

103^D CONGRESS
2^D SESSION

H. R. 3960

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 3, 1994

Mr. MILLER of California (for himself, Mr. McDERMOTT, Mr. BECERRA, Mr. CLAY, Mr. DELUGO, Mr. ENGEL, Mr. FALEOMAVAEGA, Mrs. MINK, Mr. MURPHY, Mr. OWENS, Mr. PAYNE of New Jersey, Mr. ROMERO-BARCELÓ, Mr. SCOTT, and Ms. WOOLSEY) introduced the following bill; which was referred to the Committee on Energy and Commerce, Ways and Means, Armed Services, Post Office and Civil Service, Natural Resources, and Education and Labor

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 1994”.

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. Professional, technical, and temporary advisory committees.
- Sec. 404. American Health Security Quality Council.
- Sec. 405. State health security programs.
- Sec. 406. 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 Amer-
ican Health Security Program.
- Sec. 412. National health care fraud data base.
- Sec. 413. Requirements for operation of State health care fraud and abuse con-
trol units.
- Sec. 414. Assignment of unique provider and patient identifiers.

TITLE V—QUALITY ASSESSMENT

- Sec. 501. Functions of Quality Council; development of practice guidelines and
application to outliers.
- Sec. 502. State quality review programs.
- Sec. 503. Elimination of existing utilization review programs; transition.
- Sec. 504. Development of national electronic data base.

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.

Subtitle D—Increase in Taxes on Firearms and Ammunition

Sec. 831. Increase in taxes on firearms and ammunition.

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.

Sec. 903. Repeal of continuation coverage requirements under ERISA and certain other requirements relating to group health plans.

Sec. 904. 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

1 Program to be administered by the individual States in
2 accordance with Federal standards specified in, or estab-
3 lished under, this Act.

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

8 (c) STATE DEFINED.—

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

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

23 **SEC. 102. UNIVERSAL ENTITLEMENT.**

24 (a) IN GENERAL.—Every individual who is a resident
25 of the United States and is a citizen or national of the

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

8 (b) TREATMENT OF CERTAIN NONIMMIGRANTS.—

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

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

22 (c) TREATMENT OF OTHER INDIVIDUALS.—

23 (1) BY BOARD.—The Board also may make eli-
24 gible for benefits for health care services under the
25 appropriate State health security program under this

1 Act other individuals not described in subsection (a)
2 or (b), and regulate the nature of the eligibility of
3 such individuals, in order—

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

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

9 (C) to prevent adverse financial and medi-
10 cal consequences of uncompensated care,

11 while inhibiting travel and immigration to the
12 United States for the sole purpose of obtaining
13 health care services.

14 (2) BY STATES.—Any State health security pro-
15 gram may make individuals described in paragraph

16 (1) eligible for benefits at the expense of the State.

17 (d) LAWFUL RESIDENT ALIEN DEFINED.—For pur-
18 poses of this section, the term “lawful resident alien”
19 means an alien lawfully admitted for permanent residence
20 and any other alien lawfully residing permanently in the
21 United States under color of law, including an alien with
22 lawful temporary resident status under section 210, 210A,
23 or 234A of the Immigration and Nationality Act (8 U.S.C.
24 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 1996, 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, 1996.

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 1995,

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, 1996, 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, 1995.

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 1995.

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.

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

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

24 (5) LONG-TERM AND CHRONIC CARE SERV-
25 ICES.—

1 (A) Nursing facility services.

2 (B) Home health services.

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

6 (D) Hospice care.

7 (6) PRESCRIPTION DRUGS, BIOLOGICALS, INSU-
8 LIN, MEDICAL FOODS.—

9 (A) Outpatient prescription drugs and
10 biologicals, as specified by the Board consistent
11 with section 515.

12 (B) Insulin.

13 (C) Medical foods (as defined in section
14 202(d)).

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

17 (8) MENTAL HEALTH SERVICES.—Mental
18 health services (as defined in section 202(e)).

19 (9) SUBSTANCE ABUSE TREATMENT SERV-
20 ICES.—Substance abuse treatment services (as de-
21 fined in section 202(f)).

22 (10) DIAGNOSTIC TESTS.—Diagnostic tests.

23 (11) OTHER ITEMS AND SERVICES.—

24 (A) OUTPATIENT THERAPY.—Outpatient
25 physical therapy services, outpatient speech pa-

1 thology services, and outpatient occupational
2 therapy services in all settings.

3 (B) DURABLE MEDICAL EQUIPMENT.—Du-
4 rable medical equipment.

5 (C) HOME DIALYSIS.—Home dialysis sup-
6 plies and equipment.

7 (D) AMBULANCE.—Emergency ambulance
8 service.

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

11 (F) ADDITIONAL ITEMS AND SERVICES.—
12 Such other medical or health care items or
13 services as the Board may specify.

14 (b) COST-SHARING.—There are no deductibles, coin-
15 surance, or copayments applicable to acute care and pre-
16 ventive benefits provided under this title.

17 (c) PROHIBITION OF BALANCE BILLING.—As pro-
18 vided in section 531, no person may impose a charge for
19 covered services for which benefits are provided under this
20 Act.

21 (d) NO DUPLICATE HEALTH INSURANCE.—Each
22 State health security program shall prohibit the sale of
23 health insurance in the State if payment under the insur-
24 ance duplicates payment for any items or services for
25 which payment may be made under such a program.

1 (e) STATE PROGRAM MAY PROVIDE ADDITIONAL
2 BENEFITS.—Nothing in this Act shall be construed as
3 limiting the benefits that may be made available under a
4 State health security program to residents of the State
5 at the expense of the State.

6 (f) EMPLOYERS MAY PROVIDE ADDITIONAL BENE-
7 FITS.—Nothing in this Act shall be construed as limiting
8 the additional benefits that an employer may provide to
9 employees or their dependents, or to former employees or
10 their dependents.

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

12 (a) COMMUNITY-BASED PRIMARY HEALTH SERV-
13 ICES.—In this title, the term “community-based primary
14 health services” means ambulatory health services fur-
15 nished—

16 (1) by a rural health clinic;

17 (2) by a Federally-qualified health center, and
18 which, for purposes of this Act, include services
19 furnished by State and local health agencies;

20 (3) in a school-based setting;

21 (4) by public educational agencies and other
22 providers of services to children entitled to assist-
23 ance under the Individuals with Disabilities Edu-
24 cation Act for services furnished pursuant to a

1 written Individualized Family Services Plan or
2 Individual Education Plan under such Act; and

3 (5) public and private non-profit entities receiv-
4 ing Federal assistance under the Public Health
5 Service Act.

6 (b) PREVENTIVE SERVICES.—

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

9 (A) which—

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

11 (ii) the Board determines to be effec-
12 tive in the maintenance and promotion of
13 health or minimizing the effect of illness,
14 disease, or medical condition; and

15 (B) which are provided consistent with the
16 periodicity schedule established under para-
17 graph (3).

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

20 (A) Basic immunizations.

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

23 (C) Well-child care (including periodic
24 physical examinations, hearing and vision
25 screening, and developmental screening and ex-

1 aminations) for individuals under 18 years of
2 age.

3 (D) Periodic screening mammography, Pap
4 smears, and colorectal examinations and exami-
5 nations for prostate cancer.

6 (E) Physical examinations.

7 (F) Family planning services.

8 (G) Routine eye examinations, eyeglasses,
9 and contact lenses.

10 (H) Hearing aids, but only upon a deter-
11 mination of a certified audiologist or physician
12 that a hearing problem exists and is caused by
13 a condition that can be corrected by use of a
14 hearing aid.

15 (3) SCHEDULE.—The Board shall establish, in
16 consultation with experts in preventive medicine and
17 public health and taking into consideration those
18 preventive services recommended by the Preventive
19 Services Task Force and published as the Guide to
20 Clinical Preventive Services, a periodicity schedule
21 for the coverage of preventive services under para-
22 graph (1). Such schedule shall take into consider-
23 ation the cost-effectiveness of appropriate preventive
24 care and shall be revised not less frequently than

1 once every 5 years, in consultation with experts in
2 preventive medicine and public health.

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

9 (1) Homemaker services, including meals.

10 (2) Home health aide services.

11 (3) Adult day health care, social day care or
12 psychiatric day care.

13 (4) Medical social work services.

14 (5) Care coordination services, as defined in
15 subsection (g)(1).

16 (6) Respite care, including training for informal
17 caregivers.

18 (d) MEDICAL FOODS.—In this title, the term “medi-
19 cal foods” means foods which are formulated to be
20 consumed or administered enterally under the supervision
21 of a physician and which are intended for the specific die-
22 tary management of a disease or condition for which
23 distinctive nutritional requirements, based on recognized
24 scientific principles, are established by medical evaluation.

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

6 (1) Crisis intervention.

7 (2) Outpatient mental health services.

8 (3) Partial hospitalization and day and evening
9 treatment programs.

10 (4) Psychosocial rehabilitation services.

11 (5) Pharmacotherapeutic interventions.

12 (6) Other rehabilitation services, including half-
13 way and three-quarter-way house care.

14 (7) Inpatient mental health services.

15 (8) Care coordination services (as defined in
16 subsection (g)(1)).

17 (f) SUBSTANCE ABUSE TREATMENT SERVICES.—In
18 this title, the term “substance abuse treatment services”
19 means services for the treatment of dependency on alcohol
20 or controlled substances provided through a treatment
21 program meeting State qualification standards and in-
22 cludes the following services:

23 (1) Crisis intervention, including assessment,
24 diagnosis, and referral.

1 (2) Detoxification services, in ambulatory and
2 inpatient settings.

3 (3) Outpatient services, including intensive day
4 and evening programs, continuing care, and family
5 services.

6 (4) Short-term residential services in a hospital
7 or free-standing program.

8 (5) Long-term residential services, including
9 therapeutic communities and halfway houses.

10 (6) Pharmacotherapeutic interventions.

11 (7) Care coordination services (as defined in
12 subsection (g)(1)).

13 (g) CARE COORDINATION SERVICES.—

14 (1) IN GENERAL.—In this title, the term “care
15 coordination services” means services provided by
16 care coordinators (as defined in paragraph (2)) to
17 individuals described in paragraph (3) for the co-
18 ordination and monitoring of mental health services,
19 substance abuse treatment services, and home and
20 community-based long term care services to ensure
21 appropriate, cost-effective utilization of such services
22 in a comprehensive and continuous manner, and in-
23 cludes—

24 (A) transition management between inpa-
25 tient facilities and community-based services,

1 including assisting patients in identifying and
2 gaining access to appropriate ancillary services;
3 and

4 (B) evaluating and recommending appro-
5 priate treatment services, in cooperation with
6 patients and other providers and in conjunction
7 with any quality review program or plan of care
8 under section 205.

9 (2) CARE COORDINATOR.—

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

14 (i) is capable of performing directly,
15 efficiently, and effectively the duties of a
16 care coordinator described in paragraph
17 (1), and

18 (ii) demonstrates capability in estab-
19 lishing and periodically reviewing and re-
20 vising plans of care, and in arranging for
21 and monitoring the provision and quality
22 of services under any plan.

23 (B) INDEPENDENCE.—State health secu-
24 rity programs shall establish safeguards to as-
25 sure that care coordinators have no financial in-

1 terest in treatment decisions or placements.
2 Care coordination may not be provided through
3 any structure or mechanism through which
4 quality review is performed.

5 (3) ELIGIBLE INDIVIDUALS.—An individual de-
6 scribed in this paragraph is an individual—

7 (A) described in section 203 (relating to
8 individuals qualifying for long term and chronic
9 care services); or

10 (B) determined (in a manner specified by
11 the Board)—

12 (i) to have a serious mental illness (as
13 defined by the Board), or

14 (ii) to have a history of substance
15 abuse displaying severe associated illness
16 or previous treatment failure (as defined
17 by the Board).

18 (h) DENTAL SERVICES.—In this title, the term “den-
19 tal services” means preventive and prophylactic dental
20 treatment consistent with a periodicity schedule estab-
21 lished by the Board and treatment for dental disease and
22 injury in children under 18 years of age, and does not
23 include orthodontic services.

24 (i) NURSING FACILITY; NURSING FACILITY SERV-
25 ICES.—Except as may be provided by the Board, the

1 terms “nursing facility” and “nursing facility services”
2 have the meanings given such terms in sections 1919(a)
3 and 1905(f), respectively, of the Social Security Act.

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

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

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

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

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

20 (i) bathing;

21 (ii) eating;

22 (iii) dressing;

23 (iv) toileting; and

24 (v) transferring in and out of a bed or
25 in and out of a chair; or

1 (B) due to cognitive or mental impair-
2 ments, requires supervision because the individ-
3 ual behaves in a manner that poses health or
4 safety hazards to himself or herself or others.

5 (2) CHILDREN.—Individuals under 18 years of
6 age determined (in a manner specified by the Board)
7 to meet such alternative standard of disability for
8 children as the Board develops.

9 (b) LIMIT ON SERVICES.—

10 (1) IN GENERAL.—No individual is entitled to
11 receive benefits under a State health security pro-
12 gram with respect to home and community-based
13 long term care services in a period (specified by the
14 Board) to the extent the amount of payments for
15 such benefits exceeds 65 percent (or such alternative
16 ratio as the Board establishes under paragraph (2))
17 of the average of amount of payment that would
18 have been made under the program during the pe-
19 riod if the individual were a resident of a nursing fa-
20 cility in the same area in which the services were
21 provided.

22 (2) ALTERNATIVE RATIO.—The Board may es-
23 tablish for purposes of paragraph (1) an alternative
24 ratio (of payments for home and community-based
25 long term care services to payments for nursing fa-

1 cility services) as the Board determines to be more
2 consistent with the goal of providing cost-effective
3 long-term care in the most appropriate and least
4 restrictive setting.

5 **SEC. 204. EXCLUSIONS AND LIMITATIONS.**

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

9 (b) MENTAL HEALTH SERVICES AND SUBSTANCE
10 ABUSE TREATMENT SERVICES.—

11 (1) IN GENERAL.—Mental health services and
12 substance abuse treatment services furnished for an
13 individual in excess of a threshold specified in para-
14 graph (2) are not covered services unless the services
15 are determined under a utilization review program to
16 meet the standards specified in section 201(a) and,
17 with respect to inpatient or residential treatment
18 services, to be provided in the least restrictive and
19 most appropriate setting.

20 (2) UTILIZATION REVIEW THRESHOLD.—

21 (A) IN GENERAL.—Subject to subpara-
22 graphs (B) and (C), the thresholds specified in
23 this paragraph are—

24 (i) 20 outpatient visits in a year, and

1 (ii) 15 days of inpatient services in a
2 year.

3 (B) ALTERNATIVE NATIONAL THRESH-
4 OLDS.—The Board may specify alternative
5 thresholds to those specified in subparagraph
6 (A).

7 (C) ADDITIONAL STATE THRESHOLDS.—A
8 State health security program may specify
9 thresholds in addition to those established
10 under the previous subparagraphs, which
11 thresholds may be higher or lower than the
12 number of outpatient visits or days of inpatient
13 services otherwise specified.

14 (c) TREATMENT OF EXPERIMENTAL SERVICES.—In
15 applying subsection (a), the Board shall make, after con-
16 sultation with a technical advisory committee, national
17 coverage determinations with respect to those services that
18 are experimental in nature. Such determinations shall be
19 made consistent with a process that provides for profes-
20 sional input and public comment.

21 (d) APPLICATION OF NATIONAL PRACTICE GUIDE-
22 LINES.—In the case of services for which the Board has
23 recognized national practice guidelines, the services are
24 considered to meet the standards specified in section
25 201(a) only if they have been provided in accordance with

1 such guidelines or in accordance with such guidelines as
2 are provided by the State health security program consist-
3 ent with title V.

4 (e) SPECIFIC LIMITATIONS.—

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

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

21 (3) MISCELLANEOUS EXCLUSIONS FROM COV-
22 ERED SERVICES.—Covered services under this Act
23 do not include the following:

24 (A) Surgery and other procedures (such as
25 orthodontia) performed solely for cosmetic pur-

1 poses (as defined in regulations) and hospital or
2 other services incident thereto, unless—

3 (i) required to correct a congenital
4 anomaly;

5 (ii) required to restore or correct a
6 part of the body which has been altered as
7 a result of accidental injury, disease, or
8 surgery; or

9 (iii) otherwise determined to be medi-
10 cally necessary and appropriate under sec-
11 tion 201(a).

12 (B) Personal comfort items or private
13 rooms in inpatient facilities, unless determined
14 to be medically necessary and appropriate
15 under section 201(a).

16 (C) The services of a professional practi-
17 tioner if they are furnished in a hospital or
18 other facility which is not a participating pro-
19 vider.

20 (f) NURSING FACILITY SERVICES AND HOME
21 HEALTH SERVICES.—Nursing facility services and home
22 health services (other than post-hospital services, as de-
23 fined by the Board) furnished to an individual who is not
24 described in section 203(a) are not covered services unless
25 the services are determined to meet the standards speci-

1 fied in section 201(a) and, with respect to nursing facility
2 services, to be provided in the least restrictive and most
3 appropriate setting.

4 **SEC. 205. CERTIFICATION; QUALITY REVIEW; PLANS OF**
5 **CARE.**

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

12 (b) QUALITY REVIEW.—For requirement that each
13 State health security program establish a quality review
14 program that meets the requirements for such a program
15 under title V, see section 405(b)(1)(H).

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

TITLE III—PROVIDER PARTICIPATION

SEC. 301. PROVIDER PARTICIPATION AND STANDARDS.

(a) IN GENERAL.—An individual or other entity furnishing any covered service under a State health security program under this Act is not a qualified provider unless the individual or entity—

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

(2) has filed with the State health security program a participation agreement described in subsection (b); and

(3) meets such other qualifications and conditions as are established by the Board or the State health security program under this Act.

(b) REQUIREMENTS IN PARTICIPATION AGREEMENT.—

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

(A) Services to eligible persons will be furnished by the provider without discrimination on the ground of race, national origin, income, religion, age, sex or sexual orientation, disabil-

1 ity, handicapping condition, or (subject to the
2 professional qualifications of the provider) ill-
3 ness. Nothing in this subparagraph shall be
4 construed as requiring the provision of a type
5 or class of services which services are outside
6 the scope of the provider's normal practice.

7 (B) No charge will be made for any cov-
8 ered services other than for payment authorized
9 by this Act.

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

15 (i) quality review by designated enti-
16 ties;

17 (ii) the making of payments under
18 this Act (including the examination of
19 records as may be necessary for the ver-
20 ification of information on which payments
21 are based);

22 (iii) statistical or other studies re-
23 quired for the implementation of this Act;
24 and

1 (iv) such other purposes as the Board
2 or State may specify.

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

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

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

20 (2) TERMINATION OF PARTICIPATION AGREE-
21 MENTS.—

22 (A) IN GENERAL.—Participation agree-
23 ments may be terminated, with appropriate no-
24 tice—

1 (i) by the Board or a State health se-
2 curity program for failure to meet the
3 requirements of this title, or

4 (ii) by a provider.

5 (B) TERMINATION PROCESS.—Providers
6 shall be provided notice and a reasonable oppor-
7 tunity to correct deficiencies before the Board
8 or a State health security program terminates
9 an agreement unless a more immediate termi-
10 nation is required for public safety or similar
11 reasons.

12 **SEC. 302. QUALIFICATIONS FOR PROVIDERS.**

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

16 (1) all the requirements of State law to provide
17 such services,

18 (2) applicable requirements of Federal law to
19 provide such services, and

20 (3) any applicable standards established under
21 subsection (b).

22 (b) MINIMUM PROVIDER STANDARDS.—

23 (1) IN GENERAL.—The Board shall establish,
24 evaluate, and update national minimum standards to
25 assure the quality of services provided under this

1 Act and to monitor efforts by State health security
2 programs to assure the quality of such services. A
3 State health security program may also establish ad-
4 ditional minimum standards which providers must
5 meet.

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

- 18 (A) adequacy and quality of facilities;
- 19 (B) training and competence of personnel
- 20 (including continuing education requirements);
- 21 (C) comprehensiveness of service;
- 22 (D) continuity of service;
- 23 (E) patient satisfaction (including waiting
- 24 time and access to services); and

1 (F) performance standards (including or-
2 ganization, facilities, structure of services, effi-
3 ciency of operation, and outcome in palliation,
4 improvement of health, stabilization, cure, or
5 rehabilitation).

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

13 (4) EXCHANGE OF INFORMATION.—The Board
14 shall provide for an exchange, at least annually,
15 among State health security programs of informa-
16 tion with respect to quality assurance and cost
17 containment.

18 **SEC. 303. QUALIFICATIONS FOR COMPREHENSIVE HEALTH**
19 **SERVICE ORGANIZATIONS.**

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

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

4 (2) out-of-area coverage in the case of urgently
5 needed services,

6 to an identified population which is living in or near a
7 specified service area and which enrolls voluntarily in the
8 organization.

9 (b) ENROLLMENT.—

10 (1) IN GENERAL.—All eligible persons living in
11 or near the specified service area of a CHSO are eli-
12 gible to enroll in the organization; except that the
13 number of enrollees may be limited to avoid overtax-
14 ing the resources of the organization.

15 (2) MINIMUM ENROLLMENT PERIOD.—Subject
16 to paragraph (3), the minimum period of enrollment
17 with a CHSO shall be twelve months, unless the en-
18 rolled individual becomes ineligible to enroll with the
19 organization.

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

23 (c) REQUIREMENTS FOR CHSOs.—

24 (1) ACCESSIBLE SERVICES.—Each CHSO, to
25 the maximum extent feasible, shall make all services

1 readily and promptly accessible to enrollees who live
2 in the specified service area.

3 (2) CONTINUITY OF CARE.—Each CHSO shall
4 furnish services in such manner as to provide con-
5 tinuity of care and (when services are furnished by
6 different providers) shall provide ready referral of
7 patients to such services and at such times as may
8 be medically appropriate.

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

11 (A) CONSUMER REPRESENTATION.—At
12 least one-third of the members of the CHSO's
13 board of directors must be consumer members
14 with no direct or indirect, personal or family
15 financial relationship to the organization.

16 (B) PROVIDER REPRESENTATION.—The
17 CHSO's board of directors must include at
18 least one member who represents health care
19 providers.

20 (4) PATIENT GRIEVANCE PROGRAM.—Each
21 CHSO must have in effect a patient grievance pro-
22 gram and must conduct regularly surveys of the sat-
23 isfaction of members with services provided by or
24 through the organization.

1 (5) MEDICAL STANDARDS.—Each CHSO must
2 provide that a committee or committees of health
3 care practitioners associated with the organization
4 will promulgate medical standards, oversee the pro-
5 fessional aspects of the delivery of care, perform the
6 functions of a pharmacy and drug therapeutics com-
7 mittee, and monitor and review the quality of all
8 health services (including drugs, education, and pre-
9 ventive services).

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

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

15 (A) comply with the requirements of sec-
16 tion 1876(i)(8) of the Social Security Act (re-
17 lating to prohibiting physician incentive plans
18 that provide specific inducements to reduce or
19 limit medically necessary services), and

20 (B) make available to its membership utili-
21 zation information and data regarding financial
22 performance, including bonus or incentive pay-
23 ment arrangements to practitioners.

24 (8) PROVISION OF SERVICES TO ENROLLEES AT
25 INSTITUTIONS OPERATING UNDER GLOBAL BUDG-

1 ETS.—The organization shall arrange to reimburse
2 for hospital services and other facility-based services
3 (as identified by the Board) for services provided to
4 members of the organization in accordance with the
5 global operating budget of the hospital or facility ap-
6 proved under section 611.

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

16 (10) ADDITIONAL REQUIREMENTS.—Each
17 CHSO must meet—

18 (A) such requirements relating to mini-
19 mum enrollment,

20 (B) such requirements relating to financial
21 solvency,

22 (C) such requirements relating to quality
23 and availability of care, and

24 (D) such other requirements,

1 as the Board or a State health security program
2 may specify.

3 (d) PROVISION OF EMERGENCY SERVICES TO
4 NONENROLLEES.—A CHSO may furnish emergency serv-
5 ices to persons who are not enrolled in the organization.
6 Payment for such services, if they are covered services to
7 eligible persons, shall be made to the organization unless
8 the organization requests that it be made to the individual
9 provider who furnished the services.

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

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

20 (b) EXPANSION OF PROHIBITION TO CERTAIN DES-
21 IGNATED SERVICES.—Section 1877 of the Social Security
22 Act (42 U.S.C. 1395nn) is amended—

23 (1) by striking “clinical laboratory services”
24 and “CLINICAL LABORATORY SERVICES” and insert-
25 ing “designated health services” and “DESIGNATED

1 HEALTH SERVICES”, respectively, each place either
2 appears in subsections (a)(1), (b)(2)(A)(ii)(I),
3 (b)(4), (d)(1), (d)(2), and (d)(3);

4 (2) by adding at the end of such section the fol-
5 lowing new subsection:

6 “(i) DESIGNATED HEALTH SERVICES DEFINED.—In
7 this section, the term ‘designated health services’ means—

8 “(1) clinical laboratory services;

9 “(2) physical therapy services;

10 “(3) radiology services, including magnetic reso-
11 nance imaging, computerized axial tomography
12 scans, and ultrasound services;

13 “(4) radiation therapy services;

14 “(5) the furnishing of durable medical equip-
15 ment;

16 “(6) the furnishing of parenteral and enteral
17 nutrition equipment and supplies;

18 “(7) the furnishing of outpatient prescription
19 drugs;

20 “(8) ambulance services;

21 “(9) home infusion therapy services;

22 “(10) occupational therapy services; and

23 “(11) inpatient and outpatient hospital services
24 (including services furnished at a psychiatric or re-
25 habilitation hospital).”;

1 (3) in subsection (d)(2), by striking “labora-
2 tory” and by inserting “entity”;

3 (4) in subsection (g)(1), by striking “clinical
4 laboratory service” and by inserting “designated
5 health service”; and

6 (5) in subsection (h)(7)(B), by striking “clinical
7 laboratory service” and by inserting “designated
8 health service”.

9 (c) CONFORMING AMENDMENTS.—Such section is
10 further amended—

11 (1) in subsection (a)(1)(A), by striking “for
12 which payment otherwise may be made under this
13 title” and by inserting “for which a charge is
14 imposed”;

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

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

19 “(1) DENIAL OF PAYMENT.—No payment may
20 be made under a State health security program for
21 a designated health service for which a claim is pre-
22 sented in violation of subsection (a)(1)(B). No indi-
23 vidual, third party payor, or other entity is liable for
24 payment for designated health services for which a

1 claim is presented in violation of such subsection.”;
 2 and

3 (4) In subsection (g)(3), by striking “for which
 4 payment may not be made under paragraph (1)”
 5 and by inserting “for which such a claim may not
 6 be presented under subsection (a)(1)”.

7 **TITLE IV—ADMINISTRATION**
 8 **Subtitle A—General Administrative**
 9 **Provisions**

10 **SEC. 401. AMERICAN HEALTH SECURITY STANDARDS**
 11 **BOARD.**

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

14 (b) APPOINTMENT AND TERMS OF MEMBERS.—

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

17 (A) the Secretary of Health and Human
 18 Services, and

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

22 The President shall first nominate individuals under
 23 subparagraph (B) on a timely basis so as to provide
 24 for the operation of the Board by not later than
 25 January 1, 1995.

1 (2) SELECTION OF APPOINTED MEMBERS.—

2 With respect to the individuals appointed under
3 paragraph (1)(B):

4 (A) They shall be chosen on the basis of
5 backgrounds in health policy, health economics,
6 the healing professions, and the administration
7 of health care institutions.

8 (B) They shall provide a balanced point of
9 view with respect to the various health care in-
10 terests and at least two of them shall represent
11 the interests of individual consumers.

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

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

23 (c) VACANCIES.—

24 (1) IN GENERAL.—The President shall fill any
25 vacancy in the membership of the Board in the same

1 manner as the original appointment. The vacancy
2 shall not affect the power of the remaining members
3 to execute the duties of the Board.

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 President may re-
9 appoint an appointed member of the Board for a
10 second term in the same manner as the original ap-
11 pointment. A member who has served for two con-
12 secutive 6-year terms shall not be eligible for re-
13 appointment until two years after the member has
14 ceased to serve.

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

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

21 (e) COMPENSATION.—Members of the Board (other
22 than the Secretary) shall be entitled to compensation at
23 a level equivalent to level II of the Executive Schedule,
24 in accordance with section 5313 of title 5, United States
25 Code.

1 (f) GENERAL DUTIES OF THE BOARD.—

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

5 (A) eligibility;

6 (B) enrollment;

7 (C) benefits;

8 (D) provider participation standards and
9 qualifications, as defined in title III;

10 (E) national and State funding levels;

11 (F) methods for determining amounts of
12 payments to providers of covered services, con-
13 sistent with subtitle B of title VI;

14 (G) the determination of medical necessity
15 and appropriateness with respect to coverage of
16 certain services;

17 (H) assisting State health security pro-
18 grams with planning for capital expenditures
19 and service delivery;

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

22 (J) allocating funds provided under title
23 VII; and

1 (K) encouraging States to develop regional
2 planning mechanisms (described in section
3 405(a)(3)).

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

8 (g) UNIFORM REPORTING STANDARDS; ANNUAL RE-
9 PORT; STUDIES.—

10 (1) UNIFORM REPORTING STANDARDS.—

11 (A) IN GENERAL.—The Board shall estab-
12 lish uniform reporting requirements and stand-
13 ards to ensure an adequate national data base
14 regarding health services practitioners, services
15 and finances of State health security programs,
16 approved plans, providers, and the costs of fa-
17 cilities and practitioners providing services.
18 Such standards shall include, to the maximum
19 extent feasible, health outcome measures.

20 (B) REPORTS.—The Board shall analyze
21 regularly information reported to it, and to
22 State health security programs pursuant to
23 such requirements and standards.

24 (2) ANNUAL REPORT.—Beginning January 1,
25 of the second year beginning after the date of the

1 enactment of this Act, the Board shall annually
2 report to Congress on the following:

3 (A) The status of implementation of the
4 Act.

5 (B) Enrollment under this Act.

6 (C) Benefits under this Act.

7 (D) Expenditures and financing under this
8 Act.

9 (E) Cost-containment measures and
10 achievements under this Act.

11 (F) Quality assurance.

12 (G) Health care utilization patterns, in-
13 cluding any changes attributable to the pro-
14 gram.

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

17 (I) Differences in the health status of the
18 populations of the different States, including in-
19 come and racial characteristics.

20 (J) Necessary changes in the education of
21 health personnel.

22 (K) Plans for improving service to medi-
23 cally underserved populations.

24 (L) Transition problems as a result of im-
25 plementation of this Act.

1 (M) Opportunities for improvements under
2 this Act.

3 (3) STATISTICAL ANALYSES AND OTHER STUD-
4 IES.—The Board may, either directly or by con-
5 tract—

6 (A) make statistical and other studies, on
7 a nationwide, regional, state, or local basis, of
8 any aspect of the operation of this Act, includ-
9 ing studies of the effect of the Act upon the
10 health of the people of the United States and
11 the effect of comprehensive health services upon
12 the health of persons receiving such services;

13 (B) develop and test methods of providing
14 through payment for services or otherwise, ad-
15 ditional incentives for adherence by providers to
16 standards of adequacy, access, and quality;
17 methods of consumer and peer review and peer
18 control of the utilization of drugs, of laboratory
19 services, and of other services; and methods of
20 consumer and peer review of the quality of serv-
21 ices;

22 (C) develop and test, for use by the Board,
23 records and information retrieval systems and
24 budget systems for health services administra-

1 tion, and develop and test model systems for
2 use by providers of services;

3 (D) develop and test, for use by providers
4 of services, records and information retrieval
5 systems useful in the furnishing of preventive
6 or diagnostic services;

7 (E) develop, in collaboration with the phar-
8 maceutical profession, and test, improved ad-
9 ministrative practices or improved methods for
10 the reimbursement of independent pharmacies
11 for the cost of furnishing drugs as a covered
12 service; and

13 (F) make such other studies as it may con-
14 sider necessary or promising for the evaluation,
15 or for the improvement, of the operation of this
16 Act.

17 (4) REPORT ON USE OF EXISTING FEDERAL
18 HEALTH CARE FACILITIES.—Not later than one year
19 after the date of the enactment of this Act, the
20 Board shall recommend to the Congress one or more
21 proposals for the treatment of health care facilities
22 of the Federal Government.

23 (h) EXECUTIVE DIRECTOR.—

24 (1) APPOINTMENT.—There is hereby estab-
25 lished the position of Executive Director of the

1 Board. The Director shall be appointed by the
2 Board and shall serve as secretary to the Board and
3 perform such duties in the administration of this
4 title as the Board may assign.

5 (2) DELEGATION.—The Board is authorized to
6 delegate to the Director or to any other officer or
7 employee of the Board or, with the approval of the
8 Secretary of Health and Human Services (and sub-
9 ject to reimbursement of identifiable costs), to any
10 other officer or employee of the Department of
11 Health and Human Services, any of its functions or
12 duties under this Act other than—

13 (A) the issuance of regulations; or

14 (B) the determination of the availability of
15 funds and their allocation to implement this
16 Act.

17 (3) COMPENSATION.—The Executive Director
18 of the Board shall be entitled to compensation at a
19 level equivalent to level III of the Executive Sched-
20 ule, in accordance with section 5314 of title 5,
21 United States Code.

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

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

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

7 (3) by inserting after section 8F the following:

8 **“§ 8G. Special provisions concerning American**
9 **Health Security Standards Board**

10 “The Inspector General of the American Health Se-
11 curity Standards Board, in addition to the other authori-
12 ties vested by this Act, shall have the same authority, with
13 respect to the Board and the American Health Security
14 Program under this Act, as the Inspector General for the
15 Department of Health and Human Services has with re-
16 spect to the Secretary of Health and Human Services and
17 the medicare and medicaid programs, respectively.”.

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

20 (k) ACCESS TO INFORMATION.—The Secretary of
21 Health and Human Services shall make available to the
22 Board all information available from sources within the
23 Department or from other sources, pertaining to the
24 duties of the Board.

1 **SEC. 402. AMERICAN HEALTH SECURITY ADVISORY COUN-**
2 **CIL.**

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

7 (b) MEMBERSHIP.—The Council shall be composed
8 of—

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

11 (2) twenty members, not otherwise in the em-
12 ploy of the United States, appointed by the Board
13 without regard to the provisions of title 5, United
14 States Code, governing appointments in the competi-
15 tive service.

16 The appointed members shall include, in accordance with
17 subsection (e), individuals who are representative of State
18 health security programs, public health professionals, pro-
19 viders of health services, and of individuals (who shall con-
20 stitute a majority of the Council) who are representative
21 of consumers of such services, including a balanced rep-
22 resentation of employers, unions, consumer organizations,
23 and population groups with special health care needs.

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

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

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

11 (d) VACANCIES.—

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

17 (2) VACANCY APPOINTMENTS.—Any member
18 appointed to fill a vacancy shall serve for the re-
19 mainder of the term for which the predecessor of the
20 member was appointed.

21 (3) REAPPOINTMENT.—The Board may re-
22 appoint an appointed member of the Council for a
23 second term in the same manner as the original
24 appointment.

25 (e) QUALIFICATIONS.—

1 (1) PUBLIC HEALTH REPRESENTATIVES.—

2 Members of the Council who are representative of
3 State health security programs and public health
4 professionals shall be individuals who have extensive
5 experience in the financing and delivery of care
6 under public health programs.

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

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

21 (f) DUTIES.—

22 (1) IN GENERAL.—It shall be the duty of the
23 Council—

24 (A) to advise the Board on matters of gen-
25 eral policy in the administration of this Act, in

1 the formulation of regulations, and in the per-
2 formance of the Board's duties under section
3 401; and

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

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

17 (g) STAFF.—The Council, its members, and any com-
18 mittees of the Council shall be provided with such sec-
19 retarial, clerical, or other assistance as may be authorized
20 by the Board for carrying out their respective functions.

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

1 (i) COMPENSATION.—Members of the Council shall
2 be reimbursed by the Board for travel and per diem in
3 lieu of subsistence expenses during the performance of du-
4 ties of the Board in accordance with subchapter I of chap-
5 ter 57 of title 5, United States Code.

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

9 **SEC. 403. PROFESSIONAL, TECHNICAL, AND TEMPORARY**
10 **ADVISORY COMMITTEES.**

11 (a) IN GENERAL.—The Board shall appoint the
12 standing advisory committees specified in subsections (b)
13 through (f), and such other standing professional and
14 technical committees in order to advise it in carrying out
15 its duties under this Act.

16 (b) ADVISORY COMMITTEE ON BENEFITS.—

17 (1) IN GENERAL.—The Board shall appoint a
18 standing Advisory Committee on Benefits to advise
19 it with respect to the several classes of covered
20 services under this Act.

21 (2) MEMBERSHIP.—The membership of the
22 committee shall include individuals (in such number
23 as the Board may determine) drawn from the health
24 professions, from consumers of health services, from
25 providers of health services (including non-medical

1 licensed and non-licensed providers), or from other
2 sources, whom the Board deems best qualified to ad-
3 vise it with respect to the professional and technical
4 aspects of the furnishing and utilization of, and the
5 evaluation of, a class of covered services designated
6 by the Board, and with respect to the relationship
7 of that class of services to other covered services. In
8 appointing such individuals, the Board shall assure
9 significant representation of consumers of health
10 services and providers of health services.

11 (c) ADVISORY COMMITTEE ON COST CONTAIN-
12 MENT.—

13 (1) IN GENERAL.—The Board shall appoint a
14 standing Advisory Committee on Cost Containment
15 to advise it with respect to the payments and cost
16 containment measures contained in title VI of this
17 Act.

18 (2) MEMBERSHIP.—The membership of the
19 committee shall include individuals (in such number
20 as the Board may determine) with national recogni-
21 tion for their expertise in health economics, health
22 care financing, provider reimbursement, and related
23 fields. In appointing individuals the Board shall as-
24 sure significant representation of consumers of
25 health services and providers of health services.

1 (d) ADVISORY COMMITTEE ON PRIMARY CARE AND
2 THE MEDICALLY UNDERSERVED.—

3 (1) IN GENERAL.—The Board shall appoint a
4 standing Advisory Committee on Primary Care and
5 the Medically Underserved to advise it with respect
6 to title VII of this Act, including with respect to the
7 delivery of services and the education and training
8 of health professionals, and to consider means of in-
9 creasing the supply and expanding the scope of
10 practice of mid-level professionals and the use of
11 community health outreach workers and other non-
12 professional health care workers.

13 (2) MEMBERSHIP.—The membership of the
14 committee shall include individuals (in such number
15 as the Board may determine) from the health pro-
16 fessions and health services with expertise in—

17 (A) primary care services;

18 (B) the education and training of primary
19 care practitioners;

20 (C) the special health needs of medically
21 underserved populations;

22 (D) the training, educational, and financial
23 incentives that would encourage health practi-
24 tioners to serve in medically underserved areas;

1 (E) the delivery of health services through
2 community-based and public facilities; and

3 (F) developing alternative models of deliv-
4 ering primary health services to medically un-
5 derserved populations.

6 In appointing such individuals, the Board shall as-
7 sure significant representation of consumers of
8 health services and providers of health services.

9 (e) ADVISORY COMMITTEE ON MENTAL HEALTH AND
10 SUBSTANCE ABUSE TREATMENT SERVICES.—

11 (1) IN GENERAL.—The Board shall appoint a
12 standing Advisory Committee on Mental Health and
13 Substance Abuse Treatment Services to advise it
14 with respect to the manner in which the benefits
15 under this Act for mental health services and sub-
16 stance abuse treatment services should be modified
17 to best meet the objectives of this Act.

18 (2) MEMBERSHIP.—The membership of the
19 committee shall include individuals (in such number
20 as the Board may determine) with expertise in
21 health care economics, who are representative of the
22 multi-disciplinary range of providers of such serv-
23 ices, who are consumers of such services, and who
24 represent advocacy groups representing consumers
25 of such services.

1 (3) RESPONSIBILITIES.—The committee shall—

2 (A) study changes in the utilization pat-
3 terns and costs which accompany the provision
4 of mental health services and substance abuse
5 treatment services;

6 (B) study and make recommendations on
7 any changes that may be advisable in the utili-
8 zation review thresholds specified in section
9 204(b)(2)(A);

10 (C) make recommendations on ways to cre-
11 ate a continuum of care and encourage the pro-
12 vision of care in the least restrictive appropriate
13 setting;

14 (D) develop a standard set of practices for
15 care coordination services, including—

16 (i) the range of care coordination
17 services that should be offered for a spe-
18 cific target population,

19 (ii) the organizational structure in
20 which care coordination services should be
21 based,

22 (iii) the minimum training require-
23 ments for care coordinators, and

24 (iv) the standards for the clinical ne-
25 cessity of care coordination services,

1 and study (and make recommendations con-
2 cerning) peer care coordination services; and

3 (E) report any initial recommendations to
4 the Board by January 1, 1996.

5 (4) ROLE OF SUBSTANCE ABUSE AND MENTAL
6 HEALTH SERVICES ADMINISTRATION.—The Board
7 shall consult with the Administrator of the Sub-
8 stance Abuse and Mental Health Services Adminis-
9 tration in the appointment of members to, and
10 operation of, the committee.

11 (f) ADVISORY COMMITTEE ON PRESCRIPTION
12 DRUGS.—

13 (1) IN GENERAL.—The Board shall appoint a
14 standing Advisory Committee on Prescription Drugs
15 to advise it with respect to the list of approved pre-
16 scription drugs and biologicals under section
17 616(a)(1) and other matters relating to the coverage
18 of prescription drugs under this Act.

19 (2) MEMBERSHIP.—

20 (A) IN GENERAL.—The membership of the
21 committee shall include individuals (in such
22 number as the Board may determine) with ex-
23 pertise in appropriate utilization of prescription
24 and nonprescription drug and biological thera-

pies and of the relative safety and efficacy of prescription drugs and biologicals.

(B) AREAS OF EXPERTISE.—A majority of the members of the committee shall be physicians. Members of the committee shall include at least a dentist, a nurse, and a pharmacist, and individuals with special knowledge or expertise in at least the following areas: geriatric, obstetric, pediatric, psychiatric, and neurological problems associated with drug therapies; clinical pharmacology; pharmacoepidemiology; and comparative clinical trials of drugs (including statisticians and biopharmaceutic specialists).

(C) CONFLICT OF INTEREST PROHIBITION.—No individual who is an employee of a manufacturer of a drug or biological or who otherwise has a material financial interest directly or indirectly with respect to such a manufacturer, or who has an immediate family member (as defined by the Board) who is such an employee or has such an interest, shall serve as a member of the committee.

(3) RESPONSIBILITIES.—The committee shall—

(A) continuously review scientific and medical information pertaining to the relative safety

1 and efficacy, and the comparability, of prescrip-
2 tion drugs and biologicals approved for market-
3 ing in the United States; and

4 (B) recommend drug use classifications
5 and identify, within such a classification, drugs
6 that are therapeutic alternates for a given indi-
7 cation and indications for which particular
8 drugs are superior based on safety and efficacy.

9 The committee is not authorized to engage in drug
10 price negotiations nor define acceptable costs for any
11 product.

12 (4) CONSUMER INPUT.—In conducting its ac-
13 tivities, the committee shall solicit advice and com-
14 ments from a panel of consumer advocates.

15 (g) TEMPORARY COMMITTEES.—The Board is au-
16 thorized to appoint such temporary professional and tech-
17 nical committees as it deems necessary to advise it on spe-
18 cial problems not encompassed in the assignments of
19 standing committees appointed under this section or to
20 supplement the advice of standing committees.

21 (h) REPORTING.—Committees appointed under this
22 section shall report from time to time (but not less often
23 than biannually) to the Board, and copies of their reports
24 shall be transmitted by the Board to the American Health

1 Security Advisory Council and be made readily available
2 to the public.

3 (i) COMPENSATION.—All members of the committees
4 established under this section shall be reimbursed by the
5 Board for travel and per diem in lieu of subsistence ex-
6 penses during the performance of duties of the Board in
7 accordance with subchapter I of chapter 57 of title 5,
8 United States Code.

9 (j) ADVICE FROM PROSPECTIVE PAYMENT ASSESS-
10 MENT COMMISSION, PRACTITIONER PAYMENT REVIEW
11 COMMISSION, ETC.—For provisions relating to role of cer-
12 tain commissions in reviewing payment rates, see section
13 620.

14 **SEC. 404. AMERICAN HEALTH SECURITY QUALITY COUNCIL.**

15 (a) ESTABLISHMENT.—There is hereby established
16 an American Health Security Quality Council.

17 (b) APPOINTMENT AND TERMS OF MEMBERS.—

18 (1) IN GENERAL.—The Council shall be com-
19 posed of 10 members appointed by the President.
20 The President shall first appoint individuals on a
21 timely basis so as to provide for the operation of the
22 Council by not later than January 1, 1995.

23 (2) SELECTION OF MEMBERS.—Each member
24 of the Council shall be a member of a health profes-
25 sion. Six members of the Council shall be physicians.

1 Individuals shall be appointed to the Council on the
2 basis of national reputations for clinical and aca-
3 demic excellence.

4 (3) TERMS OF MEMBERS.—Individuals ap-
5 pointed to the Council shall serve for a term of 5
6 years, except that the terms of 4 of the individuals
7 initially appointed shall be, as designated by the
8 President at the time of their appointment, for 1, 2,
9 3, and 4 years.

10 (c) VACANCIES.—

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

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

20 (3) REAPPOINTMENT.—The President may re-
21 appoint a member of the Council for a second term
22 in the same manner as the original appointment. A
23 member who has served for two consecutive 5-year
24 terms shall not be eligible for reappointment until
25 two years after the member has ceased to serve.

1 (d) CHAIR.—The President shall designate one of the
2 members of the Council to serve at the will of the Presi-
3 dent as Chair of the Council.

4 (e) COMPENSATION.—Members of the Council who
5 are not employees of the Federal Government shall be en-
6 titled to compensation at a level equivalent to level II of
7 the Executive Schedule, in accordance with section 5313
8 of title 5, United States Code.

9 (f) GENERAL DUTIES OF THE COUNCIL.—The Coun-
10 cil is responsible for quality review activities under title
11 V. The Council shall report to the Board annually on the
12 conduct of activities under such title and shall report to
13 the Board annually specifically on findings from outcomes
14 research and development of practice guidelines that may
15 affect the Board's determination of coverage of services
16 under section 401(f)(1)(G).

17 **SEC. 405. STATE HEALTH SECURITY PROGRAMS.**

18 (a) SUBMISSION OF PLANS.—

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

23 (2) REGIONAL PROGRAMS.—A State may join
24 with one or more neighboring States to submit to
25 the Board a plan for a regional health security pro-

1 gram instead of separate State health security
2 programs.

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

9 (b) REVIEW AND APPROVAL OF PLANS.—

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

17 (A) Payment for required health services
18 for eligible individuals in the State in accord-
19 ance with this Act.

20 (B) Adequate administration, including the
21 designation of a single State agency responsible
22 for the administration (or supervision of the
23 administration) of the program.

24 (C) The establishment of a State health
25 security budget.

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

3 (E) Assurances that individuals have the
4 freedom to choose practitioners and other
5 health care providers for services covered under
6 this Act.

7 (F) A procedure for carrying out long-term
8 regional management and planning functions
9 with respect to the delivery and distribution of
10 health care services that—

11 (i) ensures participation of consumers
12 of health services and providers of health
13 services, and

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

20 (G) The licensure and regulation of all
21 health providers and facilities to ensure compli-
22 ance with Federal and State laws and to
23 promote quality of care.

24 (H) Establishment of a quality review sys-
25 tem in accordance with section 502.

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

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

15 (K) Provision of a fraud and abuse preven-
16 tion and control unit that the Inspector General
17 determines meets the requirements of section
18 413(a).

19 (L) Provision that—

20 (i) all claims or requests for payment
21 for services shall be accompanied by the
22 unique provider identifier assigned under
23 section 414(a) to the provider and the
24 unique patient identifier assigned to the
25 individual under section 414(b);

1 (ii) no payment shall be made under
2 the program for the provision of health
3 care services by any provider unless the
4 provider has furnished the program with
5 the unique provider identifier assigned
6 under section 414(a);

7 (iii) the plan shall use the unique pa-
8 tient identifier assigned under section
9 414(b) to an individual as the identifier of
10 the individual in the processing of claims
11 and other purposes (as specified by the
12 Board); and

13 (iv) queries made under section
14 412(c)(2) shall be made using the unique
15 provider identifier specified under section
16 414(a).

17 (M) Prohibit payment in cases of prohib-
18 ited physician referrals under section 304.

19 (N) Effective January 1, 2001, provide for
20 use of a uniform electronic data base in accord-
21 ance with section 504(a).

22 (2) CONSEQUENCES OF FAILURE TO COMPLY.—
23 If the Board finds that a State plan submitted
24 under paragraph (1) does not meet the requirements
25 for approval under this section or that a State

1 health security program or specific portion of such
2 program, the plan for which was previously ap-
3 proved, no longer meets such requirements, the
4 Board shall provide notice to the State of such fail-
5 ure and that unless corrective action is taken within
6 a period specified by the Board, the Board shall
7 place the State health security program (or specific
8 portions of such program) in receivership under the
9 jurisdiction of the Board.

10 (c) STATE HEALTH SECURITY ADVISORY COUN-
11 CILS.—

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

18 (2) MEMBERSHIP.—Each State Health Security
19 Advisory Council shall be composed of at least 11 in-
20 dividuals. The appointed members shall include indi-
21 viduals who are representative of the State health
22 security program, public health professionals, provid-
23 ers of health services, and of individuals (who shall
24 constitute a majority) who are representative of con-
25 sumers of such services, including a balanced

1 representation of employers, unions and consumer
2 organizations.

3 (3) DUTIES.—

4 (A) IN GENERAL.—Each State Health Se-
5 curity Advisory Council shall review, and sub-
6 mit comments to the Governor concerning the
7 implementation of the State health security pro-
8 gram in the State.

9 (B) ASSISTANCE.—Each State Health Se-
10 curity Advisory Council shall provide assistance
11 and technical support to community organiza-
12 tions and public and private non-profit agencies
13 submitting applications for funding under ap-
14 propriate State and Federal public health pro-
15 grams, with particular emphasis placed on as-
16 sisting those applicants with broad consumer
17 representation.

18 (d) STATE USE OF FISCAL AGENTS.—

19 (1) IN GENERAL.—Each State health security
20 program, using competitive bidding procedures, may
21 enter into such contracts with qualified entities, such
22 as voluntary associations, as the State determines to
23 be appropriate to process claims and to perform
24 other related functions of fiscal agents under the
25 State health security program.

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

5 **SEC. 406. COMPLEMENTARY CONDUCT OF RELATED**
6 **HEALTH PROGRAMS.**

7 In performing functions with respect to health per-
8 sonnel education and training, health research, environ-
9 mental health, disability insurance, vocational rehabilita-
10 tion, the regulation of food and drugs, and all other mat-
11 ters pertaining to health, the Secretary of Health and
12 Human Services shall direct all activities of the Depart-
13 ment of Health and Human Services toward contributions
14 to the health of the people complementary to this Act.

15 **Subtitle B—Control Over Fraud**
16 **and Abuse**

17 **SEC. 411. APPLICATION OF FEDERAL SANCTIONS TO ALL**
18 **FRAUD AND ABUSE UNDER AMERICAN**
19 **HEALTH SECURITY PROGRAM.**

20 The following sections of the Social Security Act shall
21 apply to State health security programs in the same man-
22 ner as they apply to State medical assistance plans under
23 title XIX of such Act (except that in applying such provi-
24 sions any reference to the Secretary is deemed a reference
25 to the Board):

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

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

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

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

7 (5) Section 1126 (relating to disclosure of cer-
8 tain owners).

9 **SEC. 412. NATIONAL HEALTH CARE FRAUD DATA BASE.**

10 (a) ESTABLISHMENT.—The American Health Secu-
11 rity Standards Board, through the Inspector General,
12 shall establish a national data base (in this section
13 referred to as the “data base”) containing information
14 relating to health care fraud and abuse.

15 (b) DATA INCLUDED.—

16 (1) IN GENERAL.—The data base shall include
17 such information as the Inspector General, in con-
18 sultation with the Board, shall specify, and shall
19 include at least the information described in
20 paragraph (2).

21 (2) SPECIFIED INFORMATION.—The informa-
22 tion specified in this paragraph is, with respect to
23 providers of health care services, the identity of any
24 provider—

1 (A) that has been convicted of a crime for
2 which the provider may be excluded from par-
3 ticipation under a health program (as defined
4 in paragraph (3));

5 (B) whose license to provide health care
6 has been revoked or suspended (as described in
7 section 1128(b)(5) of the Social Security Act);

8 (C) that has been excluded or suspended
9 from a health program under section 1128 of
10 the Social Security Act or from any other
11 Federal or State health care program;

12 (D) with respect to whom a civil money
13 penalty has been imposed under this Act or the
14 Social Security Act; or

15 (E) that otherwise is subject to exclusion
16 from participation under a health program.

17 (3) HEALTH PROGRAM DEFINED.—In this sec-
18 tion, the term “health program” means a State
19 health security program and includes the medicare
20 program (under title XVIII of the Social Security
21 Act) and a State health care program (as defined in
22 section 1128(h) of such Act).

23 (c) REPORTING REQUIREMENT.—

24 (1) REPORTING.—Each State health security
25 program shall provide such information to the In-

1 spector General as the Inspector General may re-
2 quire in order to carry out fraud and abuse control
3 activities and for purposes of maintaining the data
4 base.

5 (2) QUERYING.—In accordance with rules es-
6 tablished by the Board (in consultation with the In-
7 spector General), each State health security program
8 shall query periodically (as specified by the Inspector
9 General)—

10 (A) the data base to determine if providers
11 of health services for which the program makes
12 payment are not disqualified from providing
13 such services, and

14 (B) the Secretary of Health and Human
15 Services, concerning information obtained by
16 the Secretary under part B of the Health Care
17 Quality Improvement Act of 1986 relating to
18 practitioners.

19 (3) COORDINATION WITH MALPRACTICE DATA
20 BASE.—The Secretary of Health and Human Serv-
21 ices shall provide for the coordination of the report-
22 ing and disclosure of information under this section
23 with information under part B of the Health Care
24 Quality Improvement Act of 1986.

1 (4) UNIFORM MANNER.—Information shall be
2 reported under this subsection in a uniform manner
3 (in accordance with standards of the Inspector Gen-
4 eral) that permits aggregation of reported informa-
5 tion.

6 (5) ACCESS FOR AUDIT.—Each State health se-
7 curity program shall provide the Inspector General
8 such access to information as may be required to
9 verify the information reported under this sub-
10 section.

11 (6) PENALTY FOR FALSE INFORMATION.—Any
12 person that submits false information required to be
13 provided under this subsection or that denies access
14 to information under paragraph (5) may be impris-
15 oned for not more than 5 years, or fined, or both,
16 in accordance with title 18, United States Code.

17 (7) CONFIDENTIALITY.—The Board shall estab-
18 lish rules that protect the confidentiality of the
19 information in the data base.

20 **SEC. 413. 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 405(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),

15 as is necessary to promote the effective and efficient con-
16 duct of the unit's activities.

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

20 (1) similar fraud units in other States,

21 (2) the Inspector General, and

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

23 (f) REPORTS.—The fraud unit must submit to the
24 Inspector General an application and annual reports con-
25 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 **SEC. 414. ASSIGNMENT OF UNIQUE PROVIDER AND PA-**
4 **TIENT IDENTIFIERS.**

5 (a) PROVIDER IDENTIFIERS.—

6 (1) IN GENERAL.—The Board shall provide for
7 the assignment, to each individual or entity provid-
8 ing health care services under a State health secu-
9 rity program, of a unique provider identifier.

10 (2) RESPONSE TO QUERIES.—Upon the request
11 of a State health security program with respect to
12 a provider, the Board shall provide the program with
13 the unique provider identifier (if any) assigned to
14 the provider under paragraph (1).

15 (b) PATIENT IDENTIFIERS.—The Board shall provide
16 for the assignment, to each eligible individual, of a unique
17 patient identifier. The identifier so assigned may be the
18 Social Security account number of the individual.

19 (c) REQUIREMENT TO USE IDENTIFIERS.—Each
20 State health security program is required under section
21 405(b)(1)(L) to use the unique identifiers assigned under
22 this section.

1 **TITLE V—QUALITY ASSESSMENT**

2 **SEC. 501. FUNCTIONS OF QUALITY COUNCIL; DEVELOP-**
3 **MENT OF PRACTICE GUIDELINES AND APPLI-**
4 **CATION TO OUTLIERS.**

5 (a) DEVELOPMENT OF PRACTICE GUIDELINES.—The
6 American Health Security Quality Council (in this title
7 referred to as the “Council”)—

8 (1) shall collect data from outcomes research,
9 including data on patient satisfaction and post-hos-
10 pital discharge experience, on an ongoing basis
11 (whether conducted by the Federal Government or
12 other entities), and

13 (2) on the basis of such data and existing
14 clinical knowledge, shall develop practice guidelines.
15 Such guidelines may vary based upon the area in which
16 the services are provided and the degree of training, spe-
17 cialization, or similar characteristics of providers. Such
18 guidelines must be updated on an annual basis and based
19 on monitoring of outcomes research and other clinical
20 data. Such guidelines shall be based on the degree to
21 which a process of care increases the probability of desired
22 patient outcomes.

23 (b) PROFILING OF PATTERNS OF PRACTICE; IDENTI-
24 FICATION OF OUTLIERS.—The Council shall adopt meth-
25 odologies for profiling the patterns of practice of health

1 care professionals and for identifying outliers (as defined
2 in subsection (f)).

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

13 (d) REMEDIAL ACTIONS.—The Council shall develop
14 standards for education and sanctions with respect to
15 outliers so as to assure the quality of health care services
16 provided under this Act.

17 (e) DISSEMINATION.—The Council shall disseminate
18 to the State—

19 (1) the guidelines developed under subsections

20 (a) and (c),

21 (2) the methodologies adopted under subsection

22 (b), and

23 (3) the standards developed under subsection

24 (d),

25 for use by the States under section 502.

1 (f) OUTLIER DEFINED.—In this title, the term
2 “outlier” means a health care provider whose pattern of
3 practice, relative to applicable practice guidelines, suggests
4 deficiencies in the quality of health care services being
5 provided.

6 **SEC. 502. STATE QUALITY REVIEW PROGRAMS.**

7 (a) REQUIREMENT.—In order to meet the require-
8 ment of section 405(b)(1)(H), each State health security
9 program shall establish one or more qualified entities to
10 conduct quality reviews of persons providing covered serv-
11 ices under the program, in accordance with standards es-
12 tablished under subsection (b)(1) (except as provided in
13 subsection (b)(2)) and subsection (d).

14 (b) FEDERAL STANDARDS.—

15 (1) IN GENERAL.—The Council shall establish
16 standards with respect to—

17 (A) the adoption of practice guidelines (de-
18 veloped under section 501(a)),

19 (B) the identification of outliers (consist-
20 ent with methodologies adopted under section
21 501(b)),

22 (C) the development of remedial programs
23 and monitoring for outliers, and

1 (D) the application of sanctions (consistent
2 with the standards developed under section
3 501(c)).

4 (2) STATE DISCRETION.—A State may apply
5 under subsection (a) standards other than those es-
6 tablished under paragraph (1) so long as the State
7 demonstrates to the satisfaction of the Council on an
8 annual basis that the standards applied have been as
9 efficacious in promoting and achieving improved
10 quality of care as the application of the standards
11 established under paragraph (1). Positive improve-
12 ments in quality shall be documented by reductions
13 in the variations of clinical care process and
14 improvement in patient outcomes.

15 (c) QUALIFICATIONS.—

16 (1) IN GENERAL.—An entity is not qualified to
17 conduct quality reviews under subsection (a) unless
18 the entity—

19 (A) is administratively independent of the
20 individual or board that administers the State
21 health security program, and

22 (B) does not provide any financial incen-
23 tive to reviewers to favor one pattern of practice
24 over another.

1 (2) PROVIDER-SPECIFIC ENTITIES.—Subject to
2 paragraph (1), a State may provide that an individ-
3 ual hospital (or other institutional provider) may
4 serve as a qualified entity to conduct quality reviews
5 under subsection (a).

6 **SEC. 503. ELIMINATION OF UTILIZATION REVIEW PRO-**
7 **GRAMS; TRANSITION.**

8 (a) INTENT.—It is the intention of this title to re-
9 place by January 1, 1998, random utilization controls with
10 a systematic review of patterns of practice that com-
11 promise the quality of care.

12 (b) SUPERSEDING CASE REVIEWS.—

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

21 (2) TRANSITION.—Before January 1, 1998, the
22 Board and the States may employ existing utiliza-
23 tion review standards and mechanisms as may be
24 necessary to effect the transition to pattern of prac-
25 tice-based reviews.

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

3 (A) as precluding the case-by-case review
4 of the provision of care—

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

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

10 (B) as precluding the case management of
11 catastrophic, mental health, or substance abuse
12 cases where such management is necessary to
13 achieve appropriate, cost-effective, and bene-
14 ficial comprehensive medical care, as provided
15 for in section 204.

16 **SEC. 504. DEVELOPMENT OF NATIONAL ELECTRONIC DATA**
17 **BASE.**

18 (a) USE BY STATES.—In order to meet the require-
19 ment of this section, for purposes of section
20 405(b)(1)(N)), each State health security program shall
21 develop and use a uniform electronic data base which uses
22 the software designated under subsection (b) and which
23 assures confidentiality under subsection (c), for all patient
24 records in order to enable systematic quality review and
25 outcomes analysis. Subject to subsection (c), data in such

1 data base shall be made available, under rules established
2 by the Board, in order to facilitate the portability of pa-
3 tient records and comparative outcomes research analysis.

4 (b) UNIFORM SOFTWARE.—The Board shall des-
5 ignate the uniform software that shall be used by States
6 in the operation of their electronic data bases, in order
7 to facilitate the portability of patient records and com-
8 parative outcomes research analysis. The Board shall not
9 grant any waiver of the requirement of the previous
10 sentence.

11 (c) CONFIDENTIALITY.—The Board shall establish
12 standards that are designed to protect the privacy and
13 otherwise shield the identity of the patients whose records
14 are included in the data base. Under such standards, gov-
15 ernment agencies shall not have access to information in
16 the data base that will identify individual patients except
17 in cases of quality review procedures which require that
18 individual patients be informed of necessary changes in
19 their treatment.

1 **TITLE VI—HEALTH SECURITY**
2 **BUDGET; PAYMENTS; COST**
3 **CONTAINMENT MEASURES**
4 **Subtitle A—Budgeting and**
5 **Payments to States**

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

7 (a) NATIONAL HEALTH SECURITY BUDGET.—

8 (1) IN GENERAL.—By not later than September
9 1 before the beginning of each year (beginning with
10 1995), the Board shall establish a national health
11 security budget, which—

12 (A) specifies the total expenditures (includ-
13 ing expenditures for administrative costs) to be
14 made by the Federal Government and the
15 States for covered health care services under
16 this Act, and

17 (B) allocates those expenditures among the
18 States consistent with section 604.

19 Pursuant to subsection (b), such budget for a year
20 shall not exceed the budget for the preceding year
21 increased by the percentage increase in gross domes-
22 tic product.

23 (2) DIVISION OF BUDGET INTO COMPONENTS.—

24 The national health security budget shall consist of
25 at least 4 components:

1 (A) A component for quality assessment
2 activities (described in title V).

3 (B) A component for health professional
4 education expenditures.

5 (C) A component for administrative costs.

6 (D) A component (in this title referred to
7 as the “operating component”) for operating
8 and other expenditures not described in sub-
9 paragraphs (A) through (C), consisting of
10 amounts not included in the other components.
11 A State may provide for the allocation of this
12 component between capital expenditures and
13 other expenditures.

14 (3) ALLOCATION AMONG COMPONENTS.—Tak-
15 ing into account the State health security budgets
16 established and submitted under section 603, the
17 Board shall allocate the national health security
18 budget among the components in a manner that—

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

22 (B) assures that the health professional
23 education expenditure component is sufficient
24 to provide for the amount of health professional
25 education expenditures sufficient to meet the

1 need for covered health care services (consistent
2 with the national health security spending
3 growth limit under subsection (b)(2)).

4 (b) BASIS FOR TOTAL EXPENDITURES.—

5 (1) IN GENERAL.—The total expenditures speci-
6 fied in such budget shall be the sum of the capita-
7 tion amounts computed under section 602(a) and
8 the amount of Federal administrative expenditures
9 needed to carry out this Act.

10 (2) NATIONAL HEALTH SECURITY SPENDING
11 GROWTH LIMIT.—For purposes of this subtitle, the
12 national health security spending growth limit de-
13 scribed in this paragraph for a year is zero, or, if
14 greater, the percentage increase in the gross domes-
15 tic product (in current dollars) from the first quar-
16 ter of the second previous year to the first quarter
17 of the previous year.

18 (c) DEFINITIONS.—In this title:

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

24 (2) HEALTH PROFESSIONAL EDUCATION EX-
25 PENDITURES.—The term “health professional edu-

1 cation expenditures” means expenditures in hospitals
2 and other health care facilities to cover costs associ-
3 ated with teaching and related research activities.

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

6 (a) CAPITATION AMOUNTS.—

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

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

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

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

24 (2) STATE CAPITATION AMOUNT.—

1 (A) IN GENERAL.—For purposes of this
2 title, the term “State capitation amount”
3 means, for a State for a year, the sum of the
4 capitation amounts computed under paragraph
5 (1) for all the residents of the State in the year,
6 as estimated by the Board before the beginning
7 of the year involved.

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

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

18 (b) COMPUTATION OF NATIONAL AVERAGE PER CAP-
19 ITA COST.—

20 (1) FOR 1995.—For 1995, the national average
21 per capita cost under this paragraph is equal to—

22 (A) the average per capita health care ex-
23 penditures in the United States in 1993 (as
24 estimated by the Board),

1 (B) increased to 1994 by the Board's esti-
2 mate of the actual amount of such per capita
3 expenditures during 1994, and

4 (C) updated to 1995 by the national health
5 security spending growth limit specified in sec-
6 tion 601(b)(2) for 1995.

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

14 (c) STATE ADJUSTMENT FACTORS.—

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

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

22 (B) any social, environmental, or geo-
23 graphic condition affecting health status or the
24 need for health care services, to the extent such

1 a condition is not taken into account in the es-
2 tablishment of risk groups under subsection (d);

3 (C) the geographic distribution of the
4 State's population, particularly the proportion
5 of the population residing in medically under-
6 served areas, to the extent such a condition is
7 not taken into account in the establishment of
8 risk groups under subsection (d); and

9 (D) any other factor relating to operating
10 costs required to assure equitable distribution
11 of funds among the States.

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

18 (A) differences among States in health
19 professional education programs in operation as
20 of the date of the enactment of this Act, and

21 (B) differences among States in their rel-
22 ative need for expenditures for health profes-
23 sional education, taking into account the health
24 professional education expenditures proposed in

1 State health security budgets under section
2 603(a).

3 (3) BUDGET NEUTRALITY.—The State adjust-
4 ment factors, as modified under paragraph (2), shall
5 be applied under this subsection in a manner that
6 results in neither an increase nor a decrease in the
7 total amount of the Federal contributions to all
8 State health security programs under subsection (b)
9 as a result of the application of such factors.

10 (4) PHASE-IN.—In applying State adjustment
11 factors under this subsection during the five-year pe-
12 riod beginning with 1995, the Board shall phase-in,
13 over such period, the use of factors described in
14 paragraph (1) in a manner so that the adjustment
15 factor for a State is based on a blend of such factors
16 and a factor that reflects the relative actual average
17 per capita costs of health services of the different
18 States as of the time of enactment of this Act.

19 (5) PERIODIC ADJUSTMENT.—In establishing
20 the national health security budget before the begin-
21 ning of each year, the Board shall provide for appro-
22 priate adjustments in the State adjustment factors
23 under this subsection.

24 (d) ADJUSTMENTS FOR RISK GROUP CLASSIFICA-
25 TION.—

1 (1) IN GENERAL.—The Board shall develop an
2 adjustment factor to the national average per capita
3 costs computed under subsection (b) for individuals
4 classified in each risk group (as designated under
5 paragraph (2)) to reflect the difference between the
6 average national average per capita costs and the
7 national average per capita cost for individuals clas-
8 sified in the risk group.

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

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

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

19 (a) ESTABLISHMENT AND SUBMISSION OF BUDG-
20 ETS.—

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

1 (A) The total expenditures (including ex-
2 penditures for administrative costs) to be made
3 under the program in the State for covered
4 health care services under this Act, consistent
5 with subsection (b), broken down as follows:

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

9 (ii) Within the operating component—

10 (I) expenditures for operating
11 costs of hospitals and other facility-
12 based services in the State,

13 (II) expenditures for payment to
14 comprehensive health service organiza-
15 tions,

16 (III) expenditures for payment of
17 services provided by health care prac-
18 titioners, and

19 (IV) expenditures for other cov-
20 ered items and services.

21 Amounts included in the operating compo-
22 nent include amounts that may be used by
23 providers for capital expenditures.

24 (B) The total revenues required to meet
25 the State health security expenditures.

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

4 (3) FINAL BUDGET.—The final budget for a
5 year shall—

6 (A) be established and submitted under
7 paragraph (1) not later than October 1 before
8 the year, and

9 (B) take into account the amounts estab-
10 lished under the national health security budget
11 under section 601 for the year.

12 (4) ADJUSTMENT IN ALLOCATIONS PER-
13 MITTED.—

14 (A) IN GENERAL.—Subject to subpara-
15 graphs (B) and (C), in the case of a final
16 budget, a State may change the allocation of
17 amounts among components.

18 (B) NOTICE.—No such change may be
19 made unless the State has provided prior notice
20 of the change to the Board.

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

24 (b) EXPENDITURE LIMITS.—

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

5 (2) LIMIT ON CLAIMS PROCESSING AND BILL-
6 ING EXPENDITURES.—Each State health security
7 budget shall provide that State administrative ex-
8 penditures, including expenditures for claims proc-
9 essing and billing, shall not exceed 3 percent of the
10 total expenditures under the State health security
11 program, unless the Board determines, on a case-by-
12 case basis, that additional administrative expendi-
13 tures would improve health care quality and cost
14 effectiveness.

15 (3) WORKER ASSISTANCE.—A State health se-
16 curity program may provide that, for budgets for
17 years before 2000, up to 1 percent of the budget
18 may be used for purposes of programs providing as-
19 sistance to workers who are currently performing
20 functions in the administration of the health insur-
21 ance system and who may experience economic dis-
22 location as a result of the implementation of the
23 program.

24 (c) APPROVAL PROCESS FOR CAPITAL EXPENDI-
25 TURES PERMITTED.—Nothing in this title shall be con-

1 strued as preventing a State health security program from
2 providing for a process for the approval of capital expendi-
3 tures based on information derived from regional planning
4 agencies.

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

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

11 (1) the State capitation amount (computed
12 under section 602(a)(2)) for the State for the year,
13 and

14 (2) the Federal contribution percentage (estab-
15 lished under subsection (b)).

16 (b) FEDERAL CONTRIBUTION PERCENTAGE.—The
17 Board shall establish a formula for the establishment of
18 a Federal contribution percentage for each State. Such
19 formula shall take into consideration a State's per capita
20 income and revenue capacity and such other relevant eco-
21 nomic indicators as the Board determines to be appro-
22 priate. In addition, during the 5-year period beginning
23 with 1995, the Board may provide for a transition adjust-
24 ment to the formula in order to take into account current
25 expenditures by the State (and local governments thereof)

1 for health services covered under the State health security
2 program. The weighted-average Federal contribution per-
3 centage for all States shall equal 86 percent and in no
4 event shall such percentage be less than 81 percent nor
5 more than 91 percent.

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

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

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

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

17 **SEC. 605. ACCOUNT FOR HEALTH PROFESSIONAL EDU-**
18 **CATION EXPENDITURES.**

19 (a) SEPARATE ACCOUNT.—Each State health secu-
20 rity program shall—

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

23 (2) specify the general manner, consistent with
24 subsection (b), in which such expenditures are to be

1 distributed among different types of institutions and
2 the different areas of the State.

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

6 (1) The disbursement of funds must be consist-
7 ent with achievement of the national and program
8 goals (specified in section 701(b)) within the State
9 health security program and the distribution of
10 funds from the account must be conditioned upon
11 the receipt of such reports as the Board may require
12 in order to monitor compliance with such goals.

13 (2) The distribution of funds from the account
14 must take into account the potentially higher costs
15 of placing health professional students in clinical
16 education programs in health professional shortage
17 areas.

18 **Subtitle B—Payments by States to**
19 **Providers**

20 **SEC. 611. PAYMENTS TO HOSPITALS AND OTHER FACILITY-**
21 **BASED SERVICES FOR OPERATING EXPENSES**
22 **ON THE BASIS OF APPROVED GLOBAL**
23 **BUDGETS.**

24 (a) DIRECT PAYMENT UNDER GLOBAL BUDGET.—
25 Payment for operating expenses for institutional and facil-

1 ity-based care, including hospital services and nursing fa-
2 cility services, under State health security programs shall
3 be made directly to each institution or facility by each
4 State health security program under an annual prospec-
5 tive global budget approved under the program. Such a
6 budget shall include payment for outpatient care and non-
7 facility-based care that is furnished by or through the fa-
8 cility. In the case of a hospital that is wholly owned (or
9 controlled) by a comprehensive health service organization
10 that is paid under section 614 on the basis of a global
11 budget, the global budget of the organization shall include
12 the budget for the hospital.

13 (b) ANNUAL NEGOTIATIONS; BUDGET APPROVAL.—

14 (1) IN GENERAL.—The prospective global budg-
15 et for an institution or facility shall be developed
16 through annual negotiations between the State
17 health security program and the institution or facil-
18 ity and be based on a nationally uniform system of
19 cost accounting established under standards of the
20 Board.

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

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

4 (B) An institution's or facility's past ex-
5 penditures.

6 (C) The extent to which debt service for
7 capital expenditures has been included in the
8 proposed operating budget.

9 (D) Change in the consumer price index
10 and other price indices.

11 (E) The cost of reasonable compensation
12 to health care practitioners.

13 (F) The compensation level of the institu-
14 tion's or facility's workforce.

15 (G) The extent to which the institution or
16 facility is providing health care services to meet
17 the needs of residents in the area served by the
18 institution or facility, including the institution's
19 or facility's occupancy level.

20 (H) The institution's or facility's previous
21 financial and clinical performance, based on uti-
22 lization and outcomes data provided under this
23 Act.

24 (I) The type of institution or facility, in-
25 cluding whether the institution or facility is

1 part of a clinical education program or serves
2 a health professional education, research or
3 other training purpose.

4 (J) Technological advances or changes.

5 (K) Costs of the institution or facility asso-
6 ciated with meeting Federal and State regula-
7 tions.

8 (L) The costs associated with necessary
9 public outreach activities.

10 (M) In the case of a for-profit facility, a
11 reasonable rate of return on equity capital,
12 independent of those operating expenses nec-
13 essary to fulfill the objectives of this Act.

14 (N) Incentives to facilities that maintain
15 costs below previous reasonable budgeted levels
16 without reducing the care provided.

17 (O) With respect to facilities that provide
18 mental health services and substance abuse
19 treatment services, any additional costs involved
20 in the treatment of dually diagnosed individ-
21 uals.

22 The portion of such a budget that relates to expendi-
23 tures for health professional education shall be con-
24 sistent with the State health security budget for
25 such expenditures.

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

9 (c) ADJUSTMENTS IN APPROVED BUDGETS.—

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

18 (2) AMENDMENTS.—In accordance with stand-
19 ards established by the Board, an operating and
20 capital budget approved under this section for a year
21 may be amended before, during, or after the year if
22 there is a substantial change in any of the factors
23 relevant to budget approval.

24 (d) DONATIONS PERMISSIBLE.—The States health
25 security programs may permit institutions and facilities

1 to raise funds from private sources to pay for newly con-
2 structed facilities, major renovations, and equipment. The
3 expenditure of such funds, whether for operating or cap-
4 ital expenditures, does not obligate the State health secu-
5 rity program to provide for continued support for such ex-
6 penditures unless included in an approved global budget.

7 **SEC. 612. PAYMENTS TO HEALTH CARE PRACTITIONERS**
8 **BASED ON PROSPECTIVE FEE SCHEDULE.**

9 (a) FEE FOR SERVICE.—

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

15 (2) GLOBAL FEE PAYMENT METHODOLOGIES.—

16 The Board shall establish models and encourage
17 State health security programs to implement alter-
18 native payment methodologies that incorporate glob-
19 al fees for related services (such as all outpatient
20 procedures for treatment of a condition) or for a
21 basic group of services (such as primary care serv-
22 ices) furnished to an individual over a period of
23 time, in order to encourage continuity and efficiency
24 in the provision of services. Such methodologies shall
25 be designed to ensure a high quality of care.

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

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

1 exceed the budgeted amount with respect to such expendi-
2 tures.

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

8 **SEC. 613. PAYMENTS TO COMPREHENSIVE HEALTH SERV-**
9 **ICE ORGANIZATIONS.**

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

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

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

17 (b) BASIC CAPITATION AMOUNT.—

18 (1) IN GENERAL.—The basic capitation amount
19 described in this subsection for an enrollee shall be
20 determined by the State health security program on
21 the basis of the average amount of expenditures that
22 is estimated would be made under the State health
23 security program for covered health care services for
24 an enrollee, based on actuarial characteristics (as de-
25 fined by the State health security program).

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

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

13 **SEC. 614. PAYMENTS FOR COMMUNITY-BASED PRIMARY**
14 **HEALTH SERVICES.**

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

18 (1) be based on a global budget described in
19 section 611,

20 (2) be based on the basic primary care capita-
21 tion amount described in subsection (c) for each in-
22 dividual enrolled with the provider of such services,
23 or

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

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

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

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

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

22 (c) BASIC PRIMARY CARE CAPITATION AMOUNT.—

23 (1) IN GENERAL.—The basic primary care capi-
24 tation amount described in this subsection for an en-
25 rollee with a provider of community-based primary

1 health services shall be determined by the State
2 health security program on the basis of the average
3 amount of expenditures that is estimated would be
4 made under the State health security program for
5 such an enrollee, based on actuarial characteristics
6 (as defined by the State health security program).

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

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

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

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

23 (a) ESTABLISHMENT OF LIST.—

24 (1) IN GENERAL.—Based upon the rec-
25 ommendations of the Advisory Committee on Pre-

1 scription Drugs under section 403, the Board shall
2 establish a list of approved prescription drugs and
3 biologicals that the Board determines are necessary
4 for the maintenance or restoration of health or of
5 employability or self-management and eligible for
6 coverage under this Act.

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

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

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

1 ing fee. In accordance with standards established by the
2 Board, each State health security program, after consulta-
3 tion with representatives of the pharmaceutical profession,
4 shall establish schedules of dispensing fees, designed to af-
5 ford reasonable compensation to independent pharmacies
6 after taking into account variations in their cost of oper-
7 ation resulting from regional differences, differences in the
8 volume of prescription drugs dispensed, differences in
9 services provided, the need to maintain expenditures with-
10 in the budgets established under this title, and other
11 relevant factors.

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

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

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

1 respect to the circumstances under which, or the frequency
2 with which, the item may be prescribed.

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

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

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

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

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

24 (2) consistent with the State health security
25 budget.

1 **SEC. 618. PAYMENT INCENTIVES FOR MEDICALLY UNDER-**
2 **SERVED AREAS.**

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

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

16 **SEC. 619. AUTHORITY FOR ALTERNATIVE PAYMENT METH-**
17 **ODOLOGIES.**

18 A State health security program, as part of its plan
19 under section 405(a), may use a payment methodology
20 other than a methodology required under this subtitle so
21 long as—

22 (1) such payment methodology does not affect
23 the entitlement of individuals to coverage, the
24 weighting of fee schedules to encourage an increase
25 in the number of primary care providers, the ability
26 of individuals to choose among qualified providers,

1 the benefits covered under the program, or the com-
2 pliance of the program with the State health security
3 budget under subtitle A, and

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

9 **Subtitle C—Mandatory Assignment** 10 **and Administrative Provisions**

11 **SEC. 631. MANDATORY ASSIGNMENT.**

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

21 (b) ENFORCEMENT.—If an entity knowingly and will-
22 fully bills for an item or service or accepts payment in
23 violation of subsection (a), the Board may apply sanctions
24 against the entity in the same manner as sanctions could
25 have been imposed under section 1842(j)(2) of the Social

1 Security Act for a violation of section 1842(j)(1) of such
2 Act. Such sanctions are in addition to any sanctions that
3 a State may impose under its State health security
4 program.

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

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

12 (b) APPEALS PROCESS.—Each State health security
13 program shall establish an appeals process to handle all
14 grievances pertaining to payment to providers under this
15 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 PRACTITION-
13 ERS.—To assure an adequate supply of primary care
14 practitioners, there shall be a number, specified by
15 the Board, of midlevel primary care practitioners (as
16 defined in subsection (e)(2)) employed in the health
17 care system as of January 1, 2000.

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 medi-
24 cal 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
6 authorized 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 1993.

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

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

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:

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) Preventive health block grants under part A
5 of title XIX of the Public Health Service Act.

6 (3) Grants to States for community mental
7 health services under subpart I of part B of title
8 XIX of the Public Health Service Act.

9 (4) Grants to States for prevention and treat-
10 ment of substance abuse under subpart II of part B
11 of title XIX of the Public Health Service Act.

12 (5) Grants for HIV health care services under
13 parts A, B, and C of title XXVI of the Public
14 Health Service Act.

15 (b) RANGE OF FUNDS.—The amount of transfers
16 under subsection (a) for any fiscal year shall be an amount
17 (specified by the Board each year) not less than $\frac{1}{10}$ per-
18 cent and not to exceed $\frac{14}{100}$ percent of the amounts the
19 Board estimates will be expended from the Trust Fund
20 in the fiscal year.

21 (c) FUNDS SUPPLEMENTAL TO OTHER FUNDS.—The
22 funds provided under this section with respect to provision
23 of services are in addition to, and not in replacement of,
24 funds made available under the programs referred to in
25 subsection (a) and shall be administered in accordance

1 with the terms of such programs. The Board shall make
2 no transfer of funds under this section for any fiscal year
3 for which the total appropriations for such programs are
4 less than the total amount appropriated for such programs
5 in fiscal year 1993.

6 **SEC. 712. SETASIDE FOR PRIMARY HEALTH CARE DELIV-**
7 **ERY.**

8 (a) TRANSFERS TO PUBLIC HEALTH SERVICE.—
9 From the amounts provided under subsection (c), the
10 Board shall make transfers from the American Health Se-
11 curity Trust Fund to the Public Health Service for the
12 program of primary care service expansion grants under
13 subpart V of part D of title III of the Public Health
14 Service Act (as added by section 713 of this Act).

15 (b) RANGE OF FUNDS.—The amount of transfers
16 under subsection (a) for any fiscal year shall be an amount
17 (specified by the Board each year) not less than $\frac{6}{100}$ per-
18 cent and not to exceed $\frac{1}{10}$ percent of the amounts the
19 Board estimates will be expended from the Trust Fund
20 in the fiscal year.

21 (c) FUNDS SUPPLEMENTAL TO OTHER FUNDS.—The
22 funds provided under this section with respect to provision
23 of services are in addition to, and not in replacement of,
24 funds made available under the sections 329, 330, 340,
25 340A, 1001, and 2655 of the Public Health Service Act.

1 The Board shall make no transfer of funds under this sec-
2 tion for any fiscal year for which the total appropriations
3 for such sections are less than the total amount appro-
4 priated under such sections in fiscal year 1993.

5 **SEC. 713. PRIMARY CARE SERVICE EXPANSION GRANTS.**

6 Part D of title III of the Public Health Service Act
7 (42 U.S.C. 254b et seq.) is amended by adding at the end
8 thereof the following new subpart:

9 **“Subpart V—Primary Care Expansion**

10 **“SEC. 340D. EXPANDING PRIMARY CARE DELIVERY CAPAC-**
11 **ITY IN URBAN AND RURAL AREAS.**

12 “(a) GRANTS FOR PRIMARY CARE CENTERS.—From
13 the amounts described in subsection (c), the American
14 Health Security Standards Board shall make grants to
15 public and nonprofit private entities for projects to plan
16 and develop primary care centers which will serve medi-
17 cally underserved populations (as defined in section
18 330(b)(3)) in urban and rural areas and to deliver primary
19 care services to such populations in such areas. The funds
20 provided under such a grant may be used for the same
21 purposes for which a grant may be made under subsection
22 (c) or (d) of section 330.

23 “(b) PROCESS OF AWARDING GRANTS.—The provi-
24 sions of subsection (e)(1) of section 330 shall apply to a
25 grant under this section in the same manner as they apply

1 to a grant under subsection (c) of such section. The provi-
 2 sions of subsection (g)(3) of such section shall apply to
 3 grants for projects to plan and develop primary care cen-
 4 ters under this section in the same manner as they apply
 5 to grants under such section.

6 “(c) FUNDING AS SET-ASIDE FROM TRUST FUND.—
 7 Funding to carry out this section is provided from the
 8 American Health Security Trust Fund in accordance with
 9 section 912 of the American Health Security Act.

10 “(d) PRIMARY CARE CENTER DEFINED.—In this sec-
 11 tion, the term ‘primary care center’ means—

12 “(1) a migrant health center (as defined in sec-
 13 tion 329(a)(1)),

14 “(2) a community health center (as defined in
 15 section 330(a)),

16 “(3) an entity qualified to receive a grant under
 17 section 340, 340A, 1001, or 2655, or

18 “(4) a Federally-qualified health center (as de-
 19 fined in section 1905(l)(2)(B) of the Social Security
 20 Act).”.

21 **Subtitle C—Primary Care and** 22 **Outcomes Research**

23 **SEC. 721. SET-ASIDE FOR OUTCOMES RESEARCH.**

24 (a) GRANTS FOR OUTCOMES RESEARCH.—From the
 25 amounts provided under subsection (c), the Board shall

1 make transfers from the Trust Fund to the Agency for
2 Health Care Policy and Research under title IX of the
3 Public Health Service Act for the purpose of carrying out
4 activities under such title.

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 $\frac{1}{100}$ per-
8 cent and not to exceed $\frac{2}{100}$ 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 to the Agency for Health Care Policy
15 and Research under section 926 of the Public Health
16 Service Act. The Board shall make no transfer of funds
17 under this section for any fiscal year for which the total
18 appropriations under such section are less than the total
19 amount appropriated under such section and title in fiscal
20 year 1993.

21 (d) CONFORMING AMENDMENT.—Section 926(a) of
22 the Public Health Service Act (42 U.S.C. 299c–5(a)) is
23 amended by striking “\$35,000,000” and all that follows
24 through the end and inserting “for each fiscal year (begin-

1 ning with fiscal year 1994) such sums as may be
2 necessary.”.

3 **SEC. 722. OFFICE OF PRIMARY CARE AND PREVENTION RE-**
4 **SEARCH.**

5 (a) IN GENERAL.—Title IV of the Public Health
6 Service Act, as amended by section 2 of Public Law 101–
7 613, is amended—

8 (1) by redesignating section 486 as section
9 485A;

10 (2) by redesignating parts F through H as
11 parts G through I, respectively; and

12 (3) by inserting after part E the following new
13 part:

14 “PART F—RESEARCH ON PRIMARY CARE AND
15 PREVENTION

16 **“SEC. 486. OFFICE OF PRIMARY CARE AND PREVENTION**
17 **RESEARCH.**

18 “(a) ESTABLISHMENT.—There is established within
19 the Office of the Director of NIH an office to be known
20 as the Office of Primary Care and Prevention Research
21 (in this part referred to as the ‘Office’). The Office shall
22 be headed by a director, who shall be appointed by the
23 Director of NIH.

24 “(b) PURPOSE.—The Director of the Office shall—

1 “(1) identify projects of research on primary
2 care and prevention that should be conducted or
3 supported by the national research institutes, with
4 particular emphasis on—

5 “(A) clinical patient care,

6 “(B) diagnostic effectiveness,

7 “(C) primary care education,

8 “(D) health and family planning services,

9 “(E) medical effectiveness outcomes of pri-
10 mary care procedures and interventions,

11 “(F) the use of multidisciplinary teams of
12 health care practitioners.

13 “(2) identify multidisciplinary research related
14 to primary care and prevention that should be so
15 conducted;

16 “(3) promote coordination and collaboration
17 among entities conducting research identified under
18 any of paragraphs (1) and (2);

19 “(4) encourage the conduct of such research by
20 entities receiving funds from the national research
21 institutes;

22 “(5) recommend an agenda for conducting and
23 supporting such research;

1 “(6) promote the sufficient allocation of the re-
2 sources of the national research institutes for con-
3 ducting and supporting such research; and

4 “(7) prepare the report required in section
5 486B.

6 “(c) PRIMARY CARE AND PREVENTION RESEARCH
7 DEFINED.—For purposes of this part, the term ‘primary
8 care and prevention research’ means research on improve-
9 ment of the practice of family medicine, general internal
10 medicine, and general pediatrics, and includes research
11 relating to—

12 “(1) obstetrics and gynecology, dentistry, or
13 mental health or substance abuse treatment when
14 provided by a primary care physician or other
15 primary care practitioner, and

16 “(2) primary care provided by multidisciplinary
17 teams.

18 **“SEC. 486A. NATIONAL DATA SYSTEM AND CLEARINGHOUSE**
19 **ON PRIMARY CARE AND PREVENTION RE-**
20 **SEARCH.**

21 “(a) DATA SYSTEM.—The Director of NIH, in con-
22 sultation with the Director of the Office, shall establish
23 a data system for the collection, storage, analysis, re-
24 trieval, and dissemination of information regarding pri-
25 mary care and prevention research that is conducted or

1 supported by the national research institutes. Information
2 from the data system shall be available through informa-
3 tion systems available to health care professionals and pro-
4 viders, researchers, and members of the public.

5 “(b) CLEARINGHOUSE.—The Director of NIH, in
6 consultation with the Director of the Office and with the
7 National Library of Medicine, shall establish, maintain,
8 and operate a program to provide, and encourage the use
9 of, information on research and prevention activities of the
10 national research institutes that relate to primary care
11 and prevention research.

12 **“SEC. 486B. BIENNIAL REPORT.**

13 “(a) IN GENERAL.—With respect to primary care
14 and prevention research, the Director of the Office shall,
15 not later than one year after the date of the enactment
16 of this part, and biennially thereafter, prepare a report—

17 “(1) describing and evaluating the progress
18 made during the preceding two fiscal years in re-
19 search and treatment conducted or supported by the
20 National Institutes of Health;

21 “(2) summarizing and analyzing expenditures
22 made by the agencies of such Institutes (and by
23 such Office) during the preceding two fiscal years;
24 and

1 “(3) making such recommendations for legisla-
2 tive and administrative initiatives as the Director of
3 the Office determines to be appropriate.

4 “(b) INCLUSION IN BIENNIAL REPORT OF DIRECTOR
5 OF NIH.—The Director of the Office shall submit each
6 report prepared under subsection (a) to the Director of
7 NIH for inclusion in the report submitted to the President
8 and the Congress under section 403.”.

9 (b) REQUIREMENT OF SUFFICIENT ALLOCATION OF
10 RESOURCES OF INSTITUTES.—Section 402(b) of the Pub-
11 lic Health Service Act (42 U.S.C. 282(b)) is amended—

12 (1) in paragraph (10), by striking “and” after
13 the semicolon at the end;

14 (2) in paragraph (11), by striking the period at
15 the end and inserting “; and”; and

16 (3) by inserting after paragraph (11) the fol-
17 lowing new paragraph:

18 “(12) after consultation with the Director of
19 the Office of Primary Care and Prevention Re-
20 search, shall ensure that resources of the National
21 Institutes of Health are sufficiently allocated for
22 projects on primary care and prevention research
23 that are identified under section 486(b).”.

24 (c) AUTHORIZATION OF APPROPRIATIONS.—Section
25 408 of the Public Health Service Act (42 U.S.C. 284(a))

3 “(3) For the Office of Primary Care and Pre-
4 vention Research, there are authorized to be appro-
5 priated \$150,000,000 for fiscal year 1994,
6 \$180,000,000 for fiscal year 1995, and
7 \$216,000,000 for fiscal year 1996.”.

(d) CONFORMING AMENDMENT.—Section 485(g) of the Public Health Service Act (42 U.S.C. 287c-2(g)) is amended by striking “section 486” and inserting “section 485A”.

Subtitle D—School-Related Health Services

(a) FUNDING FOR SCHOOL-RELATED HEALTH SERVICES.—For the purpose of carrying out this subtitle, there are authorized to be appropriated \$100,000,000 for fiscal year 1997, \$275,000,000 for fiscal year 1998, \$350,000,000 for fiscal year 1999, and \$400,000,000 for each of the fiscal years 2000 and 2001.

(b) RELATION TO OTHER FUNDS.—The authorizations of appropriations established in subsection (a) are in addition to any other authorizations of appropriations that are available for the purpose described in such subsection.

1 **SEC. 732. ELIGIBILITY FOR DEVELOPMENT AND OPER-**
2 **ATION GRANTS.**

3 (a) IN GENERAL.—Entities eligible to apply for and
4 receive grants under section 734 or 735 are the following:

5 (1) State health agencies that apply on behalf
6 of local community partnerships and other commu-
7 nities in need of health services for school-aged chil-
8 dren within the State.

9 (2) Local community partnerships in States in
10 which health agencies have not applied.

11 (b) LOCAL COMMUNITY PARTNERSHIPS.—

12 (1) IN GENERAL.—A local community partner-
13 ship under subsection (a)(2) is an entity that, at a
14 minimum, includes—

15 (A) a local health care provider with expe-
16 rience in delivering services to school-aged chil-
17 dren;

18 (B) one or more local public schools; and

19 (C) at least one community based organi-
20 zation located in the community to be served
21 that has a history of providing services to
22 school-aged children in the community who are
23 at-risk.

24 (2) PARTICIPATION.—A partnership described
25 in paragraph (1) shall, to the maximum extent fea-
26 sible, involve broad based community participation

1 from parents and adolescent children to be served,
2 health and social service providers, teachers and
3 other public school and school board personnel, de-
4 velopment and service organizations for adolescent
5 children, and interested business leaders. Such par-
6 ticipation may be evidenced through an expanded
7 partnership, or an advisory board to such partner-
8 ship.

9 (c) DEFINITIONS REGARDING CHILDREN.—For pur-
10 poses of this subtitle:

11 (1) The term “adolescent children” means
12 school-aged children who are adolescents.

13 (2) The term “school-aged children” means in-
14 dividuals who are between the ages of 4 and 19 (in-
15 clusive).

16 **SEC. 733. PREFERENCES.**

17 (a) IN GENERAL.—In making grants under sections
18 734 and 735, the Secretary shall give preference to appli-
19 cants whose communities to be served show the most sub-
20 stantial level of need for such services among school-aged
21 children, as measured by indicators of community health
22 including the following:

23 (1) High levels of poverty.

24 (2) The presence of a medically underserved
25 population.

1 (3) The presence of a health professional short-
2 age area.

3 (4) High rates of indicators of health risk
4 among school-aged children, including a high propor-
5 tion of such children receiving services through the
6 Individuals with Disabilities Education Act, adoles-
7 cent pregnancy, sexually transmitted disease (includ-
8 ing infection with the human immunodeficiency
9 virus), preventable disease, communicable disease,
10 intentional and unintentional injuries, community
11 and gang violence, unemployment among adolescent
12 children, juvenile justice involvement, and high rates
13 of drug and alcohol exposure.

14 (b) LINKAGE TO COMMUNITY HEALTH CENTERS.—
15 In making grants under sections 734 and 735, the Sec-
16 retary shall give preference to applicants that demonstrate
17 a linkage to community health centers.

18 **SEC. 734. GRANTS FOR DEVELOPMENT OF PROJECTS.**

19 (a) IN GENERAL.—The Secretary may make grants
20 to State health agencies or to local community partner-
21 ships to develop school health service sites.

22 (b) USE OF FUNDS.—A project for which a grant
23 may be made under subsection (a) may include but not
24 be limited to the cost of the following:

1 (1) Planning for the provision of school health
2 services.

3 (2) Recruitment, compensation, and training of
4 health and administrative staff.

5 (3) The development of agreements, and the ac-
6 quisition and development of equipment and infor-
7 mation services, necessary to support information
8 exchange between school health service sites and
9 health plans, health providers, and other entities au-
10 thorized to collect information under this Act.

11 (4) Other activities necessary to assume oper-
12 ational status.

13 (c) APPLICATION FOR GRANT.—

14 (1) IN GENERAL.—Applicants shall submit ap-
15 plications in a form and manner prescribed by the
16 Secretary.

17 (2) APPLICATIONS BY STATE HEALTH AGEN-
18 CIES.—

19 (A) In the case of applicants that are State
20 health agencies, the application shall contain
21 assurances that the State health agency is ap-
22 plying for funds—

23 (i) on behalf of at least one local com-
24 munity partnership; and

1 (ii) on behalf of at least one other
2 community identified by the State as in
3 need of the services funded under this sub-
4 title but without a local community part-
5 nership.

6 (B) In the case of the communities identi-
7 fied in applications submitted by State health
8 agencies that do not yet have local community
9 partnerships (including the community identi-
10 fied under subparagraph (A)(ii)), the State
11 shall describe the steps that will be taken to aid
12 the communities in developing a local commu-
13 nity partnership.

14 (C) A State applying on behalf of local
15 community partnerships and other communities
16 may retain not more than 10 percent of grants
17 awarded under this subtitle for administrative
18 costs.

19 (d) CONTENTS OF APPLICATION.—In order to receive
20 a grant under this section, an applicant must include in
21 the application the following information:

22 (1) An assessment of the need for school health
23 services in the communities to be served, using the
24 latest available health data and health goals and ob-
25 jectives established by the Secretary.

1 (2) A description of how the applicant will de-
2 sign the proposed school health services to reach the
3 maximum number of school-aged children who are at
4 risk.

5 (3) An explanation of how the applicant will in-
6 tegrate its services with those of other health and
7 social service programs within the community.

8 (4) A description of a quality assurance pro-
9 gram which complies with standards that the Sec-
10 retary may prescribe.

11 (e) NUMBER OF GRANTS.—Not more than one plan-
12 ning grant may be made to a single applicant. A planning
13 grant may not exceed two years in duration.

14 **SEC. 735. GRANTS FOR OPERATION OF PROJECTS.**

15 (a) IN GENERAL.—The Secretary may make grants
16 to State health agencies or to local community partner-
17 ships for the cost of operating school health service sites.

18 (b) USE OF GRANT.—The costs for which a grant
19 may be made under this section include but are not limited
20 to the following:

21 (1) The cost of furnishing health services that
22 are not otherwise covered under this Act or by any
23 other public or private insurer.

24 (2) The cost of furnishing services whose pur-
25 pose is to increase the capacity of individuals to uti-

1 lize available health services, including transpor-
2 tation, community and patient outreach, patient
3 education, translation services, and such other serv-
4 ices as the Secretary determines to be appropriate in
5 carrying out such purpose.

6 (3) Training, recruitment and compensation of
7 health professionals and other staff.

8 (4) Outreach services to school-aged children
9 who are at-risk and to the parents of such children.

10 (5) Linkage of individuals to health plans, com-
11 munity health services and social services.

12 (6) Other activities deemed necessary by the
13 Secretary.

14 (c) APPLICATION FOR GRANT.—Applicants shall sub-
15 mit applications in a form and manner prescribed by the
16 Secretary. In order to receive a grant under this section,
17 an applicant must include in the application the following
18 information:

19 (1) A description of the services to be furnished
20 by the applicant.

21 (2) The amounts and sources of funding that
22 the applicant will expend, including estimates of the
23 amount of payments the applicant will receive from
24 sources other than the grant.

1 (3) Such other information as the Secretary de-
2 termines to be appropriate.

3 (d) ADDITIONAL CONTENTS OF APPLICATION.—In
4 order to receive a grant under this section, an applicant
5 must meet the following conditions:

6 (1) The applicant furnishes the following serv-
7 ices:

8 (A) Diagnosis and treatment of simple ill-
9 nesses and minor injuries.

10 (B) Preventive health services, including
11 health screenings.

12 (C) Services provided for the purpose de-
13 scribed in subsection (b)(2).

14 (D) Referrals and followups in situations
15 involving illness or injury.

16 (E) Health and social services, counseling
17 services, and necessary referrals, including re-
18 ferrals regarding mental health and substance
19 abuse.

20 (F) Such other services as the Secretary
21 determines to be appropriate.

22 (2) The applicant is a participating provider in
23 the State's program for medical assistance under
24 title XIX of the Social Security Act.

1 (3) The applicant does not impose charges on
2 students or their families for services (including col-
3 lection of any cost-sharing for services under the
4 comprehensive benefit package that otherwise would
5 be required).

6 (4) The applicant has reviewed and will periodi-
7 cally review the needs of the population served by
8 the applicant in order to ensure that its services are
9 accessible to the maximum number of school-aged
10 children in the area, and that, to the maximum ex-
11 tent possible, barriers to access to services of the ap-
12 plicant are removed (including barriers resulting
13 from the area's physical characteristics, its eco-
14 nomic, social and cultural grouping, the health care
15 utilization patterns of such children, and available
16 transportation).

17 (5) In the case of an applicant which serves a
18 population that includes a substantial proportion of
19 individuals of limited English speaking ability, the
20 applicant has developed a plan to meet the needs of
21 such population to the extent practicable in the lan-
22 guage and cultural context most appropriate to such
23 individuals.

1 (6) The applicant will provide non-Federal con-
2 tributions toward the cost of the project in an
3 amount determined by the Secretary.

4 (7) The applicant will operate a quality assur-
5 ance program consistent with section 734(d).

6 (e) DURATION OF GRANT.—A grant under this sec-
7 tion shall be for a period determined by the Secretary.

8 (f) REPORTS.—A recipient of funding under this sec-
9 tion shall provide such reports and information as are re-
10 quired in regulations of the Secretary.

11 **SEC. 736. FEDERAL ADMINISTRATIVE COSTS.**

12 Of the amounts made available under section 731, the
13 Secretary may reserve not more than 5 percent for admin-
14 istrative expenses regarding this subtitle.

15 **SEC. 737. DEFINITIONS.**

16 For purposes of this subtitle:

17 (1) The term “adolescent children” has the
18 meaning given such term in section 732(c).

19 (2) The term “at risk” means at-risk with re-
20 spect to health.

21 (3) The term “community health center” has
22 the meaning given such term in section 330 of the
23 Public Health Service Act.

24 (4) The term “health professional shortage
25 area” means a health professional shortage area des-

1 ignated under section 332 of the Public Health Serv-
2 ice Act.

3 (5) The term “medically underserved popu-
4 lation” has the meaning given such term in section
5 330 of the Public Health Service Act.

6 (6) The term “school-aged children” has the
7 meaning given such term in section 732(c).

8 **TITLE VIII—FINANCING PROVI-**
9 **SIONS; AMERICAN HEALTH**
10 **SECURITY TRUST FUND**

11 **SEC. 800. AMENDMENT OF 1986 CODE; SECTION 15 NOT TO**
12 **APPLY.**

13 (a) AMENDMENT OF 1986 CODE.—Except as other-
14 wise expressly provided, whenever in this title an amend-
15 ment or repeal is expressed in terms of an amendment
16 to, or repeal of, a section or other provision, the reference
17 shall be considered to be made to a section or other provi-
18 sion of the Internal Revenue Code of 1986.

19 (b) SECTION 15 NOT TO APPLY.—The amendments
20 made by subtitle B shall not be treated as a change in
21 a rate of tax for purposes of section 15 of the Internal
22 Revenue Code of 1986.

1 **Subtitle A—American Health**
2 **Security Trust Fund**

3 **SEC. 801. AMERICAN HEALTH SECURITY TRUST FUND.**

4 (a) IN GENERAL.—There is hereby created on the
5 books of the Treasury of the United States a trust fund
6 to be known as the American Health Security Trust Fund
7 (in this section referred to as the “Trust Fund”). The
8 Trust Fund shall consist of such gifts and bequests as
9 may be made and such amounts as may be deposited in,
10 or appropriated to, such Trust Fund as provided in this
11 Act.

12 (b) APPROPRIATIONS INTO TRUST FUND.—

13 (1) TAXES.—There are hereby appropriated to
14 the Trust Fund for each fiscal year (beginning with
15 fiscal year 1995), out of any moneys in the Treasury
16 not otherwise appropriated, amounts equivalent to
17 100 percent of the aggregate increase in tax liabil-
18 ities under the Internal Revenue Code of 1986 which
19 is attributable to the application of the amendments
20 made by this title. The amounts appropriated by the
21 preceding sentence shall be transferred from time to
22 time (but not less frequently than monthly) from the
23 general fund in the Treasury to the Trust Fund,
24 such amounts to be determined on the basis of esti-
25 mates by the Secretary of the Treasury of the taxes

1 paid to or deposited into the Treasury; and proper
2 adjustments shall be made in amounts subsequently
3 transferred to the extent prior estimates were in ex-
4 cess of or were less than the amounts that should
5 have been so transferred.

6 (2) CURRENT PROGRAM RECEIPTS.—Notwith-
7 standing any other provision of law, there are hereby
8 appropriated to the Trust Fund for each fiscal year
9 (beginning with fiscal year 1995) the amounts that
10 would otherwise have been appropriated to carry out
11 the following programs:

12 (A) The medicare program, under parts A
13 and B of title XVIII of the Social Security Act
14 (other than amounts attributable to any pre-
15 miums under such parts).

16 (B) The medicaid program, under State
17 plans approved under title XIX of such Act.

18 (C) The Federal employees health benefit
19 program, under chapter 89 of title 5, United
20 States Code.

21 (D) The CHAMPUS program, under chap-
22 ter 55 of title 10, United States Code.

23 (E) The maternal and child health pro-
24 gram (under title V of the Social Security Act),
25 vocational rehabilitation programs, programs

1 for drug abuse and mental health services
2 under the Public Health Service Act, programs
3 providing general hospital or medical assistance,
4 and any other Federal program identified by
5 the Board, in consultation with the Secretary of
6 the Treasury, to the extent the programs pro-
7 vide for payment for health services the pay-
8 ment of which may be made under this Act.

9 (c) INCORPORATION OF PROVISIONS.—The provisions
10 of subsections (b) through (i) of section 1817 of the Social
11 Security Act shall apply to the Trust Fund under this Act
12 in the same manner as they applied to the Federal Hos-
13 pital Insurance Trust Fund under part A of title XVIII
14 of such Act, except that the American Health Security
15 Standards Board shall constitute the Board of Trustees
16 of the Trust Fund.

17 (d) TRANSFER OF FUNDS.—Any amounts remaining
18 in the Federal Hospital Insurance Trust Fund or the Fed-
19 eral Supplementary Medical Insurance Trust Fund after
20 the settlement of claims for payments under title XVIII
21 have been completed, shall be transferred into the Amer-
22 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.—

9 “(1) IN GENERAL.—In addition to other taxes,
10 there is hereby imposed on every employer an excise
11 tax, with respect to having individuals in his employ,
12 equal to the applicable percentage of the wages (as
13 defined in section 3121(a)) paid by him with respect
14 to employment (as defined in section 3121(b)).

15 “(2) APPLICABLE PERCENTAGE.—For purposes
16 of paragraph (1), the term ‘applicable percentage’
17 means—

18 “(A) 4 percent in the case of a small em-
19 ployer, and

20 “(B) 8.4 percent in the case of any other
21 employer.

22 “(3) SMALL EMPLOYER.—

23 “(A) IN GENERAL.—For purposes of para-
24 graph (2), the term ‘small employer’ means any
25 employer if—

1 “(i) the average number of full-time
2 employees (or the equivalent) of such em-
3 ployer during the preceding calendar year
4 is less than 75, and

5 “(ii) the average annual wages (as de-
6 fined in section 3121(a)) paid by such em-
7 ployer to such employees during such year
8 is less than \$24,000.

9 “(B) CONTROLLED GROUPS.—All persons
10 treated as a single employer under subsection
11 (a) or (b) of section 52 or subsection (m) or (o)
12 of section 414 shall be treated as 1 employer
13 for purposes of subparagraph (A).”

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.—

20 “(1) IN GENERAL.—In addition to other taxes,
21 there shall be imposed for each taxable year, on the
22 self-employment income of every individual, a tax
23 equal to the applicable percentage (as defined in sec-
24 tion 3111(c)) of the amount of the self-employment
25 income for such taxable year.

1 “(2) SPECIAL RULE FOR DETERMINING APPLI-
2 CABLE PERCENTAGE.—In determining the applicable
3 percentage for purposes of paragraph (1), section
4 3111(c) shall be applied by treating such individual
5 as an employee receiving wages equal to such indi-
6 vidual’s self-employment income for the taxable
7 year.”

8 (c) COMPARABLE TAXES FOR RAILROAD SERV-
9 ICES.—

10 (1) TAX ON EMPLOYERS.—Section 3221 is
11 amended by redesignating subsections (c), (d), and
12 (e) as subsections (d), (e), and (f), respectively, and
13 by inserting after subsection (b) the following new
14 subsection:

15 “(c) HEALTH CARE.—In addition to other taxes,
16 there is hereby imposed on every employer an excise tax,
17 with respect to having individuals in his employ, equal to
18 the applicable percentage (as defined in section 3111(c))
19 of the compensation paid by such employer for services
20 rendered to such employer.”

21 (2) TAX ON EMPLOYEE REPRESENTATIVES.—
22 Subsection (a) of section 3211 (relating to tax on
23 employee representatives) is amended by redesignat-
24 ing paragraph (3) as paragraph (4) and by inserting
25 after paragraph (2) the following new paragraph:

1 “(3) HEALTH CARE.—

2 “(A) IN GENERAL.—In addition to other
3 taxes, there is hereby imposed on the income of
4 each employee representative a tax equal to the
5 applicable percentage of the compensation re-
6 ceived during the calendar year by such em-
7 ployee representative for services rendered by
8 such employee representative.

9 “(B) SPECIAL RULE FOR DETERMINING
10 APPLICABLE PERCENTAGE.—In determining the
11 applicable percentage for purposes of subpara-
12 graph (A), section 3111(c) shall be applied by
13 treated such individual as an employee receiving
14 wages equal to such individual’s compensation
15 for the taxable year.”

16 (3) NO APPLICABLE BASE.—Subparagraph (A)
17 of section 3231(e)(2) is amended by adding at the
18 end thereof the following new clause:

19 “(iv) HEALTH CARE TAXES.—Clause
20 (i) shall not apply to the taxes imposed by
21 sections 3221(c) and 3211(a)(3).”

22 (4) TECHNICAL AMENDMENTS.—

23 (A) Paragraph (4) of section 3211, as re-
24 designated by paragraph (2), is amended by

1 striking “and (2)” and inserting “, (2), and
2 (3)”.

3 (B) Subsection (f) of section 3221, as re-
4 designated by paragraph (1), is amended by
5 striking “and (b)” and inserting “, (b), and
6 (c)”.

7 (d) EFFECTIVE DATE.—The amendments made by
8 this section shall apply to remuneration paid after Decem-
9 ber 31, 1996.

10 **SEC. 812. HEALTH CARE INCOME TAX.**

11 (a) GENERAL RULE.—Subchapter A of chapter 1 (re-
12 lating to determination of tax liability) is amended by add-
13 ing at the end thereof the following new part:

14 **“PART VIII—HEALTH CARE INCOME TAX ON**
15 **INDIVIDUALS**

 “Sec. 59B. Health care income tax.

16 **“SEC. 59B. HEALTH CARE INCOME TAX.**

17 “(a) IMPOSITION OF TAX.—In the case of an individ-
18 ual, there is hereby imposed a tax (in addition to any other
19 tax imposed by this subtitle) equal to 2.1 percent of the
20 taxable income of the taxpayer for the taxable year.

21 “(b) NO CREDITS AGAINST TAX; NO EFFECT ON
22 MINIMUM TAX.—The tax imposed by this section shall not
23 be treated as a tax imposed by this chapter for purposes
24 of determining—

1 “(1) the amount of any credit allowable under
2 this chapter, or

3 “(2) the amount of the minimum tax imposed
4 by section 55.

5 “(c) SPECIAL RULES.—

6 “(1) TAX TO BE WITHHELD, ETC.—For pur-
7 poses of this title, the tax imposed by this section
8 shall be treated as imposed by section 1.

9 “(2) REIMBURSEMENT OF TAX BY EMPLOYER
10 NOT INCLUDIBLE IN GROSS INCOME.—The gross in-
11 come of an employee shall not include any payment
12 by his employer to reimburse the employee for the
13 tax paid by the employee under this section.

14 “(3) OTHER RULES.—The rules of section
15 59A(d) shall apply to the tax imposed by this sec-
16 tion.”

17 (b) CLERICAL AMENDMENT.—The table of parts for
18 subchapter A of chapter 1 is amended by adding at the
19 end the following new item:

 “Part VIII. Health care income tax on individuals.”

20 (c) EFFECTIVE DATE.—The amendments made by
21 this section shall apply to taxable years beginning after
22 December 31, 1996.

1 **Subtitle C—Increase in Excise**
2 **Taxes on Tobacco Products**

3 **SEC. 821. INCREASE IN EXCISE TAXES ON TOBACCO PROD-**
4 **UCTS.**

5 (a) CIGARETTES.—Subsection (b) of section 5701 is
6 amended—

7 (1) by striking “\$12 per thousand (\$10 per
8 thousand on cigarettes removed during 1991 or
9 1992)” in paragraph (1) and inserting “\$100 per
10 thousand”, and

11 (2) by striking “\$25.20 per thousand (\$21 per
12 thousand on cigarettes removed during 1991 or
13 1992)” in paragraph (2) and inserting “\$210 per
14 thousand”.

15 (b) CIGARS.—Subsection (a) of section 5701 is
16 amended—

17 (1) by striking “\$1.125 cents per thousand
18 (93.75 cents per thousand on cigars removed during
19 1991 or 1992)” in paragraph (1) and inserting
20 “\$9.38 per thousand”, and

21 (2) by striking “equal to” and all that follows
22 in paragraph (2) and inserting “equal to 106.25 per-
23 cent of the price for which sold but not more than
24 \$250 per thousand.”

1 (c) CIGARETTE PAPERS.—Subsection (c) of section
2 5701 is amended by striking “0.75 cent (0.625 cent on
3 cigarette papers removed during 1991 or 1992)” and in-
4 serting “6.25 cents”.

5 (d) CIGARETTE TUBES.—Subsection (d) of section
6 5701 is amended by striking “1.5 cents (1.25 cents on
7 cigarette tubes removed during 1991 or 1992)” and in-
8 serting “12.5 cents”.

9 (e) SMOKELESS TOBACCO.—Subsection (e) of section
10 5701 is amended—

11 (1) by striking “36 cents (30 cents on snuff re-
12 moved during 1991 or 1992)” in paragraph (1) and
13 inserting “\$3.00”, and

14 (2) by striking “12 cents (10 cents on chewing
15 tobacco removed during 1991 or 1992)” in para-
16 graph (2) and inserting “\$1.00”.

17 (f) PIPE TOBACCO.—Subsection (f) of section 5701
18 is amended by striking “67.5 cents (56.25 cents on pipe
19 tobacco removed during 1991 or 1992)” and inserting
20 “\$5.63”.

21 (g) EFFECTIVE DATE.—The amendments made by
22 this section shall apply to articles removed (as defined in
23 section 5702(k) of the Internal Revenue Code of 1986)
24 after December 31, 1996.

25 (h) FLOOR STOCKS TAXES.—

1 (1) IMPOSITION OF TAX.—On tobacco products
2 and cigarette papers and tubes manufactured in or
3 imported into the United States which are removed
4 before January 1, 1997, and held on such date for
5 sale by any person, there is hereby imposed a tax in
6 an amount equal to the excess of—

7 (A) the tax which would be imposed under
8 section 5701 of the Internal Revenue Code of
9 1986 on the article if the article had been re-
10 moved on such date, over

11 (B) the prior tax (if any) imposed under
12 section 5701 or 7652 of such Code on such ar-
13 ticle.

14 (2) AUTHORITY TO EXEMPT CIGARETTES HELD
15 IN VENDING MACHINES.—To the extent provided in
16 regulations prescribed by the Secretary, no tax shall
17 be imposed by paragraph (1) on cigarettes held for
18 retail sale on January 1, 1997, by any person in any
19 vending machine. If the Secretary provides such a
20 benefit with respect to any person, the Secretary
21 may reduce the \$500 amount in paragraph (3) with
22 respect to such person.

23 (3) CREDIT AGAINST TAX.—Each person shall
24 be allowed as a credit against the taxes imposed by
25 paragraph (1) an amount equal to \$500. Such credit

1 shall not exceed the amount of taxes imposed by
2 paragraph (1) for which such person is liable.

3 (4) LIABILITY FOR TAX AND METHOD OF PAY-
4 MENT.—

5 (A) LIABILITY FOR TAX.—A person hold-
6 ing any article on January 1, 1997, to which
7 any tax imposed by paragraph (1) applies shall
8 be liable for such tax.

9 (B) METHOD OF PAYMENT.—The tax im-
10 posed by paragraph (1) shall be paid in such
11 manner as the Secretary shall prescribe by reg-
12 ulations.

13 (C) TIME FOR PAYMENT.—The tax im-
14 posed by paragraph (1) shall be paid on or be-
15 fore July 31, 1997.

16 (5) ARTICLES IN FOREIGN TRADE ZONES.—
17 Notwithstanding the Act of June 18, 1934 (48 Stat.
18 998, 19 U.S.C. 81a) and any other provision of law,
19 any article which is located in a foreign trade zone
20 on January 1, 1997, shall be subject to the tax im-
21 posed by paragraph (1) if—

22 (A) internal revenue taxes have been deter-
23 mined, or customs duties liquidated, with re-
24 spect to such article before such date pursuant

1 to a request made under the 1st proviso of sec-
2 tion 3(a) of such Act, or

3 (B) such article is held on such date under
4 the supervision of a customs officer pursuant to
5 the 2d proviso of such section 3(a).

6 (6) DEFINITIONS.—For purposes of this sub-
7 section—

8 (A) IN GENERAL.—Terms used in this sub-
9 section which are also used in section 5702 of
10 the Internal Revenue Code of 1986 shall have
11 the respective meanings such terms have in
12 such section.

13 (B) SECRETARY.—The term “Secretary”
14 means the Secretary of the Treasury or his del-
15 egate.

16 (7) CONTROLLED GROUPS.—Rules similar to
17 the rules of section 5061(e)(3) of such Code shall
18 apply for purposes of this subsection.

19 (8) OTHER LAWS APPLICABLE.—All provisions
20 of law, including penalties, applicable with respect to
21 the taxes imposed by section 5701 of such Code
22 shall, insofar as applicable and not inconsistent with
23 the provisions of this subsection, apply to the floor
24 stocks taxes imposed by paragraph (1), to the same
25 extent as if such taxes were imposed by such section

1 5701. The Secretary may treat any person who bore
2 the ultimate burden of the tax imposed by para-
3 graph (1) as the person to whom a credit or refund
4 under such provisions may be allowed or made.

5 **Subtitle D—Increase in Taxes on**
6 **Firearms and Ammunition**

7 **SEC. 831. INCREASE IN TAXES ON FIREARMS AND AMMUNI-**
8 **TION.**

9 (a) PISTOLS AND REVOLVERS.—The text of section
10 4181 (relating to imposition of tax on firearms) is amend-
11 ed to read as follows:

12 “There is hereby imposed upon the sale by the manu-
13 facturer, producer, or importer of any pistol, revolver, fire-
14 arm, shell, or cartridge a tax equal to 50 percent of the
15 price for which so sold.”

16 (b) ADDITIONAL TAXES NOT ADDED TO WILDLIFE
17 FUND.—Section 3(a) of the Act of September 2, 1937 (16
18 U.S.C. 669b(a)), commonly referred to as the “Pittman-
19 Robertson Wildlife Restoration Act”, is amended by add-
20 ing at the end the following new sentence: “There shall
21 not be covered into the fund the portion of the tax imposed
22 by such section 4181 that is attributable to any increase
23 in amounts received in the Treasury under such section
24 by reason of the amendment made by section 831 of the

1 American Health Security Act, as estimated by the Sec-
2 retary.”.

3 (c) EFFECTIVE DATE.—The amendments made by
4 this section shall take effect on January 1, 1997.

5 (d) FLOOR STOCKS TAX.—

6 (1) IMPOSITION OF TAX.—In the case of any
7 taxable article on which tax was imposed under sec-
8 tion 4181 of the Internal Revenue Code of 1986 be-
9 fore January 1, 1997, and which is held by a dealer
10 on such date, there is hereby imposed a floor stocks
11 tax equal to the excess of—

12 (A) the tax which would be imposed by
13 such section if such article had been sold by the
14 manufacturer, producer, or importer on such
15 date, over

16 (B) the tax imposed by such section on
17 such article.

18 (2) LIABILITY FOR TAX AND METHOD OF PAY-
19 MENT.—

20 (A) LIABILITY FOR TAX.—The dealer hold-
21 ing the taxable article on January 1, 1997, to
22 which the tax imposed by paragraph (1) applies
23 shall be liable for such tax.

24 (B) METHOD OF PAYMENT.—The tax im-
25 posed by paragraph (1) shall be paid in such

1 manner as the Secretary of the Treasury or his
2 delegate shall prescribe.

3 (C) TIME FOR PAYMENT.—The tax im-
4 posed by paragraph (1) shall be paid on or be-
5 fore July 31, 1997.

6 (3) DEFINITIONS.—For purposes of this sub-
7 section—

8 (A) TAXABLE ARTICLE.—The term ‘tax-
9 able article’ means any article subject to tax
10 under section 4181 of such Code, other than an
11 article exempt from such tax under section
12 4182 of such Code.

13 (B) HELD BY A DEALER.—The term ‘held
14 by a dealer’ has the meaning given such term
15 by section 6412 of such Code.

16 (4) ARTICLES IN FOREIGN TRADE ZONES.—
17 Notwithstanding the Act of June 18, 1934 (48 Stat.
18 998, 19 U.S.C. 81a) and any other provision of law,
19 any article which is located in a foreign trade zone
20 on January 1, 1997, shall be subject to the tax im-
21 posed by paragraph (1) if—

22 (A) internal revenue taxes have been deter-
23 mined, or customs duties liquidated, with re-
24 spect to such article before such date pursuant

1 to a request made under the 1st proviso of sec-
2 tion 3(a) of such Act, or

3 (B) such article is held on such date under
4 the supervision of a customs officer pursuant to
5 the 2d proviso of such section 3(a).

6 (5) OTHER LAWS APPLICABLE.—All provisions
7 of law, including penalties, applicable with respect to
8 the taxes imposed by section 4181 of such Code
9 shall, insofar as applicable and not inconsistent with
10 the provisions of this subsection, apply with respect
11 to the floor stock taxes imposed by paragraph (1) to
12 the same extent as if such taxes were imposed by
13 such section 4181.

14 **TITLE IX—CONFORMING AMEND-**
15 **MENTS TO THE EMPLOYEE**
16 **RETIREMENT INCOME SECU-**
17 **RITY ACT OF 1974**

18 **SEC. 901. ERISA INAPPLICABLE TO HEALTH COVERAGE AR-**
19 **RANGEMENTS UNDER STATE HEALTH SECU-**
20 **RITY PROGRAMS.**

21 Section 4 of the Employee Retirement Income Secu-
22 rity Act of 1974 (29 U.S.C. 1003) is amended—

23 (1) in subsection (a), by striking “subsection
24 (b)” and inserting “subsections (b) and (c)”; and

1 (2) by adding at the end the following new sub-
2 section:

3 “(c) The provisions of this title shall not apply to any
4 arrangement forming a part of a State health security pro-
5 gram established pursuant to section 101(b) of the Amer-
6 ican Health Security Act of 1994.”.

7 **SEC. 902. EXEMPTION OF STATE HEALTH SECURITY PRO-**
8 **GRAMS FROM ERISA PREEMPTION.**

9 Section 514(b) of the Employee Retirement Income
10 Security Act of 1974 (29 U.S.C. 1144(b)) is amended by
11 adding at the end the following new paragraph:

12 “(9) Subsection (a) of this section shall not apply to
13 State health security programs established pursuant to
14 section 101(b) of the American Health Security Act of
15 1994.”.

16 **SEC. 903. PROHIBITION OF EMPLOYEE BENEFITS DUPLICA-**
17 **TIVE OF BENEFITS UNDER STATE HEALTH**
18 **SECURITY PROGRAMS.**

19 Part 5 of subtitle B of title I of the Employee Retire-
20 ment Income Security Act of 1974 is amended by adding
21 at the end the following new section:

22 “PROHIBITION OF EMPLOYEE BENEFITS DUPLICATIVE OF
23 STATE HEALTH SECURITY PROGRAM BENEFITS

24 “SEC. 516. No employee benefit plan may provide
25 benefits which duplicate payment for any items or services
26 for which payment may be made under a State health se-

1 curity program established pursuant to section 101(b) of
2 the American Health Security Act of 1994.”.

3 **SEC. 903. REPEAL OF CONTINUATION COVERAGE REQUIRE-**
4 **MENTS UNDER ERISA AND CERTAIN OTHER**
5 **REQUIREMENTS RELATING TO GROUP**
6 **HEALTH PLANS.**

7 (a) IN GENERAL.—Part 6 of subtitle B of title I of
8 the Employee Retirement Income Security Act of 1974
9 (29 U.S.C. 1161 et seq.) is repealed.

10 (b) CONFORMING AMENDMENTS.—

11 (1) Section 502(a)(7) of such Act (29 U.S.C.
12 1132(a)(7)) is amended—

13 (A) by striking paragraph (7); and

14 (B) by redesignating paragraph (8) as
15 paragraph (7).

16 (2) Section 502(c)(1) of such Act (29 U.S.C.
17 1132(c)(1)) is amended by striking “paragraph (1)
18 or (4) of section 606 or”.

19 (3) Section 4301(c)(4) of the Omnibus Budget
20 Reconciliation Act of 1993 (Public Law 103–66; 107
21 Stat. 377) and the amendments made thereby are
22 repealed.

23 (4) The table of contents in section 1 of the
24 Employee Retirement Income Security Act of 1974

1 is amended by striking the items relating to part 6
2 of subtitle B of title I of such Act.

3 **SEC. 904. EFFECTIVE DATE OF TITLE.**

4 The amendments made by this title shall take effect
5 January 1, 1996.

○

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