, or

other limits on the scope and duration of treatment, as covered by a group health plan (or health insurance coverage offered in connection with such a plan). Such term does not include limits on benefits or coverage based solely on medical necessity.

''(C) FINANCIAL REQUIREMENTS.—The term 'financial requirements' means copayments, deductibles, out-of-network charges, out-of-pocket contributions or fees, annual limits, and lifetime aggregate limits imposed on covered individuals.

''(8) POVERTY LINE.—The term 'poverty line' has the meaning given such term in section 673(2) of the Community Services Block Grant Act (42 U.S.C. 9902(2)), including any revision required by such section.

''(9) PREMIUM.—The term 'premium' includes any enrollment fees and other similar charges.

''(10) QUALIFIED PLAN.—The term 'qualified plan' means a health plan that satisfies the coverage requirements described under section 2203 and participates in an expansion phase (phase I) plan.''.

TITLE II—HEALTH SECURITY FOR ALL AMERICANS—UNIVERSAL PHASE (PHASE II)

SEC. 201. UNIVERSAL PHASE (PHASE II) STATE UNIVERSAL HEALTH INSURANCE COVERAGE PLANS.

Title XXII of the Social Security Act, as added by section 101, is amended by adding at the end the following:

"PART B—UNIVERSAL PHASE (PHASE II) PLANS

"SEC. 2211. PURPOSE; MANDATORY STATE PLANS.

''(a) PURPOSE.—The purposes of this part are to—

''(1) require States to establish and implement State-administered systems to ensure universal health insurance coverage; and

''(2) provide funds to States for the establishment and implementation of such systems.

''(b) UNIVERSAL PHASE (PHASE II) PLAN REQUIRED.—

''(1) IN GENERAL.—Except as provided in paragraph (2), not later than January 1, 2007, a State shall submit to the Secretary a plan that sets forth how the State intends to use the funds provided under this part to ensure universal, affordable, and comprehensive health insurance coverage to eligible

residents of the State consistent with the provisions of this part.

''(2) STATES WITH PHASE I PLANS.—

''(A) IN GENERAL.—Not later than January 1, 2007, a State with a phase I State plan shall submit an addendum to such plan that provides assurances to the Secretary that such plan conforms to the requirements of this part.

''(B) CONVERSION TO UNIVERSAL PHASE (PHASE II) PLAN.—If an addendum to an expansion phase (phase I) plan is approved by the Secretary—

''(i) the plan shall be automatically converted to a universal phase (phase II) plan; and

''(ii) section 2214 and any provision of part A that is inconsistent with this part shall not apply to the plan.

''(3) FAILURE TO SUBMIT PLAN OR ADDENDUM.—If a State fails to submit a plan as required in paragraph (1) (or an addendum as required in paragraph (2)), or fails to have such plan or addendum approved by the Secretary, such State shall be in violation of this part; and any residents of such a State may bring a cause of action against the

State in Federal district court to require the State to comply with the provisions of this part.

"SEC. 2212. PLAN REQUIREMENTS.

"(a) IN GENERAL.—A universal phase (phase II) plan shall include a description, consistent with the requirements of this part, of the following:

"(1) DETAILS OF THE UNIVERSAL PHASE (PHASE II) PLAN.—The activities that the State intends to carry out using funds received under this part to ensure that all eligible residents of the State have access to the coverage provided under this part, including how the State will coordinate efforts under the program under this part with existing State efforts to increase to 100 percent the health insurance coverage of eligible residents of the State by January 1, 2009.

"(2) REQUIREMENTS FOR EMPLOYERS.—The manner in which the State will ensure that employers within the State will comply with the requirements of section 2214.

"(3) PART A PROVISIONS.—The following provisions apply to a universal phase (phase II) plan under this part in the same manner as such provisions apply to an expansion phase (phase I) plan under part A:

"(A) STATE OUTREACH PROGRAMS; ACCESS.—Section 2202(a)(4).

"(B) ASSURANCE OF COVERAGE OF ESSENTIAL SERVICES.—Section 2202(a)(5).

"(C) REPRESENTATION ON BOARDS AND COMMISSIONS.—Section 2202(a)(6).

"(D) DISCLOSURE OF INFORMATION TO THE PUBLIC.—Section 2202(a)(7).

"(E) CONSUMER PROTECTIONS AND WORKFORCE STANDARDS.—Section 2202(a)(8).

"(F) PUBLIC REVIEW.—Section 2202(a)(9).

"(G) SERVICES IN RURAL AND UNDERSERVED AREAS; CULTURAL COMPETENCY.—Section 2202(a)(10).

"(H) PURCHASING POOLS.—Section 2202(a)(11).

"(I) LIMITATION ON ADMINISTRATIVE EXPENDITURES.—Section 2202(a)(12).

"(J) SELF-EMPLOYED AND MULTIEMPLOYED.—Section 2202(a)(13).

"(K) MEDICAID WRAPAROUND COVERAGE.—Section 2202(a)(14).

"(4) OTHER MATTERS.—Any other matter determined appropriate by the Secretary.

''(b) PERMISSIBLE ACTIVITIES.—A State may use amounts provided under this part for any activities consistent with this part that are appropriate to enroll individuals in health plans to ensure that all eligible residents of the State are provided coverage under this part, including through the use of direct payments to health plans or providers of services.

''(c) COST CONTAINMENT; COMPETITIVE BIDDING.—Notwithstanding subsection (b), State purchasing pools shall solicit bids from health plans at least annually.

''(d) PROCESS FOR SUBMISSION, APPROVAL, AND AMENDMENT OF UNIVERSAL PHASE (PHASE II) PLAN.—Section 2106 applies to a universal phase (phase II) plan under this part in the same manner as such section applies to a State plan under title XXI, except that no universal phase (phase II) plan may be effective earlier than January 1, 2008, and all such plans must be submitted for approval by not later than January 1, 2007.

''SEC. 2213. COVERAGE REQUIREMENTS FOR UNIVERSAL PHASE (PHASE II) PLANS.

''(a) REQUIRED SCOPE OF HEALTH INSURANCE COVERAGE.—Section 2203(a) applies to a universal phase (phase II) plan under this part.

''(b) UNIVERSAL COVERAGE.—All States shall ensure that by January 1, 2009, 100 percent of eligible residents

of the State have health insurance coverage that meets the requirements of section 2203(a).

''(c) LIMITATIONS ON PREMIUMS AND COST-SHARING.—Section 2203(b) applies to a universal phase (phase II) plan under this part.

''(d) APPLICATION OF CERTAIN REQUIREMENTS.—Section 2203(c) applies to a universal phase (phase II) plan under this part.

''SEC. 2214. REQUIREMENTS FOR EMPLOYERS REGARDING THE PROVISION OF BENEFITS.

''(a) REQUIREMENTS.—Subject to subsection (c)(2)(B), an employer in a State shall comply with the following requirements:

''(1) EMPLOYERS WITH LESS THAN 500 EMPLOYEES.—

''(A) IN GENERAL.—An employer with less than 500 employees shall enroll each employee in a State-designated purchasing pool.

''(B) CONTRIBUTIONS.—

''(i) IN GENERAL.—Notwithstanding subparagraph (A) and subject to clause (ii), the employer shall make a contribution on behalf of each employee for health insurance coverage that is equal to at least 80 percent of the total premiums for such

coverage for employees and their families if the employee elects dependent coverage.

"(ii) LIMITATION.—An employer shall not be liable under subparagraph (B) for more than 10 percent of each employee's annual wages.

"(2) EMPLOYERS WITH AT LEAST 500 EMPLOYEES.—

"(A) IN GENERAL.—An employer with at least 500 employees, a majority of whose wages fall below an amount equal to 300 percent of the poverty line applicable to a family of the size involved, shall comply with the requirements applicable to an employer under paragraph (1).

"(B) OTHER EMPLOYERS.—

"(i) IN GENERAL.—An employer with at least 500 employees that is not described in subparagraph (A) shall, at the option of the employer, either—

"(I) comply with the requirements applicable to an employer under paragraph (1); or

"(II) provide health insurance coverage to all employees and their

families (if the employee elects dependent coverage) that meets the requirements of section 2213 and the employer contribution required under paragraph (1)(B).

''(ii) ADDITIONAL EMPLOYER CONTRIBUTION.—An employer that elects to comply with clause (i)(I) shall contribute an additional 1 percent of payroll into the State-designated purchasing pool in which it participates.

''(3) RULE OF CONSTRUCTION.—Nothing in this title shall be construed as prohibiting a labor organization from collectively bargaining for an employer contribution that is greater than the contribution that is required under paragraph (1)(B) or, as applicable, for health insurance benefits that are greater than the coverage required under paragraph section 2203(a).

''(4) PART-TIME EMPLOYEES.—An employer shall be responsible for meeting the requirements under this subsection for all employees of the employer.

''(5) MULTIEMPLOYER FAMILIES.—In the case of a family with more than 1 employer, the employ-

ers of individuals within the family shall apportion their contributions in accordance with rules established by the State.

''(b) NONAPPLICABILITY.—This section shall not apply—

''(1) to any State that establishes a single payor system; or

''(2) to any State that established a universal phase (phase II) plan through an approved addendum to an expansion phase (phase I) plan.

''(c) PRIVATE CAUSE OF ACTION.—

''(1) LIABILITY.—An employer that fails to comply with the requirements of subsection (a) or otherwise takes adverse action against an employee for the purpose of interfering with the attainment of any right to which the employee may be entitled to under this title, shall be liable to the employee affected.

''(2) AMOUNT.—The amount of the liability described in paragraph (1) shall be an amount equal to—

''(A) the contributions that otherwise would have been made by the employer on behalf of the employee under this section;

''(B) an additional amount as liquidated damages; and

''(C) consequential damages for reasonably foreseeable injuries resulting from such action.

''(3) JURISDICTION; EQUITABLE RELIEF.—

''(A) JURISDICTION.—An action under this subsection may be maintained against any employer in any Federal or State court of competent jurisdiction by any 1 or more employees.

''(B) EQUITABLE RELIEF.—In addition to the damages described in paragraph (2), a court may enjoin any act or practice that violates this title.

''(4) ATTORNEY'S FEES.—If a plaintiff or plaintiffs prevail in an action brought under this subsection, the court shall, in addition to any judgment awarded to the plaintiff or plaintiffs, award the reasonable attorney's fees and costs associated with the bringing of the action.

''SEC. 2215. ALLOTMENTS.

''(a) STATE ALLOTMENTS.—Subsections (a) and (b) of section 2204 apply to a universal phase (phase II) plan under this part in the same manner as such subsections apply to an expansion phase (phase I) plan under part A.

''(b) SPECIAL RULE FOR EXPANSION PHASE (PHASE I) PLANS.—A State that operated an expansion phase (phase I) plan and converted such plan to a universal phase (phase II) plan pursuant to section 2211(b)(2)(B) shall continue to be eligible for the enhanced Federal participation rate determined under section 2204(c).

''(c) GRANTS TO INDIAN TRIBES, NATIVE HAWAIIAN ORGANIZATIONS, AND ALASKA NATIVE ORGANIZATIONS.—Section 2204(d) applies to a universal phase (phase II) plan under this part.

''(d) APPROPRIATION.—

''(1) IN GENERAL.—Out of any funds in the Treasury not otherwise appropriated, there is appropriated to carry out this title such sums as may be necessary for fiscal year 2008 and each fiscal year thereafter.

''(2) BUDGET AUTHORITY.—Paragraph (1) constitutes budget authority in advance of appropriations Acts and represents the obligation of the Federal Government to provide States, Indian tribes, Native Hawaiian organizations, and Alaska Native organizations with the allotments determined under this section and the grants for administrative and outreach activities under section 2205(a)(1)(B) (as applied to this part under section 2216(a)).

"SEC. 2216. ADMINISTRATION; DEFINITIONS.

"(a) ADMINISTRATION.—The provisions of section 2205 (other than subsection (c) of such section) apply to a universal phase (phase II) plan under this part in the same manner as such provisions apply to an expansion phase (phase I) plan under part A.

"(b) DEFINITIONS.—

"(1) APPLICATION OF SECTION 2206.—The definitions set forth in section 2206 apply to a universal phase (phase II) plan under this part in the same manner as such provisions apply to an expansion phase (phase I) plan under part A except that for purposes of this part, the definition of 'eligible residents of a State' set forth in section 2206(2) shall be applied without regard to subparagraphs (A)(ii) and (B).

"(2) UNIVERSAL PHASE (PHASE II) PLAN.—In this title, the term 'universal phase (phase II) plan' means the State universal health insurance coverage plan submitted under section 2211(b).".

SEC. 202. CONSUMER PROTECTIONS.

Title XXII of the Social Security Act, as amended by section 201, is amended by adding at the end the following:

"PART C—CONSUMER PROTECTIONS

"SEC. 2221. HOME CARE STANDARDS.

''In order to ensure that home care services are provided in a consumer-directed manner, a State participating under part A, and, effective January 1, 2008, all States under part B, shall satisfy the Secretary that any health plan that provides home care services under this title creates, or contracts with, a viable entity other than the consumer or individual provider to provide effective billing, payments for services, tax withholding, unemployment insurance, and workers compensation coverage, and to serve as the statutory employer of the home care provider. Recipients of such services shall retain the right to independently select, hire, terminate, and direct the work of the home care provider.

"SEC. 2222. CONSUMER PROTECTION IN THE EVENT OF TERMINATION OR SUSPENSION OF SERVICES.

''A State participating under part A, and, effective January 1, 2008, all States under part B, shall satisfy the Secretary that any health plan providing services under this title shall ensure that enrollees will receive continued health services in the event that the plan's health care services are terminated or suspended, including as the result of the plan filing for bankruptcy relief under title 11, United States Code, or the failure of the plan

to provide payments to providers, lockouts, work stoppages, or other labor management problems.

"SEC. 2223. CONSUMER PROTECTION THROUGH DISCLOSURE OF INFORMATION.

"(a) IN GENERAL.—A State participating under part A, and, effective January 1, 2008, all States under part B, shall satisfy the Secretary that any health care provider that provides services to individuals under this title shall provide to the State information regarding the identity, employment location, and qualifications of health care workers providing services under—

"(1) the licensure of the provider; or

"(2) a contract between the provider and a health plan or the State.

"(b) AVAILABILITY TO PUBLIC.—A health care provider shall make the information described in subsection (a) available to the public.

"SEC. 2224. CONSUMER PROTECTION THROUGH NOTICE OF CHANGES IN HEALTH CARE DELIVERY.

"A State participating under part A, and, effective January 1, 2008, all States under part B, shall describe how the State will provide, at a minimum, the following protections:

''(1) Adequate advance notice to the public, the affected health care workers, and labor organizations representing such workers, of a pending—

''(A) facility or operating unit closure;

''(B) sale, merger, or consolidation of a facility or operating unit;

''(C) transfer of work from 1 facility or entity to another facility or entity; or

''(D) reduction of services.

''(2) A right of first refusal for similar vacant positions with—

''(A) the resulting entity, in the case of a health care worker whose position was eliminated following a merger of the worker's original employer with a new entity; or

''(B) the contractor, in the case of a health care worker whose position was eliminated following the contracting out of the work the worker formerly performed.''.

TITLE III—PATIENT PROTECTIONS

SEC. 301. INCORPORATION OF CERTAIN PROTECTIONS.

(a) INCORPORATION.—The provisions of the following bills are hereby enacted into law:

(1) S. 1052 of the 107th Congress, as passed by the Senate on June 29, 2001.

(2) H.R. 2340 of the 107th Congress, as introduced on June 27, 2001.

(b) PUBLICATION.—In publishing this Act in slip form and in the United States Statutes at Large pursuant to section 112, of title 1, United States Code, the Archivist of the United States shall include after the date of approval at the end appendixes setting forth the texts of the bills referred to in subsection (a) of this section.

TITLE IV—HEALTH CARE QUALITY, PATIENT SAFETY, AND WORKFORCE STANDARDS

SEC. 401. HEALTH CARE QUALITY, PATIENT SAFETY, AND WORKFORCE STANDARDS INSTITUTE.

(a) ESTABLISHMENT.—

(1) INSTITUTE.—There is established within the Agency for Healthcare Research and Quality, an institute to be known as the Health Care Quality, Patient Safety, and Workforce Standards Institute (in this section referred to as the ''Institute'').

(2) DIRECTOR.—The Secretary of Health and Human Services shall appoint a director of the Institute. The director shall administer the Institute and carry out the duties of the director under this sec-

tion subject to the authority, direction, and control of the Secretary.

(b) MISSION.—The mission of the Institute is to—

(1) demonstrate how patient safety issues and workplace conditions are linked to quality patient care and the reduction of the incidence of medical errors; and

(2) reduce the incidence of medical errors and improve patient safety and quality of care.

(c) DUTIES.—In carrying out the mission of the Institute, the director of the Institute shall—

(1) work closely with the director of the Agency for Healthcare Research and Quality to ensure that issues related to workplace conditions are reflected in the activities conducted by such agency in order to reduce the incidence of medical errors and improve patient safety and quality of care, including—

(A) the establishment of national goals;

(B) the development and implementation of a research agenda;

(C) the development and promotion of best practices;

(D) the development of performance and staffing standards in consultation with the

Health Care Financing Administration and other Federal agencies, as appropriate; and

(E) the development and dissemination of information, educational and training materials, and other criteria as it relates to the delivery of quality care;

(2) provide recommendations to the Secretary of Health and Human Services and other Federal agencies with responsibility for health care quality and the development of standards that impact on the delivery of quality patient care on standards related to workplace conditions and patient safety;

(3) support the activities of the Health Care Financing Administration related to the development of new or revised conditions of participation under the medicare and medicaid programs and subsequent rulemaking on issues related to workplace conditions, medical errors, and patient safety and quality of care; and

(4) conduct other activities determined appropriate by the director of the Institute.

(d) WORKPLACE CONDITIONS.—For purposes of this section, the term ''workplace conditions'' shall include issues related to—

(1) health care worker staffing;

(2) hours of work;

(3) confidentiality and whistleblower protections;

(4) employee participation in decisionmaking roles that contribute to improved quality of care and the reduction of the incidence of medical errors;

(5) workforce training; and

(6) the impact of health care delivery restructuring on communities and health care workers.

(e) DEFINITION OF HEALTH CARE WORKER.—

(1) IN GENERAL.—In this section, the term ''health care worker'' means an individual employed by an employer that provides—

(A) health care services; or

(B) necessary related services, including administrative, food service, janitorial, or maintenance service to an entity that provides such health care services.

(2) HEALTH CARE SERVICES.—In paragraph (1), the term ''health care services'' includes medical, surgical, mental health, and substance abuse services, whether provided on an in-patient or outpatient basis.

(f) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated to the Institute such

sums as may be necessary to carry out the purposes of this section.

SEC. 402. HEALTH CARE QUALITY, PATIENT SAFETY, AND WORKFORCE STANDARDS ADVISORY COMMITTEE.

(a) ESTABLISHMENT OF COMMITTEE.—There is established a Health Care Quality, Patient Safety, and Workforce Standards Committee (in this section referred to as the ''Committee'').

(b) FUNCTIONS OF COMMITTEE.—

(1) ADVICE TO INSTITUTE.—The Committee shall provide advice to the Director of the Health Care Quality, Patient Safety, and Workforce Standards Institute established under section 401 on issues related to the duties of the Director.

(2) INITIAL REPORT.—Not later than December 31, 2004, the Committee shall submit an initial report to the Secretary that contains—

(A) recommendations regarding minimal workforce standards that are critical for improved health care quality and patient safety; and

(B) recommendations regarding additional ways to reduce the incidence of medical errors

and to improve patient safety and quality of care.

(3) FINAL REPORT.—Not later than December 31, 2005, the Committee shall submit a final report to the Secretary of Health and Human Services regarding the recommendations contained in the initial report required under paragraph (2), including any modifications of such recommendations.

(c) STRUCTURE AND MEMBERSHIP OF THE COMMITTEE.—

(1) STRUCTURE.—The Committee shall be composed of the Director of the Health Care Quality, Patient Safety, and Workforce Standards Institute established under section 401 and 15 additional members who shall be appointed by the Secretary of Health and Human Services.

(2) MEMBERSHIP.—

(A) IN GENERAL.—The members of the Committee shall be chosen on the basis of their integrity, impartiality, and good judgment, and shall be individuals who are, by reason of their education, experience, and attainments, exceptionally qualified to perform the duties of members of the Committee.

(B) SPECIFIC MEMBERS.—In making appointments under paragraph (1), the Secretary of Health and Human Services shall ensure that the following groups are represented:

(i) Health care providers and health care workers, including labor unions representing health care workers.

(ii) Consumer organizations.

(iii) Health care institutions.

(iv) Health education organizations.

(d) CHAIRMAN.—The Director of the Health Care Quality, Patient Safety, and Workforce Standards Institute established under section 401 shall chair the Committee.

TITLE V—IMPROVING MEDICARE BENEFITS

SEC. 501. FULL MENTAL HEALTH AND SUBSTANCE ABUSE TREATMENT BENEFITS PARITY.

Notwithstanding any provision of title XVIII of the Social Security Act (42 U.S.C. 1395 et seq.), beginning January 1, 2004, each individual who is entitled to benefits under part A or enrolled under part B of the medicare program, including an individual enrolled in a Medicare+Choice plan offered by a Medicare+Choice organization under part C of such program, shall be pro-

vided full mental health and substance abuse treatment parity under the medicare program established under such title of such Act consistent with title XXII of the Social Security Act (as added by this Act).

TITLE VI—LONG-TERM AND HOME HEALTH CARE

SEC. 601. STUDIES AND DEMONSTRATION PROJECTS TO IDENTIFY MODEL PROGRAMS.

The Secretary of Health and Human Services shall—

(1) conduct studies and demonstration projects, through grant, contract, or interagency agreement, that are designed to identify model programs for the provision of long-term and home health care services;

(2) report regularly to Congress on the results of such studies and demonstration projects; and

(3) include in such report any recommendations for legislation to expand or continue such studies and projects.

TITLE VII—MISCELLANEOUS

SEC. 701. NONAPPLICATION OF ERISA.

The provisions of section 514 of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1144) shall not apply with respect to health benefits provided under a group health plan (as defined in section 733(a) of that

Act (29 U.S.C. 1191b(a))) qualified to offer such benefits under an expansion phase (phase I) plan under title XXII of the Social Security Act (as added by this Act) or under a universal phase (phase II) plan under such title.

SEC. 702. SENSE OF CONGRESS REGARDING OFFSETS.

It is the sense of Congress that any sums necessary for the implementation of this Act, and the amendments made by this Act, should be offset by—

(1) general revenues available as a result of an on-budget surplus for a fiscal year;

(2) direct savings in health care expenditures resulting from the implementation of this Act; and

(3) reductions in unnecessary Federal tax benefits available only to individuals and large corporations that are in the maximum tax brackets.

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