

111TH CONGRESS
1ST SESSION

S. 703

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

IN THE SENATE OF THE UNITED STATES

MARCH 25, 2009

Mr. SANDERS introduced the following bill; which was read twice and referred to the Committee on Finance

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 2009”.

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

Sec. 1. Short title; table of contents.

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

Sec. 101. Establishment of a State-based American Health Security Program.

- Sec. 102. Universal entitlement.
- Sec. 103. Enrollment.
- Sec. 104. Portability of benefits.
- Sec. 105. Effective date of benefits.
- Sec. 106. Relationship to existing Federal health programs.

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

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

TITLE III—PROVIDER PARTICIPATION

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

TITLE IV—ADMINISTRATION

Subtitle A—General Administrative Provisions

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

Subtitle B—Control Over Fraud and Abuse

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

TITLE V—QUALITY ASSESSMENT

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

TITLE VI—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. Payments for 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. 631. Mandatory assignment.
- Sec. 632. 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. Set-aside for public health.
- Sec. 712. Set-aside 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.

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

- Sec. 901. ERISA inapplicable to health coverage arrangements under State health security programs.
 Sec. 902. Exemption of State health security programs from ERISA preemption.
 Sec. 903. Prohibition of employee benefits duplicative of benefits under State health security programs; coordination in case of workers' compensation.
 Sec. 904. Repeal of continuation coverage requirements under ERISA and certain other requirements relating to group health plans.
 Sec. 905. Effective date of title.

TITLE X—ADDITIONAL CONFORMING AMENDMENTS

- Sec. 1001. Repeal of certain provisions in Internal Revenue Code of 1986.
 Sec. 1002. Repeal of certain provisions in the Employee Retirement Income Security Act of 1974.
 Sec. 1003. Repeal of certain provisions in the Public Health Service Act and related provisions.
 Sec. 1004. Effective date of title.

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

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

8 (a) IN GENERAL.—There is hereby established in the
 9 United States a State-Based American Health Security
 10 Program to be administered by the individual States in
 11 accordance with Federal standards specified in, or estab-
 12 lished under, this Act.

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

5 (c) STATE DEFINED.—

6 (1) IN GENERAL.—In this Act, subject to para-
7 graph (2), the term “State” means each of the 50
8 States and the District of Columbia.

9 (2) ELECTION.—If the Governor of Puerto
10 Rico, the Virgin Islands, Guam, American Samoa, or
11 the Northern Mariana Islands certifies to the Presi-
12 dent that the legislature of the Commonwealth or
13 territory has enacted legislation desiring that the
14 Commonwealth or territory be included as a State
15 under the provisions of this Act, such Common-
16 wealth or territory shall be included as a “State”
17 under this Act beginning January 1 of the first year
18 beginning 90 days after the President receives the
19 notification.

20 **SEC. 102. UNIVERSAL ENTITLEMENT.**

21 (a) IN GENERAL.—Every individual who is a resident
22 of the United States and is a citizen or national of the
23 United States or lawful resident alien (as defined in sub-
24 section (d)) is entitled to benefits for health care services
25 under this Act under the appropriate State health security

1 program. In this section, the term “appropriate State
2 health security program” means, with respect to an indi-
3 vidual, the State health security program for the State in
4 which the individual maintains a primary residence.

5 (b) TREATMENT OF CERTAIN NONIMMIGRANTS.—

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

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

19 (c) TREATMENT OF OTHER INDIVIDUALS.—

20 (1) BY BOARD.—The Board also may make eli-
21 gible for benefits for health care services under the
22 appropriate State health security program under this
23 Act other individuals not described in subsection (a)
24 or (b), and regulate the nature of the eligibility of
25 such individuals, in order—

1 (A) to preserve the public health of com-
2 munities;

3 (B) to compensate States for the addi-
4 tional health care financing burdens created by
5 such individuals; and

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

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

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

22 **SEC. 103. ENROLLMENT.**

23 (a) **IN GENERAL.**—Each State health security pro-
24 gram shall provide a mechanism for the enrollment of indi-

1 individuals entitled or eligible for benefits under this Act. The
2 mechanism shall—

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

8 (2) provide for the enrollment, as of January 1,
9 2011, of all individuals who are eligible to be en-
10 rolled as of such date; and

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

14 (b) AVAILABILITY OF APPLICATIONS.—Each State
15 health security program shall make applications for enroll-
16 ment under the program available—

17 (1) at employment and payroll offices of em-
18 ployers located in the State;

19 (2) at local offices of the Social Security Ad-
20 ministration;

21 (3) at social services locations;

22 (4) at out-reach sites (such as provider and
23 practitioner locations); and

1 (5) at other locations (including post offices
2 and schools) accessible to a broad cross-section of in-
3 dividuals 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 that shall
8 be used for purposes of identification and processing of
9 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 3 months before residents of the State are enti-
20 tled to, or eligible for, such benefits under the pro-
21 gram;

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 eli-
3 gibility 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, 2011.

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

8 (a) MEDICARE, MEDICAID AND STATE CHILDREN'S
9 HEALTH INSURANCE PROGRAM (SCHIP).—

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

12 (A) no benefits shall be available under
13 title XVIII of the Social Security Act for any
14 item or service furnished after December 31,
15 2010;

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

20 (C) no individual is entitled to medical as-
21 sistance under an SCHIP plan under title XXI
22 of such Act for any item or service furnished
23 after such date; and

24 (D) no payment shall be made to a State
25 under section 1903(a) or 2105(a) of such Act

1 with respect to medical assistance or child
2 health assistance for any item or service fur-
3 nished after such date.

4 (2) TRANSITION.—In the case of inpatient hos-
5 pital services and extended care services during a
6 continuous period of stay which began before Janu-
7 ary 1, 2011, and which had not ended as of such
8 date, for which benefits are provided under title
9 XVIII, under a State plan under title XIX, or a
10 State child health plan under title XXI, of the Social
11 Security Act, the Secretary of Health and Human
12 Services and each State plan, respectively, shall pro-
13 vide for continuation of benefits under such title or
14 plan until the end of the period of stay.

15 (b) FEDERAL EMPLOYEES HEALTH BENEFITS PRO-
16 GRAM.—No benefits shall be made available under chapter
17 89 of title 5, United States Code, for any part of a cov-
18 erage period occurring after December 31, 2010.

19 (c) CHAMPUS.—No benefits shall be made available
20 under sections 1079 and 1086 of title 10, United States
21 Code, for items or services furnished after December 31,
22 2010.

23 (d) TREATMENT OF BENEFITS FOR VETERANS AND
24 NATIVE AMERICANS.—Nothing in this Act shall affect the
25 eligibility of veterans for the medical benefits and services

1 provided under title 38, United States Code, or of Indians
 2 for the medical benefits and services provided by or
 3 through the Indian Health Service.

4 **TITLE II—COMPREHENSIVE BEN-**
 5 **EFITS, INCLUDING PREVEN-**
 6 **TIVE BENEFITS AND BENE-**
 7 **FITS FOR LONG-TERM CARE**

8 **SEC. 201. COMPREHENSIVE BENEFITS.**

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

16 (1) HOSPITAL SERVICES.—Inpatient and out-
 17 patient hospital care, including 24-hour-a-day emer-
 18 gency services.

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

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

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

6 (5) LONG-TERM, ACUTE, AND CHRONIC CARE
7 SERVICES.—

8 (A) Nursing facility services.

9 (B) Home health services.

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

13 (D) Hospice care.

14 (E) Services in intermediate care facilities
15 for individuals with mental retardation.

16 (6) PRESCRIPTION DRUGS, BIOLOGICALS, INSU-
17 LIN, MEDICAL FOODS.—

18 (A) Outpatient prescription drugs and bio-
19 logics, as specified by the Board consistent with
20 section 615.

21 (B) Insulin.

22 (C) Medical foods (as defined in section
23 202(e)).

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

1 (8) MENTAL HEALTH AND SUBSTANCE ABUSE
2 TREATMENT SERVICES.—Mental health and sub-
3 stance abuse treatment services (as defined in sec-
4 tion 202(f)).

5 (9) DIAGNOSTIC TESTS.—Diagnostic tests.

6 (10) OTHER ITEMS AND SERVICES.—

7 (A) OUTPATIENT THERAPY.—Outpatient
8 physical therapy services, outpatient speech pa-
9 thology services, and outpatient occupational
10 therapy services in all settings.

11 (B) DURABLE MEDICAL EQUIPMENT.—Du-
12 rable medical equipment.

13 (C) HOME DIALYSIS.—Home dialysis sup-
14 plies and equipment.

15 (D) AMBULANCE.—Emergency ambulance
16 service.

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

19 (F) ADDITIONAL ITEMS AND SERVICES.—
20 Such other medical or health care items or serv-
21 ices as the Board may specify.

22 (b) PROHIBITION OF BALANCE BILLING.—As pro-
23 vided in section 531, no person may impose a charge for
24 covered services for which benefits are provided under this
25 Act.

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

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

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

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

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

21 (1) by a rural health clinic;

22 (2) by a federally qualified health center (as de-
23 fined in section 1905(l)(2)(B) of the Social Security
24 Act), and which, for purposes of this Act, include
25 services furnished by State and local health agencies;

1 (3) in a school-based setting;

2 (4) by public educational agencies and other
3 providers of services to children entitled to assist-
4 ance under the Individuals with Disabilities Edu-
5 cation Act for services furnished pursuant to a writ-
6 ten Individualized Family Services Plan or Indi-
7 vidual Education Plan under such Act; and

8 (5) public and private nonprofit entities receiv-
9 ing Federal assistance under the Public Health
10 Service Act.

11 (b) PREVENTIVE SERVICES.—

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

14 (A) which—

15 (i) are specified in paragraph (2); or

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

20 (B) which are provided consistent with the
21 periodicity schedule established under para-
22 graph (3).

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

25 (A) Basic immunizations.

1 (B) Prenatal and well-baby care (for in-
2 fants under 1 year of age).

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

8 (D) Periodic screening mammography, Pap
9 smears, and colorectal examinations and exami-
10 nations for prostate cancer.

11 (E) Physical examinations.

12 (F) Family planning services.

13 (G) Routine eye examinations, eyeglasses,
14 and contact lenses.

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

20 (3) SCHEDULE.—The Board shall establish, in
21 consultation with experts in preventive medicine and
22 public health and taking into consideration those
23 preventive services recommended by the Preventive
24 Services Task Force and published as the Guide to
25 Clinical Preventive Services, a periodicity schedule

1 for the coverage of preventive services under para-
2 graph (1). Such schedule shall take into consider-
3 ation the cost-effectiveness of appropriate preventive
4 care and shall be revised not less frequently than
5 once every 5 years, in consultation with experts in
6 preventive medicine and public health.

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

13 (1) Home health aide services.

14 (2) Adult day health care, social day care or
15 psychiatric day care.

16 (3) Medical social work services.

17 (4) Care coordination services, as defined in
18 subsection (g)(1).

19 (5) Respite care, including training for informal
20 caregivers.

21 (6) Personal assistance services, and home-
22 maker services (including meals) incidental to the
23 provision of personal assistance services.

24 (d) HOME HEALTH SERVICES.—

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

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

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

20 (f) MENTAL HEALTH AND SUBSTANCE ABUSE
21 TREATMENT SERVICES.—

22 (1) SERVICES DESCRIBED.—In this title, the
23 term “mental health and substance abuse treatment
24 services” means the following services related to the

1 prevention, diagnosis, treatment, and rehabilitation
2 of mental illness and promotion of mental health:

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

23 (B) INTENSIVE RESIDENTIAL SERVICES.—
24 Intensive residential services (as defined in
25 paragraph (2)) furnished to an individual for

1 up to 120 days during any calendar year, ex-
2 cept that—

3 (i) such services may be furnished to
4 the individual for additional days during
5 the year if necessary for the individual to
6 complete a course of treatment to the ex-
7 tent that the number of days of inpatient
8 hospital services described in subparagraph
9 (A) that may be furnished to the individual
10 during the year (as reduced under such
11 subparagraph) is not less than 15; and

12 (ii) reduced by a number of days de-
13 termined by the Secretary so that the actu-
14 arial value of providing such number of
15 days of services under this paragraph to
16 the individual is equal to the actuarial
17 value of the days of intensive community-
18 based services furnished to the individual
19 under subparagraph (D) during the year
20 after such services have been furnished to
21 the individual for 90 days (or, in the case
22 of services described in subparagraph
23 (D)(ii), for 180 days) during the year
24 (rounded to the nearest day).

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

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

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

1 (as determined in accordance with criteria
2 established by the Secretary);

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

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

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

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

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

3 (i) Residential detoxification centers.

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

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

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

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

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

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

1 quality of the intensive residential services
2 provided.

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

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

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

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

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

19 (B) ITEMS AND SERVICES DESCRIBED.—
20 The items and services described in this sub-
21 paragraph are—

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

25 (ii) psychiatric rehabilitation services;

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

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

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

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

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

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

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

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

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

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

6 (viii) Diagnostic services.

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

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

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

22 (g) CARE COORDINATION SERVICES.—

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

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

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

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

16 (2) CARE COORDINATOR.—

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

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

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

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

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

17 (h) DENTAL SERVICES.—

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

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

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

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

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

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

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

11 (F) Full dentures.

12 (G) Medically necessary oral health care.

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

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

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

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

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

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

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

12 (A) PREVENTION AND DIAGNOSIS.—

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

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

1 tection of the 1st permanent molars. Such
2 sealants are covered for individuals 10
3 years of age or older for protection of the
4 2d permanent molars.

5 (B) TREATMENT OF DENTAL DISEASE.—

6 Prior to January 1, 2016, the items and serv-
7 ices described in paragraph (1)(C) are covered
8 only for individuals less than 18 years of age
9 and special needs patients. On or after such
10 date, such items and services are covered for all
11 individuals enrolled for benefits under this Act,
12 except that endodontic services are not covered
13 for individuals 18 years of age or older.

14 (C) SPACE MAINTENANCE.—The items and
15 services described in paragraph (1)(D) are cov-
16 ered only for individuals at least 3 years of age,
17 but less than 13 years of age and—

18 (i) are limited to posterior teeth;

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

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

1 pected eruption of the permanent posterior
2 tooth concerned.

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

4 (A) MEDICALLY NECESSARY ORAL HEALTH
5 CARE.—The term “medically necessary oral
6 health care” means oral health care that is re-
7 quired as a direct result of, or would have a di-
8 rect impact on, an underlying medical condi-
9 tion. Such term includes oral health care di-
10 rected toward control or elimination of pain, in-
11 fection, or reestablishment of oral function.

12 (B) SPECIAL NEEDS PATIENT.—The term
13 “special needs patient” includes an individual
14 with a genetic or birth defect, a developmental
15 disability, or an acquired medical disability.

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

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

24 (1) the term “intermediate care facility for indi-
25 viduals with mental retardation” has the meaning

1 specified in section 1905(d) of the Social Security
2 Act (as in effect before the enactment of this Act);
3 and

4 (2) the term “services in intermediate care fa-
5 cilities for individuals with mental retardation”
6 means services described in section 1905(a)(15) of
7 such Act (as so in effect) in an intermediate care fa-
8 cility for individuals with mental retardation to an
9 individual determined to require such services in ac-
10 cordance with standards specified by the Board and
11 comparable to the standards described in section
12 1902(a)(31)(A) of such Act (as so in effect).

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

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

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

21 (1) ADULTS.—Individuals 18 years of age or
22 older determined (in a manner specified by the
23 Board)—

24 (A) to be unable to perform, without the
25 assistance of an individual, at least 2 of the fol-

1 lowing 5 activities of daily living (or who has a
2 similar level of disability due to cognitive im-
3 pairment)—

4 (i) bathing;

5 (ii) eating;

6 (iii) dressing;

7 (iv) toileting; and

8 (v) transferring in and out of a bed or
9 in and out of a chair;

10 (B) due to cognitive or mental impair-
11 ments, to require supervision because the indi-
12 vidual behaves in a manner that poses health or
13 safety hazards to himself or herself or others;
14 or

15 (C) due to cognitive or mental impair-
16 ments, to require queuing to perform activities
17 of daily living.

18 (2) CHILDREN.—Individuals under 18 years of
19 age determined (in a manner specified by the Board)
20 to meet such alternative standard of disability for
21 children as the Board develops. Such alternative
22 standard shall be comparable to the standard for
23 adults and appropriate for children.

24 (b) LIMIT ON SERVICES.—

1 (1) IN GENERAL.—The aggregate expenditures
2 by a State health security program with respect to
3 home and community-based long-term care services
4 in a period (specified by the Board) may not exceed
5 65 percent (or such alternative ratio as the Board
6 establishes under paragraph (2)) of the average of
7 the amount of payment that would have been made
8 under the program during the period if all the home-
9 based long-term care beneficiaries had been resi-
10 dents of nursing facilities in the same area in which
11 the services were provided.

12 (2) ALTERNATIVE RATIO.—The Board may es-
13 tablish for purposes of paragraph (1) an alternative
14 ratio (of payments for home and community-based
15 long term care services to payments for nursing fa-
16 cility services) as the Board determines to be more
17 consistent with the goal of providing cost-effective
18 long-term care in the most appropriate and least re-
19 strictive setting.

20 **SEC. 204. EXCLUSIONS AND LIMITATIONS.**

21 (a) IN GENERAL.—Subject to section 201(e), benefits
22 for service are not available under this Act unless the serv-
23 ices meet the standards specified in section 201(a).

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

4 (1) REQUIRING SERVICES TO BE PROVIDED
5 THROUGH ORGANIZED SYSTEMS OF CARE.—A State
6 health security program shall ensure that mental
7 health services and substance abuse treatment serv-
8 ices are furnished through an organized system of
9 care, as described in paragraph (2), if—

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

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

14 (C) the individual is, or is at imminent risk
15 of being, subject to the authority of, or in need
16 of the services of, at least 1 public agency that
17 serves the needs of children, including an agen-
18 cy involved with child welfare, special education,
19 juvenile justice, or criminal justice.

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

1 (A) The system has established linkages
2 with existing mental health services and sub-
3 stance abuse treatment service delivery pro-
4 grams in the plan service area (or is in the
5 process of developing or operating a system
6 with appropriate public agencies in the area to
7 coordinate the delivery of such services to indi-
8 viduals in the area).

9 (B) The system provides for the participa-
10 tion and coordination of multiple agencies and
11 providers that serve the needs of children in the
12 area, including agencies and providers involved
13 with child welfare, education, juvenile justice,
14 criminal justice, health care, mental health, and
15 substance abuse prevention and treatment.

16 (C) The system provides for the involve-
17 ment of the families of children to whom mental
18 health services and substance abuse treatment
19 services are provided in the planning of treat-
20 ment and the delivery of services.

21 (D) The system provides for the develop-
22 ment and implementation of individualized
23 treatment plans by multidisciplinary and multi-
24 agency teams, which are recognized and fol-

1 lowed by the applicable agencies and providers
2 in the area.

3 (E) The system ensures the delivery and
4 coordination of the range of mental health serv-
5 ices and substance abuse treatment services re-
6 quired by individuals under 22 years of age who
7 have a serious emotional disturbance or a sub-
8 stance abuse disorder.

9 (F) The system provides for the manage-
10 ment of the individualized treatment plans de-
11 scribed in subparagraph (D) and for a flexible
12 response to changes in treatment needs over
13 time.

14 (c) TREATMENT OF EXPERIMENTAL SERVICES.—In
15 applying subsection (a), the Board shall make national
16 coverage determinations with respect to those services that
17 are experimental in nature. Such determinations shall be
18 made consistent with a process that provides for input
19 from representatives of health care professionals and pa-
20 tients and public comment.

21 (d) APPLICATION OF PRACTICE GUIDELINES.—In
22 the case of services for which the American Health Secu-
23 rity Quality Council (established under section 501) has
24 recognized a national practice guideline, the services are
25 considered to meet the standards specified in section

1 201(a) if they have been provided in accordance with such
2 guideline or in accordance with such guidelines as are pro-
3 vided by the State health security program consistent with
4 title V. For purposes of this subsection, a service shall
5 be considered to have been provided in accordance with
6 a practice guideline if the health care provider providing
7 the service exercised appropriate professional discretion to
8 deviate from the guideline in a manner authorized or an-
9 ticipated by the guideline.

10 (e) SPECIFIC LIMITATIONS.—

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

21 (2) OVERLAP WITH PREVENTIVE SERVICES.—

22 The coverage of services described in section 201(a)
23 (other than paragraph (3)) which also are preventive
24 services are required to be covered only to the extent

1 that they are required to be covered as preventive
2 services.

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

6 (A) Surgery and other procedures (such as
7 orthodontia) performed solely for cosmetic pur-
8 poses (as defined in regulations) and hospital or
9 other services incident thereto, unless—

10 (i) required to correct a congenital
11 anomaly;

12 (ii) required to restore or correct a
13 part of the body which has been altered as
14 a result of accidental injury, disease, or
15 surgery; or

16 (iii) otherwise determined to be medi-
17 cally necessary and appropriate under sec-
18 tion 201(a).

19 (B) Personal comfort items or private
20 rooms in inpatient facilities, unless determined
21 to be medically necessary and appropriate
22 under section 201(a).

23 (C) The services of a professional practi-
24 tioner if they are furnished in a hospital or

1 other facility which is not a participating pro-
2 vider.

3 (f) NURSING FACILITY SERVICES AND HOME
4 HEALTH SERVICES.—Nursing facility services and home
5 health services (other than post-hospital services, as de-
6 fined by the Board) furnished to an individual who is not
7 described in section 203(a) are not covered services unless
8 the services are determined to meet the standards speci-
9 fied in section 201(a) and, with respect to nursing facility
10 services, to be provided in the least restrictive and most
11 appropriate setting.

12 **SEC. 205. CERTIFICATION; QUALITY REVIEW; PLANS OF**
13 **CARE.**

14 (a) CERTIFICATIONS.—State health security pro-
15 grams may require, as a condition of payment for institu-
16 tional health care services and other services of the type
17 described in such sections 1814(a) and 1835(a) of the So-
18 cial Security Act, periodic professional certifications of the
19 kind described in such sections.

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

24 (c) PLAN OF CARE REQUIREMENTS.—A State health
25 security program may require, consistent with standards

1 established by the Board, that payment for services ex-
 2 ceeding specified levels or duration be provided only as
 3 consistent with a plan of care or treatment formulated by
 4 one or more providers of the services or other qualified
 5 professionals. Such a plan may include, consistent with
 6 subsection (b), case management at specified intervals as
 7 a further condition of payment for services.

8 **TITLE III—PROVIDER** 9 **PARTICIPATION**

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

11 (a) **IN GENERAL.**—An individual or other entity fur-
 12 nishing any covered service under a State health security
 13 program under this Act is not a qualified provider unless
 14 the individual or entity—

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

17 (2) has filed with the State health security pro-
 18 gram a participation agreement described in sub-
 19 section (b); and

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

23 (b) **REQUIREMENTS IN PARTICIPATION AGREE-**
 24 **MENT.**—

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

5 (A) Services to eligible persons will be fur-
6 nished by the provider without discrimination
7 on the ground of race, national origin, income,
8 religion, age, sex or sexual orientation, dis-
9 ability, handicapping condition, or (subject to
10 the professional qualifications of the provider)
11 illness. Nothing in this subparagraph shall be
12 construed as requiring the provision of a type
13 or class of services which services are outside
14 the scope of the provider's normal practice.

15 (B) No charge will be made for any cov-
16 ered services other than for payment authorized
17 by this Act.

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

23 (i) quality review by designated enti-
24 ties;

1 (ii) the making of payments under
2 this Act (including the examination of
3 records as may be necessary for the
4 verification of information on which pay-
5 ments are based);

6 (iii) statistical or other studies re-
7 quired for the implementation of this Act;
8 and

9 (iv) such other purposes as the Board
10 or State may specify.

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

14 (E) In the case of a provider that is not
15 an individual, the provider agrees not to employ
16 or use for the provision of health services any
17 individual or other provider who or which has
18 had a participation agreement under this sub-
19 section terminated for cause.

20 (F) In the case of a provider paid under a
21 fee-for-service basis under section 612, the pro-
22 vider agrees to submit bills and any required
23 supporting documentation relating to the provi-
24 sion of covered services within 30 days (or such
25 shorter period as a State health security pro-

1 gram may require) after the date of providing
2 such services.

3 (2) TERMINATION OF PARTICIPATION AGREE-
4 MENTS.—

5 (A) IN GENERAL.—Participation agree-
6 ments may be terminated, with appropriate no-
7 tice—

8 (i) by the Board or a State health se-
9 curity program for failure to meet the re-
10 quirements of this title; or

11 (ii) by a provider.

12 (B) TERMINATION PROCESS.—Providers
13 shall be provided notice and a reasonable oppor-
14 tunity to correct deficiencies before the Board
15 or a State health security program terminates
16 an agreement unless a more immediate termi-
17 nation is required for public safety or similar
18 reasons.

19 **SEC. 302. QUALIFICATIONS FOR PROVIDERS.**

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

23 (1) all the requirements of State law to provide
24 such services;

1 (2) applicable requirements of Federal law to
2 provide such services; and

3 (3) any applicable standards established under
4 subsection (b).

5 (b) MINIMUM PROVIDER STANDARDS.—

6 (1) IN GENERAL.—The Board shall establish,
7 evaluate, and update national minimum standards to
8 assure the quality of services provided under this
9 Act and to monitor efforts by State health security
10 programs to assure the quality of such services. A
11 State health security program may also establish ad-
12 ditional minimum standards which providers must
13 meet.

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

- 1 (A) adequacy and quality of facilities;
2 (B) training and competence of personnel
3 (including continuing education requirements);
4 (C) comprehensiveness of service;
5 (D) continuity of service;
6 (E) patient satisfaction (including waiting
7 time and access to services); and
8 (F) performance standards (including or-
9 ganization, facilities, structure of services, effi-
10 ciency of operation, and outcome in palliation,
11 improvement of health, stabilization, cure, or
12 rehabilitation).

13 (3) TRANSITION IN APPLICATION.—If the
14 Board provides for additional requirements for pro-
15 viders under this subsection, any such additional re-
16 quirement shall be implemented in a manner that
17 provides for a reasonable period during which a pre-
18 viously qualified provider is permitted to meet such
19 an additional requirement.

20 (4) EXCHANGE OF INFORMATION.—The Board
21 shall provide for an exchange, at least annually,
22 among State health security programs of informa-
23 tion with respect to quality assurance and cost con-
24 tainment.

1 **SEC. 303. QUALIFICATIONS FOR COMPREHENSIVE HEALTH**
2 **SERVICE ORGANIZATIONS.**

3 (a) IN GENERAL.—For purposes of this Act, a com-
4 prehensive health service organization (in this section re-
5 ferred to as a “CHSO”) is a public or private organization
6 which, in return for a capitated payment amount, under-
7 takes to furnish, arrange for the provision of, or provide
8 payment with respect to—

9 (1) a full range of health services (as identified
10 by the Board), including at least hospital services
11 and physicians services; and

12 (2) out-of-area coverage in the case of urgently
13 needed services;
14 to an identified population which is living in or near a
15 specified service area and which enrolls voluntarily in the
16 organization.

17 (b) ENROLLMENT.—

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

23 (2) MINIMUM ENROLLMENT PERIOD.—Subject
24 to paragraph (3), the minimum period of enrollment
25 with a CHSO shall be twelve months, unless the en-

1 rolled individual becomes ineligible to enroll with the
2 organization.

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

6 (c) REQUIREMENTS FOR CHSOs.—

7 (1) ACCESSIBLE SERVICES.—Each CHSO, to
8 the maximum extent feasible, shall make all services
9 readily and promptly accessible to enrollees who live
10 in the specified service area.

11 (2) CONTINUITY OF CARE.—Each CHSO shall
12 furnish services in such manner as to provide con-
13 tinuity of care and (when services are furnished by
14 different providers) shall provide ready referral of
15 patients to such services and at such times as may
16 be medically appropriate.

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

19 (A) CONSUMER REPRESENTATION.—At
20 least one-third of the members of the CHSO's
21 board of directors must be consumer members
22 with no direct or indirect, personal or family fi-
23 nancial relationship to the organization.

24 (B) PROVIDER REPRESENTATION.—The
25 CHSO's board of directors must include at

1 least one member who represents health care
2 providers.

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

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

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

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

22 (A) comply with the requirements of sec-
23 tion 1876(i)(8) of the Social Security Act (re-
24 lating to prohibiting physician incentive plans

1 that provide specific inducements to reduce or
2 limit medically necessary services); and

3 (B) make available to its membership utili-
4 zation information and data regarding financial
5 performance, including bonus or incentive pay-
6 ment arrangements to practitioners.

7 (8) PROVISION OF SERVICES TO ENROLLEES AT
8 INSTITUTIONS OPERATING UNDER GLOBAL BUDG-
9 ETS.—The organization shall arrange to reimburse
10 for hospital services and other facility-based services
11 (as identified by the Board) for services provided to
12 members of the organization in accordance with the
13 global operating budget of the hospital or facility ap-
14 proved under section 611.

15 (9) BROAD MARKETING.—Each CHSO must
16 provide for the marketing of its services (including
17 dissemination of marketing materials) to potential
18 enrollees in a manner that is designed to enroll indi-
19 viduals representative of the different population
20 groups and geographic areas included within its
21 service area and meets such requirements as the
22 Board or a State health security program may speci-
23 fy.

24 (10) ADDITIONAL REQUIREMENTS.—Each
25 CHSO must meet—

1 (A) such requirements relating to min-
2 imum enrollment;

3 (B) such requirements relating to financial
4 solvency;

5 (C) such requirements relating to quality
6 and availability of care; and

7 (D) such other requirements,

8 as the Board or a State health security program
9 may specify.

10 (d) PROVISION OF EMERGENCY SERVICES TO NON-
11 ENROLLEES.—A CHSO may furnish emergency services
12 to persons who are not enrolled in the organization. Pay-
13 ment for such services, if they are covered services to eligi-
14 ble persons, shall be made to the organization unless the
15 organization requests that it be made to the individual
16 provider who furnished the services.

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

18 (a) APPLICATION TO AMERICAN HEALTH SECURITY
19 PROGRAM.—Section 1877 of the Social Security Act, as
20 amended by subsections (b) and (c), shall apply under this
21 Act in the same manner as it applies under title XVIII
22 of the Social Security Act; except that in applying such
23 section under this Act any references in such section to
24 the Secretary or title XVIII of the Social Security Act are

1 deemed references to the Board and the American Health
2 Security Program under this Act, respectively.

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

7 “(M) Ambulance services.

8 “(N) Home infusion therapy services.”.

9 (c) CONFORMING AMENDMENTS.—Section 1877 of
10 such Act is further amended—

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

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

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

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

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

5 **TITLE IV—ADMINISTRATION**
6 **Subtitle A—General Administrative**
7 **Provisions**

8 **SEC. 401. AMERICAN HEALTH SECURITY STANDARDS**
9 **BOARD.**

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

12 (b) APPOINTMENT AND TERMS OF MEMBERS.—

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

15 (A) the Secretary of Health and Human
16 Services; and

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

20 The President shall first nominate individuals under
21 subparagraph (B) on a timely basis so as to provide
22 for the operation of the Board by not later than
23 January 1, 2010.

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 2 of them shall represent
11 the interests of individual consumers.

12 (C) Not more than 3 of them shall be from
13 the same political party.

14 (D) To the greatest extent feasible, they
15 shall represent the various geographic regions
16 of the United States and shall reflect the racial,
17 ethnic, and gender composition of the popu-
18 lation of the United States.

19 (3) TERMS OF APPOINTED MEMBERS.—Individ-
20 uals appointed under paragraph (1)(B) shall serve
21 for a term of 6 years, except that the terms of 5 of
22 the individuals initially appointed shall be, as des-
23 ignated by the President at the time of their ap-
24 pointment, for 1, 2, 3, 4, and 5 years. During a
25 term of membership on the Board, no member shall

1 engage in any other business, vocation or employ-
2 ment.

3 (c) VACANCIES.—

4 (1) IN GENERAL.—The President shall fill any
5 vacancy in the membership of the Board in the same
6 manner as the original appointment. The vacancy
7 shall not affect the power of the remaining members
8 to execute the duties of the Board.

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

13 (3) REAPPOINTMENT.—The President may re-
14 appoint an appointed member of the Board for a
15 second term in the same manner as the original ap-
16 pointment. A member who has served for 2 consecu-
17 tive 6-year terms shall not be eligible for reappoint-
18 ment until 2 years after the member has ceased to
19 serve.

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

23 (d) CHAIR.—The President shall designate 1 of the
24 members of the Board, other than the Secretary, to serve
25 at the will of the President as Chair of the Board.

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

6 (f) GENERAL DUTIES OF THE BOARD.—

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

10 (A) eligibility;

11 (B) enrollment;

12 (C) benefits;

13 (D) provider participation standards and
14 qualifications, as defined in title III;

15 (E) national and State funding levels;

16 (F) methods for determining amounts of
17 payments to providers of covered services, con-
18 sistent with subtitle B of title VI;

19 (G) the determination of medical necessity
20 and appropriateness with respect to coverage of
21 certain services;

22 (H) assisting State health security pro-
23 grams with planning for capital expenditures
24 and service delivery;

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

3 (J) allocating funds provided under title
4 VII; and

5 (K) encouraging States to develop regional
6 planning mechanisms (described in section
7 404(a)(3)).

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

12 (g) UNIFORM REPORTING STANDARDS; ANNUAL RE-
13 PORT; STUDIES.—

14 (1) UNIFORM REPORTING STANDARDS.—

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

24 (B) REPORTS.—The Board shall analyze
25 regularly information reported to it, and to

1 State health security programs pursuant to
2 such requirements and standards.

3 (2) ANNUAL REPORT.—Beginning January 1,
4 of the second year beginning after the date of the
5 enactment of this Act, the Board shall annually re-
6 port to Congress on the following:

7 (A) The status of implementation of the
8 Act.

9 (B) Enrollment under this Act.

10 (C) Benefits under this Act.

11 (D) Expenditures and financing under this
12 Act.

13 (E) Cost-containment measures and
14 achievements under this Act.

15 (F) Quality assurance.

16 (G) Health care utilization patterns, in-
17 cluding any changes attributable to the pro-
18 gram.

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

21 (I) Differences in the health status of the
22 populations of the different States, including in-
23 come and racial characteristics.

24 (J) Necessary changes in the education of
25 health personnel.

1 (K) Plans for improving service to medi-
2 cally underserved populations.

3 (L) Transition problems as a result of im-
4 plementation of this Act.

5 (M) Opportunities for improvements under
6 this Act.

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

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

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

1 (C) develop and test, for use by the Board,
2 records and information retrieval systems and
3 budget systems for health services administra-
4 tion, and develop and test model systems for
5 use by providers of services;

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

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

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

20 (4) REPORT ON USE OF EXISTING FEDERAL
21 HEALTH CARE FACILITIES.—Not later than 1 year
22 after the date of the enactment of this Act, the
23 Board shall recommend to the Congress one or more
24 proposals for the treatment of health care facilities
25 of the Federal Government.

1 (h) EXECUTIVE DIRECTOR.—

2 (1) APPOINTMENT.—There is hereby estab-
3 lished the position of Executive Director of the
4 Board. The Director shall be appointed by the
5 Board and shall serve as secretary to the Board and
6 perform such duties in the administration of this
7 title as the Board may assign.

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

16 (A) the issuance of regulations; or

17 (B) the determination of the availability of
18 funds and their allocation to implement this
19 Act.

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

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

3 (1) in section 12(1), by inserting after “Cor-
4 poration;” the first place it appears the following:
5 “the Chair of the American Health Security Stand-
6 ards Board;”;

7 (2) in section 12(2), by inserting after “Resolu-
8 tion Trust Corporation,” the following: “the Amer-
9 ican Health Security Standards Board,”; and

10 (3) by inserting before section 9 the following:

11 “SPECIAL PROVISIONS CONCERNING AMERICAN HEALTH
12 SECURITY STANDARDS BOARD

13 “SEC. 8M. The Inspector General of the American
14 Health Security Standards Board, in addition to the other
15 authorities vested by this Act, shall have the same author-
16 ity, with respect to the Board and the American Health
17 Security Program under this Act, as the Inspector General
18 for the Department of Health and Human Services has
19 with respect to the Secretary of Health and Human Serv-
20 ices and the medicare and medicaid programs, respec-
21 tively.”.

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

24 (k) ACCESS TO INFORMATION.—The Secretary of
25 Health and Human Services shall make available to the
26 Board all information available from sources within the

1 Department or from other sources, pertaining to the du-
2 ties of the Board.

3 **SEC. 402. AMERICAN HEALTH SECURITY ADVISORY COUN-**
4 **CIL.**

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

9 (b) MEMBERSHIP.—The Council shall be composed
10 of—

11 (1) the Chair of the Board, who shall serve as
12 Chair of the Council; and

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

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

1 the greatest extent feasible, the membership of the Council
2 shall represent the various geographic regions of the
3 United States and shall reflect the racial, ethnic, and gen-
4 der composition of the population of the United States.

5 (c) TERMS OF MEMBERS.—Each appointed member
6 shall hold office for a term of 4 years, except that—

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

11 (2) the terms of the members first taking office
12 shall expire, as designated by the Board at the time
13 of appointment, 5 at the end of the first year, 5 at
14 the end of the second year, 5 at the end of the third
15 year, and 5 at the end of the fourth year after the
16 date of enactment of this Act.

17 (d) VACANCIES.—

18 (1) IN GENERAL.—The Board shall fill any va-
19 cancy in the membership of the Council in the same
20 manner as the original appointment. The vacancy
21 shall not affect the power of the remaining members
22 to execute the duties of the Council.

23 (2) VACANCY APPOINTMENTS.—Any member
24 appointed to fill a vacancy shall serve for the re-

1 mainder of the term for which the predecessor of the
2 member was appointed.

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

7 (e) QUALIFICATIONS.—

8 (1) PUBLIC HEALTH REPRESENTATIVES.—
9 Members of the Council who are representative of
10 State health security programs and public health
11 professionals shall be individuals who have extensive
12 experience in the financing and delivery of care
13 under public health programs.

14 (2) PROVIDERS.—Members of the Council who
15 are representative of providers of health care shall
16 be individuals who are outstanding in fields related
17 to medical, hospital, or other health activities, or
18 who are representative of organizations or associa-
19 tions of professional health practitioners.

20 (3) CONSUMERS.—Members who are represent-
21 ative of consumers of such care shall be individuals,
22 not engaged in and having no financial interest in
23 the furnishing of health services, who are familiar
24 with the needs of various segments of the population
25 for personal health services and are experienced in

1 dealing with problems associated with the consump-
2 tion of such services.

3 (f) DUTIES.—

4 (1) IN GENERAL.—It shall be the duty of the
5 Council—

6 (A) to advise the Board on matters of gen-
7 eral policy in the administration of this Act, in
8 the formulation of regulations, and in the per-
9 formance of the Board's duties under section
10 401; and

11 (B) to study the operation of this Act and
12 the utilization of health services under it, with
13 a view to recommending any changes in the ad-
14 ministration of the Act or in its provisions
15 which may appear desirable.

16 (2) REPORT.—The Council shall make an an-
17 nual report to the Board on the performance of its
18 functions, including any recommendations it may
19 have with respect thereto, and the Board shall
20 promptly transmit the report to the Congress, to-
21 gether with a report by the Board on any rec-
22 ommendations of the Council that have not been fol-
23 lowed.

24 (g) STAFF.—The Council, its members, and any com-
25 mittees of the Council shall be provided with such secre-

1 tarial, clerical, or other assistance as may be authorized
2 by the Board for carrying out their respective functions.

3 (h) MEETINGS.—The Council shall meet as fre-
4 quently as the Board deems necessary, but not less than
5 4 times each year. Upon request by 7 or more members
6 it shall be the duty of the Chair to call a meeting of the
7 Council.

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

13 (j) FACA NOT APPLICABLE.—The provisions of the
14 Federal Advisory Committee Act shall not apply to the
15 Council.

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

17 The Secretary and the Board shall consult with pri-
18 vate entities, such as professional societies, national asso-
19 ciations, nationally recognized associations of experts,
20 medical schools and academic health centers, consumer
21 groups, and labor and business organizations in the for-
22 mulation of guidelines, regulations, policy initiatives, and
23 information gathering to assure the broadest and most in-
24 formed input in the administration of this Act. Nothing
25 in this Act shall prevent the Secretary from adopting

1 guidelines developed by such a private entity if, in the Sec-
2 retary's and Board's judgment, such guidelines are gen-
3 erally accepted as reasonable and prudent and consistent
4 with this Act.

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

6 (a) SUBMISSION OF PLANS.—

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

11 (2) REGIONAL PROGRAMS.—A State may join
12 with 1 or more neighboring States to submit to the
13 Board a plan for a regional health security program
14 instead of separate State health security programs.

15 (3) REGIONAL PLANNING MECHANISMS.—The
16 Board shall provide incentives for States to develop
17 regional planning mechanisms to promote the ration-
18 al distribution of, adequate access to, and efficient
19 use of, tertiary care facilities, equipment, and serv-
20 ices.

21 (b) REVIEW AND APPROVAL OF PLANS.—

22 (1) IN GENERAL.—The Board shall review
23 plans submitted under subsection (a) and determine
24 whether such plans meet the requirements for ap-
25 proval. The Board shall not approve such a plan un-

1 less it finds that the plan (or State law) provides,
2 consistent with the provisions of this Act, for the fol-
3 lowing:

4 (A) Payment for required health services
5 for eligible individuals in the State in accord-
6 ance with this Act.

7 (B) Adequate administration, including the
8 designation of a single State agency responsible
9 for the administration (or supervision of the ad-
10 ministration) of the program.

11 (C) The establishment of a State health se-
12 curity budget.

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

15 (E) Assurances that individuals have the
16 freedom to choose practitioners and other
17 health care providers for services covered under
18 this Act.

19 (F) A procedure for carrying out long-term
20 regional management and planning functions
21 with respect to the delivery and distribution of
22 health care services that—

23 (i) ensures participation of consumers
24 of health services and providers of health
25 services; and

1 (ii) gives priority to the most acute
2 shortages and maldistributions of health
3 personnel and facilities and the most seri-
4 ous deficiencies in the delivery of covered
5 services and to the means for the speedy
6 alleviation of these shortcomings.

7 (G) The licensure and regulation of all
8 health providers and facilities to ensure compli-
9 ance with Federal and State laws and to pro-
10 mote quality of care.

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

13 (I) Establishment of an independent om-
14 budsman for consumers to register complaints
15 about the organization and administration of
16 the State health security program and to help
17 resolve complaints and disputes between con-
18 sumers and providers.

19 (J) Publication of an annual report on the
20 operation of the State health security program,
21 which report shall include information on cost,
22 progress towards achieving full enrollment, pub-
23 lic access to health services, quality review,
24 health outcomes, health professional training,

1 and the needs of medically underserved popu-
 2 lations.

3 (K) Provision of a fraud and abuse preven-
 4 tion and control unit that the Inspector General
 5 determines meets the requirements of section
 6 412(a).

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

9 (2) CONSEQUENCES OF FAILURE TO COMPLY.—

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

22 (c) STATE HEALTH SECURITY ADVISORY COUN-
 23 CILS.—

24 (1) IN GENERAL.—For each State, the Gov-
 25 ernor shall provide for appointment of a State

1 Health Security Advisory Council to advise and
2 make recommendations to the Governor and State
3 with respect to the implementation of the State
4 health security program in the State.

5 (2) MEMBERSHIP.—Each State Health Security
6 Advisory Council shall be composed of at least 11 in-
7 dividuals. The appointed members shall include indi-
8 viduals who are representative of the State health
9 security program, public health professionals, pro-
10 viders of health services, and of individuals (who
11 shall constitute a majority) who are representative of
12 consumers of such services, including a balanced
13 representation of employers, unions and consumer
14 organizations. To the greatest extent feasible, the
15 membership of each State Health Security Advisory
16 Council shall represent the various geographic re-
17 gions of the State and shall reflect the racial, ethnic,
18 and gender composition of the population of the
19 State.

20 (3) DUTIES.—

21 (A) IN GENERAL.—Each State Health Se-
22 curity Advisory Council shall review, and sub-
23 mit comments to the Governor concerning the
24 implementation of the State health security pro-
25 gram in the State.

1 (B) ASSISTANCE.—Each State Health Se-
2 curity Advisory Council shall provide assistance
3 and technical support to community organiza-
4 tions and public and private non-profit agencies
5 submitting applications for funding under ap-
6 propriate State and Federal public health pro-
7 grams, with particular emphasis placed on as-
8 sisting those applicants with broad consumer
9 representation.

10 (d) STATE USE OF FISCAL AGENTS.—

11 (1) IN GENERAL.—Each State health security
12 program, using competitive bidding procedures, may
13 enter into such contracts with qualified entities, such
14 as voluntary associations, as the State determines to
15 be appropriate to process claims and to perform
16 other related functions of fiscal agents under the
17 State health security program.

18 (2) RESTRICTION.—Except as the Board may
19 provide for good cause shown, in no case may more
20 than 1 contract described in paragraph (1) be en-
21 tered into under a State health security program.

22 **SEC. 405. COMPLEMENTARY CONDUCT OF RELATED**
23 **HEALTH PROGRAMS.**

24 In performing functions with respect to health per-
25 sonnel education and training, health research, environ-

1 mental health, disability insurance, vocational rehabilita-
2 tion, the regulation of food and drugs, and all other mat-
3 ters pertaining to health, the Secretary of Health and
4 Human Services shall direct all activities of the Depart-
5 ment of Health and Human Services toward contributions
6 to the health of the people complementary to this Act.

7 **Subtitle B—Control Over Fraud** 8 **and Abuse**

9 **SEC. 411. APPLICATION OF FEDERAL SANCTIONS TO ALL** 10 **FRAUD AND ABUSE UNDER AMERICAN** 11 **HEALTH SECURITY PROGRAM.**

12 The following sections of the Social Security Act shall
13 apply to State health security programs in the same man-
14 ner as they apply to State medical assistance plans under
15 title XIX of such Act (except that in applying such provi-
16 sions any reference to the Secretary is deemed a reference
17 to the Board):

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

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

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

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

24 (5) Section 1126 (relating to disclosure of cer-
25 tain owners).

1 **SEC. 412. REQUIREMENTS FOR OPERATION OF STATE**
2 **HEALTH CARE FRAUD AND ABUSE CONTROL**
3 **UNITS.**

4 (a) **REQUIREMENT.**—In order to meet the require-
5 ment of section 404(b)(1)(K), each State health security
6 program must establish and maintain a health care fraud
7 and abuse control unit (in this section referred to as a
8 “fraud unit”) that meets requirements of this section and
9 other requirements of the Board. Such a unit may be a
10 State medicaid fraud control unit (described in section
11 1903(q) of the Social Security Act).

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

13 (1) be a single identifiable entity of the State
14 government;

15 (2) be separate and distinct from the State
16 agency with principal responsibility for the adminis-
17 tration of the State health security program; and

18 (3) meet 1 of the following requirements:

19 (A) It must be a unit of the office of the
20 State Attorney General or of another depart-
21 ment of State government which possesses
22 statewide authority to prosecute individuals for
23 criminal violations.

24 (B) If it is in a State the constitution of
25 which does not provide for the criminal prosecu-
26 tion of individuals by a statewide authority and

1 has formal procedures, approved by the Board,
2 that—

3 (i) assure its referral of suspected
4 criminal violations relating to the State
5 health insurance plan to the appropriate
6 authority or authorities in the States for
7 prosecution; and

8 (ii) assure its assistance of, and co-
9 ordination with, such authority or authori-
10 ties in such prosecutions.

11 (C) It must have a formal working rela-
12 tionship with the office of the State Attorney
13 General and have formal procedures (including
14 procedures for its referral of suspected criminal
15 violations to such office) which are approved by
16 the Board and which provide effective coordina-
17 tion of activities between the fraud unit and
18 such office with respect to the detection, inves-
19 tigation, and prosecution of suspected criminal
20 violations relating to the State health insurance
21 plan.

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

23 (1) have the function of conducting a statewide
24 program for the investigation and prosecution of vio-
25 lations of all applicable State laws regarding any

1 and all aspects of fraud in connection with any as-
2 pect of the provision of health care services and ac-
3 tivities of providers of such services under the State
4 health security program;

5 (2) have procedures for reviewing complaints of
6 the abuse and neglect of patients of providers and
7 facilities that receive payments under the State
8 health security program, and, where appropriate, for
9 acting upon such complaints under the criminal laws
10 of the State or for referring them to other State
11 agencies for action; and

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

17 (d) RESOURCES.—The fraud unit must—

18 (1) employ such auditors, attorneys, investiga-
19 tors, and other necessary personnel;

20 (2) be organized in such a manner; and

21 (3) provide sufficient resources (as specified by
22 the Board),

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

1 (e) COOPERATIVE AGREEMENTS.—The fraud unit
 2 must have cooperative agreements (as specified by the
 3 Board) with—

- 4 (1) similar fraud units in other States;
- 5 (2) the Inspector General; and
- 6 (3) the Attorney General of the United States.

7 (f) REPORTS.—The fraud unit must submit to the
 8 Inspector General an application and annual reports con-
 9 taining such information as the Inspector General deter-
 10 mines to be necessary to determine whether the unit meets
 11 the previous requirements of this section.

12 **TITLE V—QUALITY ASSESSMENT**

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

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

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

- 19 (1) PRACTICE GUIDELINES.—The Council shall
 20 review and evaluate each practice guideline devel-
 21 oped under part B of title IX of the Public Health
 22 Service Act. The Council shall determine whether
 23 the guideline should be recognized as a national
 24 practice guideline to be used under section 204(d)

1 for purposes of determining payments under a State
2 health security program.

3 (2) STANDARDS OF QUALITY, PERFORMANCE
4 MEASURES, AND MEDICAL REVIEW CRITERIA.—The
5 Council shall review and evaluate each standard of
6 quality, performance measure, and medical review
7 criterion developed under part B of title IX of the
8 Public Health Service Act. The Council shall deter-
9 mine whether the standard, measure, or criterion is
10 appropriate for use in assessing or reviewing the
11 quality of services provided by State health security
12 programs, health care institutions, or health care
13 professionals.

14 (3) CRITERIA FOR ENTITIES CONDUCTING
15 QUALITY REVIEWS.—The Council shall develop min-
16 imum criteria for competence for entities that can
17 qualify to conduct ongoing and continuous external
18 quality review for State quality review programs
19 under section 503. Such criteria shall require such
20 an entity to be administratively independent of the
21 individual or board that administers the State health
22 security program and shall ensure that such entities
23 do not provide financial incentives to reviewers to
24 favor one pattern of practice over another. The
25 Council shall ensure coordination and reporting by

1 such entities to assure national consistency in qual-
2 ity standards.

3 (4) REPORTING.—The Council shall report to
4 the Board annually on the conduct of activities
5 under such title and shall report to the Board annu-
6 ally specifically on findings from outcomes research
7 and development of practice guidelines that may af-
8 fect the Board’s determination of coverage of serv-
9 ices under section 401(f)(1)(G).

10 (5) OTHER FUNCTIONS.—The Council shall
11 perform the functions of the Council described in
12 section 502.

13 (c) APPOINTMENT AND TERMS OF MEMBERS.—

14 (1) IN GENERAL.—The Council shall be com-
15 posed of 10 members appointed by the President.
16 The President shall first appoint individuals on a
17 timely basis so as to provide for the operation of the
18 Council by not later than January 1, 2010.

19 (2) SELECTION OF MEMBERS.—Each member
20 of the Council shall be a member of a health profes-
21 sion. Five members of the Council shall be physi-
22 cians. Individuals shall be appointed to the Council
23 on the basis of national reputations for clinical and
24 academic excellence. To the greatest extent feasible,
25 the membership of the Council shall represent the

1 various geographic regions of the United States and
2 shall reflect the racial, ethnic, and gender composi-
3 tion of the population of the United States.

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 (d) 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 2 consecutive 5-year
24 terms shall not be eligible for reappointment until 2
25 years after the member has ceased to serve.

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

4 (f) 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 **SEC. 502. DEVELOPMENT OF CERTAIN METHODOLOGIES,**
10 **GUIDELINES, AND STANDARDS.**

11 (a) PROFILING OF PATTERNS OF PRACTICE; IDENTI-
12 FICATION OF OUTLIERS.—The Council shall adopt meth-
13 odologies for profiling the patterns of practice of health
14 care professionals and for identifying outliers (as defined
15 in subsection (e)).

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

1 (c) REMEDIAL ACTIONS.—The Council shall develop
2 standards for education and sanctions with respect to
3 outliers so as to assure the quality of health care services
4 provided under this Act. The Council shall develop criteria
5 for referral of providers to the State licensing board if edu-
6 cation proves ineffective in correcting provider practice be-
7 havior.

8 (d) DISSEMINATION.—The Council shall disseminate
9 to the State—

10 (1) the methodologies adopted under subsection

11 (a);

12 (2) the guidelines developed under subsection

13 (b); and

14 (3) the standards developed under subsection

15 (c);

16 for use by the States under section 503.

17 (e) OUTLIER DEFINED.—In this title, the term
18 “outlier” means a health care provider whose pattern of
19 practice, relative to applicable practice guidelines, suggests
20 deficiencies in the quality of health care services being pro-
21 vided.

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

23 (a) REQUIREMENT.—In order to meet the require-
24 ment of section 404(b)(1)(H), each State health security
25 program shall establish 1 or more qualified entities to con-

1 duct quality reviews of persons providing covered services
2 under the program, in accordance with standards estab-
3 lished under subsection (b)(1) (except as provided in sub-
4 section (b)(2)) and subsection (d).

5 (b) FEDERAL STANDARDS.—

6 (1) IN GENERAL.—The Council shall establish
7 standards with respect to—

8 (A) the adoption of practice guidelines
9 (whether developed by the Federal Government
10 or other entities);

11 (B) the identification of outliers (con-
12 sistent with methodologies adopted under sec-
13 tion 502(a));

14 (C) the development of remedial programs
15 and monitoring for outliers; and

16 (D) the application of sanctions (consistent
17 with the standards developed under section
18 502(c)).

19 (2) STATE DISCRETION.—A State may apply
20 under subsection (a) standards other than those es-
21 tablished under paragraph (1) so long as the State
22 demonstrates to the satisfaction of the Council on an
23 annual basis that the standards applied have been as
24 efficacious in promoting and achieving improved
25 quality of care as the application of the standards

1 established under paragraph (1). Positive improve-
2 ments in quality shall be documented by reductions
3 in the variations of clinical care process and im-
4 provement in patient outcomes.

5 (c) QUALIFICATIONS.—An entity is not qualified to
6 conduct quality reviews under subsection (a) unless the
7 entity satisfies the criteria for competence for such entities
8 developed by the Council under section 501(b)(3).

9 (d) INTERNAL QUALITY REVIEW.—Nothing in this
10 section shall preclude an institutional provider from estab-
11 lishing its own internal quality review and enhancement
12 programs.

13 **SEC. 504. ELIMINATION OF UTILIZATION REVIEW PRO-**
14 **GRAMS; TRANSITION.**

15 (a) INTENT.—It is the intention of this title to re-
16 place by January 1, 2013, random utilization controls with
17 a systematic review of patterns of practice that com-
18 promise the quality of care.

19 (b) SUPERSEDING CASE REVIEWS.—

20 (1) IN GENERAL.—Subject to the succeeding
21 provisions of this subsection, the program of quality
22 review provided under the previous sections of this
23 title supersede all existing Federal requirements for
24 utilization review programs, including requirements
25 for random case-by-case reviews and programs re-

1 quiring pre-certification of medical procedures on a
2 case-by-case basis.

3 (2) TRANSITION.—Before January 1, 2013, the
4 Board and the States may employ existing utiliza-
5 tion review standards and mechanisms as may be
6 necessary to effect the transition to pattern of prac-
7 tice-based reviews.

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

10 (A) as precluding the case-by-case review
11 of the provision of care—

12 (i) in individual incidents where the
13 quality of care has significantly deviated
14 from acceptable standards of practice; and

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

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

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 2010), 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 (A) zero, or,
14 if greater, (B) the average annual percentage in-
15 crease in the gross domestic product (in current dol-
16 lars) during the 3-year period beginning with the
17 first quarter of the fourth previous year to the first
18 quarter of the previous year minus the percentage
19 increase (if any) in the number of eligible individuals
20 residing in any State the United States from the
21 first quarter of the second previous year to the first
22 quarter of the previous year.

23 (c) DEFINITIONS.—In this title:

24 (1) CAPITAL EXPENDITURES.—The term “cap-
25 ital expenditures” means expenses for the purchase,

1 lease, construction, or renovation of capital facilities
 2 and for equipment and includes return on equity
 3 capital.

4 (2) HEALTH PROFESSIONAL EDUCATION EX-
 5 PENDITURES.—The term “health professional edu-
 6 cation expenditures” means expenditures in hospitals
 7 and other health care facilities to cover costs associ-
 8 ated with teaching and related research activities.

9 **SEC. 602. COMPUTATION OF INDIVIDUAL AND STATE CAPI-**
 10 **TATION AMOUNTS.**

11 (a) CAPITATION AMOUNTS.—

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

22 (A) a national average per capita cost for
 23 all covered health care services (computed
 24 under subsection (b));

1 (B) the State adjustment factor (estab-
2 lished under subsection (c)) for the State; and

3 (C) the risk adjustment factor (established
4 under subsection (d)) for the risk group.

5 (2) STATE CAPITATION AMOUNT.—

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

13 (B) USE OF STATISTICAL MODEL.—The
14 Board may provide for the computation of
15 State capitation amounts based on statistical
16 models that fairly reflect the elements that com-
17 prise the State capitation amount described in
18 subparagraph (A).

19 (C) POPULATION INFORMATION.—The Bu-
20 reau of the Census shall assist the Board in de-
21 termining the number, place of residence, and
22 risk group classification of eligible individuals.

23 (b) COMPUTATION OF NATIONAL AVERAGE PER CAP-
24 ITA COST.—

1 (1) FOR 2010.—For 2010, the national average
2 per capita cost under this paragraph is equal to—

3 (A) the average per capita health care ex-
4 penditures in the United States in 2008 (as es-
5 timated by the Board);

6 (B) increased to 2009 by the Board’s esti-
7 mate of the actual amount of such per capita
8 expenditures during 2009; and

9 (C) updated to 2010 by the national health
10 security spending growth limit specified in sec-
11 tion 601(b)(2) for 2010.

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

19 (c) STATE ADJUSTMENT FACTORS.—

20 (1) IN GENERAL.—Subject to the succeeding
21 paragraphs of this subsection, the Board shall de-
22 velop for each State a factor to adjust the national
23 average per capita costs to reflect differences be-
24 tween the State and the United States in—

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

3 (B) any social, environmental, or geo-
4 graphic condition affecting health status or the
5 need for health care services, to the extent such
6 a condition is not taken into account in the es-
7 tablishment of risk groups under subsection (d);

8 (C) the geographic distribution of the
9 State's population, particularly the proportion
10 of the population residing in medically under-
11 served areas, to the extent such a condition is
12 not taken into account in the establishment of
13 risk groups under subsection (d); and

14 (D) any other factor relating to operating
15 costs required to assure equitable distribution
16 of funds among the States.

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

23 (A) differences among States in health
24 professional education programs in operation as
25 of the date of the enactment of this Act; and

1 (B) differences among States in their rel-
2 ative need for expenditures for health profes-
3 sional education, taking into account the health
4 professional education expenditures proposed in
5 State health security budgets under section
6 603(a).

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

14 (4) PHASE-IN.—In applying State adjustment
15 factors under this subsection during the 5-year pe-
16 riod beginning with 2010, the Board shall phase-in,
17 over such period, the use of factors described in
18 paragraph (1) in a manner so that the adjustment
19 factor for a State is based on a blend of such factors
20 and a factor that reflects the relative actual average
21 per capita costs of health services of the different
22 States as of the time of enactment of this Act.

23 (5) PERIODIC ADJUSTMENT.—In establishing
24 the national health security budget before the begin-
25 ning of each year, the Board shall provide for appro-

1 appropriate adjustments in the State adjustment factors
2 under this subsection.

3 (d) ADJUSTMENTS FOR RISK GROUP CLASSIFICA-
4 TION.—

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

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

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

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

23 (a) ESTABLISHMENT AND SUBMISSION OF BUDG-
24 ETS.—

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

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

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

13 (ii) Within the operating component—

14 (I) expenditures for operating
15 costs of hospitals and other facility-
16 based services in the State;

17 (II) expenditures for payment to
18 comprehensive health service organiza-
19 tions;

20 (III) expenditures for payment of
21 services provided by health care prac-
22 titioners; and

23 (IV) expenditures for other cov-
24 ered items and services.

1 Amounts included in the operating compo-
2 nent include amounts that may be used by
3 providers for capital expenditures.

4 (B) The total revenues required to meet
5 the State health security expenditures.

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

9 (3) FINAL BUDGET.—The final budget for a
10 year shall—

11 (A) be established and submitted under
12 paragraph (1) not later than October 1 before
13 the year, and

14 (B) take into account the amounts estab-
15 lished under the national health security budget
16 under section 601 for the year.

17 (4) ADJUSTMENT IN ALLOCATIONS PER-
18 MITTED.—

19 (A) IN GENERAL.—Subject to subpara-
20 graphs (B) and (C), in the case of a final budg-
21 et, a State may change the allocation of
22 amounts among components.

23 (B) NOTICE.—No such change may be
24 made unless the State has provided prior notice
25 of the change to the Board.

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

4 (b) EXPENDITURE LIMITS.—

5 (1) IN GENERAL.—The total expenditures speci-
6 fied in each State health security budget under sub-
7 section (a)(1) shall take into account Federal con-
8 tributions made under section 604.

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

19 (3) WORKER ASSISTANCE.—A State health se-
20 curity program may provide that, for budgets for
21 years before 2013, up to 1 percent of the budget
22 may be used for purposes of programs providing as-
23 sistance to workers who are currently performing
24 functions in the administration of the health insur-
25 ance system and who may experience economic dis-

1 location as a result of the implementation of the pro-
2 gram.

3 (c) APPROVAL PROCESS FOR CAPITAL EXPENDI-
4 TURES PERMITTED.—Nothing in this title shall be con-
5 strued as preventing a State health security program from
6 providing for a process for the approval of capital expendi-
7 tures based on information derived from regional planning
8 agencies.

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

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

15 (1) the State capitation amount (computed
16 under section 602(a)(2)) for the State for the year;
17 and

18 (2) the Federal contribution percentage (estab-
19 lished under subsection (b)).

20 (b) FEDERAL CONTRIBUTION PERCENTAGE.—The
21 Board shall establish a formula for the establishment of
22 a Federal contribution percentage for each State. Such
23 formula shall take into consideration a State's per capita
24 income and revenue capacity and such other relevant eco-
25 nomic indicators as the Board determines to be appro-

1 priate. In addition, during the 5-year period beginning
2 with 2010, the Board may provide for a transition adjust-
3 ment to the formula in order to take into account current
4 expenditures by the State (and local governments thereof)
5 for health services covered under the State health security
6 program. The weighted-average Federal contribution per-
7 centage for all States shall equal 86 percent and in no
8 event shall such percentage be less than 81 percent nor
9 more than 91 percent.

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

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

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

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

21 **SEC. 605. ACCOUNT FOR HEALTH PROFESSIONAL EDU-**
22 **CATION EXPENDITURES.**

23 (a) SEPARATE ACCOUNT.—Each State health secu-
24 rity program shall—

1 (1) include a separate account for health pro-
2 fessional education expenditures; and

3 (2) specify the general manner, consistent with
4 subsection (b), in which such expenditures are to be
5 distributed among different types of institutions and
6 the different areas of the State.

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

10 (1) The disbursement of funds must be con-
11 sistent with achievement of the national and pro-
12 gram goals (specified in section 701(b)) within the
13 State health security program and the distribution
14 of funds from the account must be conditioned upon
15 the receipt of such reports as the Board may require
16 in order to monitor compliance with such goals.

17 (2) The distribution of funds from the account
18 must take into account the potentially higher costs
19 of placing health professional students in clinical
20 education programs in health professional shortage
21 areas.

1 **Subtitle B—Payments by States to**
2 **Providers**

3 **SEC. 611. PAYMENTS TO HOSPITALS AND OTHER FACILITY-**
4 **BASED SERVICES FOR OPERATING EXPENSES**
5 **ON THE BASIS OF APPROVED GLOBAL BUDG-**
6 **ETS.**

7 (a) DIRECT PAYMENT UNDER GLOBAL BUDGET.—

8 Payment for operating expenses for institutional and facil-
9 ity-based care, including hospital services and nursing fa-
10 cility services, under State health security programs shall
11 be made directly to each institution or facility by each
12 State health security program under an annual prospec-
13 tive global budget approved under the program. Such a
14 budget shall include payment for outpatient care and non-
15 facility-based care that is furnished by or through the fa-
16 cility. In the case of a hospital that is wholly owned (or
17 controlled) by a comprehensive health service organization
18 that is paid under section 614 on the basis of a global
19 budget, the global budget of the organization shall include
20 the budget for the hospital.

21 (b) ANNUAL NEGOTIATIONS; BUDGET APPROVAL.—

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

24 (A) be developed through annual negotia-
25 tions between—

1 (i) a panel of individuals who are ap-
2 pointed by the Governor of the State and
3 who represent consumers, labor, business,
4 and the State government; and

5 (ii) the institution or facility; and

6 (B) be based on a nationally uniform sys-
7 tem of cost accounting established under stand-
8 ards of the Board.

9 (2) CONSIDERATIONS.—In developing a budget
10 through negotiations, there shall be taken into ac-
11 count at least the following:

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

15 (B) An institution's or facility's past ex-
16 penditures.

17 (C) The extent to which debt service for
18 capital expenditures has been included in the
19 proposed operating budget.

20 (D) The extent to which capital expendi-
21 tures are financed directly or indirectly through
22 reductions in direct care to patients, including
23 (but not limited to) reductions in registered
24 nursing staffing patterns or changes in emer-

1 agency room or primary care services or avail-
2 ability.

3 (E) Change in the consumer price index
4 and other price indices.

5 (F) The cost of reasonable compensation
6 to health care practitioners.

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

9 (H) The extent to which the institution or
10 facility is providing health care services to meet
11 the needs of residents in the area served by the
12 institution or facility, including the institution's
13 or facility's occupancy level.

14 (I) The institution's or facility's previous
15 financial and clinical performance, based on uti-
16 lization and outcomes data provided under this
17 Act.

18 (J) The type of institution or facility, in-
19 cluding whether the institution or facility is
20 part of a clinical education program or serves
21 a health professional education, research or
22 other training purpose.

23 (K) Technological advances or changes.

1 (L) Costs of the institution or facility asso-
2 ciated with meeting Federal and State regula-
3 tions.

4 (M) The costs associated with necessary
5 public outreach activities.

6 (N) In the case of a for-profit facility, a
7 reasonable rate of return on equity capital,
8 independent of those operating expenses nec-
9 essary to fulfill the objectives of this Act.

10 (O) Incentives to facilities that maintain
11 costs below previous reasonable budgeted levels
12 without reducing the care provided.

13 (P) With respect to facilities that provide
14 mental health services and substance abuse
15 treatment services, any additional costs involved
16 in the treatment of dually diagnosed individ-
17 uals.

18 The portion of such a budget that relates to expendi-
19 tures for health professional education shall be con-
20 sistent with the State health security budget for
21 such expenditures.

22 (3) PROVISION OF REQUIRED INFORMATION; DI-
23 AGNOSIS-RELATED GROUP.—No budget for an insti-
24 tution or facility for a year may be approved unless
25 the institution or facility has submitted on a timely

1 basis to the State health security program such in-
2 formation as the program or the Board shall specify,
3 including in the case of hospitals information on dis-
4 charges classified by diagnosis-related group.

5 (c) ADJUSTMENTS IN APPROVED BUDGETS.—

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

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

20 (d) DONATIONS PERMISSIBLE.—The States health
21 security programs may permit institutions and facilities
22 to raise funds from private sources to pay for newly con-
23 structed facilities, major renovations, and equipment. The
24 expenditure of such funds, whether for operating or cap-
25 ital expenditures, does not obligate the State health secu-

1 rity program to provide for continued support for such ex-
2 penditures unless included in an approved global budget.

3 **SEC. 612. PAYMENTS TO HEALTH CARE PRACTITIONERS**

4 **BASED ON PROSPECTIVE FEE SCHEDULE.**

5 (a) FEE FOR SERVICE.—

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

11 (2) GLOBAL FEE PAYMENT METHODOLOGIES.—

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

22 (3) BILLING DEADLINES; ELECTRONIC BILL-
23 ING.—A State health security program may deny
24 payment for any service of an independent health
25 care practitioner for which it did not receive a bill

1 and appropriate supporting documentation (which
2 had been previously specified) within 30 days after
3 the date the service was provided. Such a program
4 may require that bills for services for which payment
5 may be made under this section, or for any class of
6 such services, be submitted electronically.

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

23 (c) BILLABLE COVERED SERVICE DEFINED.—In this
24 section, the term “billable covered service” means a service
25 covered under section 201 for which a practitioner is enti-

1 tled to compensation by payment of a fee determined
2 under this section.

3 **SEC. 613. PAYMENTS TO COMPREHENSIVE HEALTH SERV-**
4 **ICE ORGANIZATIONS.**

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

8 (1) based on a global budget described in sec-
9 tion 611; or

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

12 (b) BASIC CAPITATION AMOUNT.—

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

21 (2) ADJUSTMENT FOR SPECIAL HEALTH
22 NEEDS.—The State health security program shall
23 adjust such average amounts to take into account
24 the special health needs, including a disproportionate

1 number of medically underserved individuals, of pop-
2 ulations served by the organization.

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

9 **SEC. 614. PAYMENTS FOR COMMUNITY-BASED PRIMARY**
10 **HEALTH SERVICES.**

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

14 (1) be based on a global budget described in
15 section 611;

16 (2) be based on the basic primary care capita-
17 tion amount described in subsection (c) for each in-
18 dividual enrolled with the provider of such services;
19 or

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

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

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

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

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

19 (c) BASIC PRIMARY CARE CAPITATION AMOUNT.—

20 (1) IN GENERAL.—The basic primary care capi-
21 tation amount described in this subsection for an en-
22 rollee with a provider of community-based primary
23 health services shall be determined by the State
24 health security program on the basis of the average
25 amount of expenditures that is estimated would be

1 made under the State health security program for
 2 such an enrollee, based on actuarial characteristics
 3 (as defined by the State health security program).

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

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

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

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

20 (a) ESTABLISHMENT OF LIST.—

21 (1) IN GENERAL.—The Board shall establish a
 22 list of approved prescription drugs and biologicals
 23 that the Board determines are necessary for the
 24 maintenance or restoration of health or of employ-

1 ability or self-management and eligible for coverage
2 under this Act.

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

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

16 (c) CHARGES BY INDEPENDENT PHARMACIES.—
17 Each State health security program shall provide for pay-
18 ment for a prescription drug or biological or insulin fur-
19 nished by an independent pharmacy based on the drug's
20 cost to the pharmacy (not in excess of the applicable prod-
21 uct price established under subsection (b)) plus a dis-
22 pensing fee. In accordance with standards established by
23 the Board, each State health security program, after con-
24 sultation with representatives of the pharmaceutical pro-
25 fession, shall establish schedules of dispensing fees, de-

1 signed to afford reasonable compensation to independent
2 pharmacies after taking into account variations in their
3 cost of operation resulting from regional differences, dif-
4 ferences in the volume of prescription drugs dispensed, dif-
5 ferences in services provided, the need to maintain expend-
6 itures within the budgets established under this title, and
7 other relevant factors.

8 **SEC. 616. PAYMENTS FOR APPROVED DEVICES AND EQUIP-**
9 **MENT.**

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

17 (b) **CONSIDERATIONS AND CONDITIONS.**—In estab-
18 lishing the list under subsection (a), the Board shall take
19 into consideration the efficacy, safety, and cost of each
20 item contained on such list, and shall attach to any item
21 such conditions as the Board determines appropriate with
22 respect to the circumstances under which, or the frequency
23 with which, the item may be prescribed.

24 (c) **PRICES.**—For each such listed item covered under
25 this Act, the Board shall from time to time determine a

1 product price or prices which shall constitute the max-
2 imum to be recognized under this Act as the cost of the
3 item to a provider thereof. The Board may conduct nego-
4 tiations, on behalf of State health security programs, with
5 equipment and device manufacturers and distributors in
6 determining the applicable product price or prices.

7 (d) EXCLUSIONS.—The Board may exclude from cov-
8 erage under this Act ineffective, unsafe, or overpriced
9 products where better alternatives are determined to be
10 available.

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

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

15 (1) in accordance with payment methodologies
16 which are specified by the Board, after consultation
17 with the American Health Security Advisory Coun-
18 cil, or methodologies established by the State under
19 section 620; and

20 (2) consistent with the State health security
21 budget.

22 **SEC. 618. PAYMENT INCENTIVES FOR MEDICALLY UNDER-**
23 **SERVED AREAS.**

24 (a) MODEL PAYMENT METHODOLOGIES.—In addi-
25 tion to the payment amounts otherwise provided in this

1 title, the Board shall establish model payment methodolo-
2 gies and other incentives that promote the provision of
3 covered health care services in medically underserved
4 areas, particularly in rural and inner-city underserved
5 areas.

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

12 **SEC. 619. AUTHORITY FOR ALTERNATIVE PAYMENT METH-**
13 **ODOLOGIES.**

14 A State health security program, as part of its plan
15 under section 404(a), may use a payment methodology
16 other than a methodology required under this subtitle so
17 long as—

18 (1) such payment methodology does not affect
19 the entitlement of individuals to coverage, the
20 weighting of fee schedules to encourage an increase
21 in the number of primary care providers, the ability
22 of individuals to choose among qualified providers,
23 the benefits covered under the program, or the com-
24 pliance of the program with the State health security
25 budget under subtitle A; and

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

6 **Subtitle C—Mandatory Assignment**
7 **and Administrative Provisions**

8 **SEC. 631. MANDATORY ASSIGNMENT.**

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

18 (b) ENFORCEMENT.—If an entity knowingly and will-
19 fully bills for an item or service or accepts payment in
20 violation of subsection (a), the Board may apply sanctions
21 against the entity in the same manner as sanctions could
22 have been imposed under section 1842(j)(2) of the Social
23 Security Act for a violation of section 1842(j)(1) of such
24 Act. Such sanctions are in addition to any sanctions that

1 a State may impose under its State health security pro-
2 gram.

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

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

10 (b) APPEALS PROCESS.—Each State health security
11 program shall establish an appeals process to handle all
12 grievances pertaining to payment to providers under this
13 title.

14 **TITLE VII—PROMOTION OF PRI-**
15 **MARY HEALTH CARE; DEVEL-**
16 **OPMENT OF HEALTH SERV-**
17 **ICE CAPACITY; PROGRAMS TO**
18 **ASSIST THE MEDICALLY UN-**
19 **DESERVED**

20 **Subtitle A—Promotion and Expans-**
21 **ion of Primary Care Profes-**
22 **sional Training**

23 **SEC. 701. ROLE OF BOARD; ESTABLISHMENT OF PRIMARY**
24 **CARE PROFESSIONAL OUTPUT GOALS.**

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

1 (1) coordinating health professional education
2 policies and goals, in consultation with the Secretary
3 of Health and Human Services (in this title referred
4 to as the “Secretary”), to achieve the national goals
5 specified in subsection (b);

6 (2) overseeing the health professional education
7 expenditures of the State health security programs
8 from the account established under section 602(c);

9 (3) developing and maintaining, in cooperation
10 with the Secretary, a system to monitor the number
11 and specialties of individuals through their health
12 professional education, any postgraduate training,
13 and professional practice; and

14 (4) developing, coordinating, and promoting
15 other policies that expand the number of primary
16 care practitioners.

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

19 (1) GRADUATE MEDICAL EDUCATION.—By not
20 later than 5 years after the date of the enactment
21 of this Act, at least 50 percent of the residents in
22 medical residency education programs (as defined in
23 subsection (e)(1)) are primary care residents (as de-
24 fined in subsection (e)(3)).

1 (2) MIDDLELEVEL PRIMARY CARE PRACTI-
2 TIONERS.—To assure an adequate supply of primary
3 care practitioners, there shall be a number, specified
4 by the Board, of midlevel primary care practitioners
5 (as defined in subsection (e)(2)) employed in the
6 health care system as of January 1, 2013.

7 (3) DENTISTRY.—To assure an adequate supply
8 of dental care practitioners, there shall be a number,
9 specified by the Board, of dentists (as defined in
10 subsection (e)(1)) employed in the health care sys-
11 tem as of January 1, 2013.

12 (c) METHOD FOR ATTAINMENT OF NATIONAL GOAL
13 FOR GRADUATE MEDICAL EDUCATION; PROGRAM
14 GOALS.—

15 (1) IN GENERAL.—The Board shall establish a
16 method of applying the national goal in subsection
17 (b)(1) to program goals for each medical residency
18 education program or to medical residency education
19 consortia.

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

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

7 (A) includes at least 1 medical school with
8 a teaching hospital and related teaching set-
9 tings; and

10 (B) has an affiliation with qualified com-
11 munity-based primary health service providers
12 described in section 202(a) and with at least 1
13 comprehensive health service organization es-
14 tablished under section 303.

15 (4) ENFORCEMENT THROUGH STATE HEALTH
16 SECURITY BUDGETS.—The Board shall develop a
17 formula for reducing payments to State health secu-
18 rity programs (that provide for payments to a med-
19 ical residency education program) that failed to meet
20 the goal for the program established under this sub-
21 section.

22 (d) METHOD FOR ATTAINMENT OF NATIONAL GOAL
23 FOR MIDDLELEVEL PRIMARY CARE PRACTITIONERS.—To as-
24 sist in attaining the national goal identified in subsection
25 (b)(2), the Board shall—

1 (1) advise the Public Health Service on alloca-
2 tions of funding under titles VII and VIII of the
3 Public Health Service Act, the National Health
4 Service Corps, and other programs in order to in-
5 crease the supply of midlevel primary care practi-
6 tioners; and

7 (2) commission a study of the potential benefits
8 and disadvantages of expanding the scope of practice
9 authorized under State laws for any class of midlevel
10 primary care practitioners.

11 (e) DEFINITIONS.—In this title:

12 (1) DENTIST.—The term “dentist” means a
13 practitioner who performs the evaluation, diagnosis,
14 prevention or treatment (nonsurgical, surgical or re-
15 lated procedures) of diseases, disorders or conditions
16 of the oral cavity, maxillofacial area or the adjacent
17 and associated structures and their impact on the
18 human body, within the scope of his or her edu-
19 cation, training and experience, in accordance with
20 the ethics of the profession and applicable law.

21 (2) MEDICAL RESIDENCY EDUCATION PRO-
22 GRAM.—The term “medical residency education pro-
23 gram” means a program that provides education
24 and training to graduates of medical schools in order
25 to meet requirements for licensing and certification

1 as a physician, and includes the medical school su-
2 pervising the program and includes the hospital or
3 other facility in which the program is operated.

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

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

16 **SEC. 702. ESTABLISHMENT OF ADVISORY COMMITTEE ON**
17 **HEALTH PROFESSIONAL EDUCATION.**

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

22 (b) MEMBERSHIP.—The Committee shall be com-
23 posed of—

24 (1) the Chair of the Board, who shall serve as
25 Chair of the Committee; and

1 (2) 12 members, not otherwise in the employ of
2 the United States, appointed by the Board without
3 regard to the provisions of title 5, United States
4 Code, governing appointments in the competitive
5 service.

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

14 (c) TERMS OF MEMBERS.—Each appointed member
15 shall hold office for a term of 5 years, except that—

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

20 (2) the terms of the members first taking office
21 shall expire, as designated by the Board at the time
22 of appointment, 2 at the end of the second year, 2
23 at the end of the third year, 2 at the end of the
24 fourth year, and 3 at the end of the fifth year after
25 the date of enactment of this Act.

1 (d) VACANCIES.—

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

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

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

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

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

23 (g) MEETINGS.—The Committee shall meet as fre-
24 quently as the Board deems necessary, but not less than
25 4 times each year. Upon request by 4 or more members

1 it shall be the duty of the Chair to call a meeting of the
2 Committee.

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

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

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

14 (a) TRANSFERS TO PUBLIC HEALTH SERVICE.—The
15 Board shall make transfers from the American Health Se-
16 curity Trust Fund to the Public Health Service under sub-
17 part II of part D of title III, title VII, and title VIII of
18 the Public Health Service Act for the support of the Na-
19 tional Health Service Corps, health professions education,
20 and nursing education, including education of clinical
21 nurse practitioners, certified registered nurse anesthetists,
22 certified nurse midwives, and physician assistants. The
23 amounts transferred for the support of the National
24 Health Service Corps shall be in the following amounts
25 for the fiscal year indicated:

1 (1) For fiscal year 2010, \$320,461,632.

2 (2) For fiscal year 2011, \$414,095,394.

3 (3) For fiscal year 2012, \$535,087,442.

4 (4) For fiscal year 2013, \$691,431,432.

5 (5) For fiscal year 2014, \$893,456,433.

6 (6) For fiscal year 2015, \$1,154,510,336.

7 (7) For fiscal year 2016, and each subsequent
8 fiscal year, the amount transferred for the preceding
9 fiscal year adjusted by the product of—

10 (A) one plus the average percentage in-
11 crease in the costs of health professions edu-
12 cation during the prior fiscal year; and

13 (B) one plus the average percentage
14 change in the number of individuals residing in
15 health professions shortage areas designated
16 under section 333 during the prior fiscal year,
17 relative to the number of individuals residing in
18 such areas during the previous fiscal year.

19 (b) RANGE OF FUNDS.—The amount of transfers
20 under subsection (a) for any fiscal year for title VII and
21 VIII shall be an amount (specified by the Board each
22 year) not less than $\frac{3}{100}$ percent and not to exceed $\frac{4}{100}$
23 percent of the amounts the Board estimates will be ex-
24 pended from the Trust Fund in the fiscal year.

1 (c) FUNDS SUPPLEMENTAL TO OTHER FUNDS.—The
 2 funds provided under this section with respect to provision
 3 of services are in addition to, and not in replacement of,
 4 funds made available under the provisions referred to in
 5 subsection (a) and shall be administered in accordance
 6 with the terms of such provisions. The Board shall make
 7 no transfer of funds under this section for any fiscal year
 8 for which the total appropriations for the programs au-
 9 thorized by such provisions are less than the total amount
 10 appropriated for such programs in fiscal year 2009.

11 **Subtitle B—Direct Health Care**
 12 **Delivery**

13 **SEC. 711. SET-ASIDE FOR PUBLIC HEALTH.**

14 (a) TRANSFERS TO PUBLIC HEALTH SERVICE.—
 15 From the amounts provided under subsection (c), the
 16 Board shall make transfers from the American Health Se-
 17 curity Trust Fund to the Public Health Service for the
 18 following purposes (other than payment for services cov-
 19 ered under title II):

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

23 (2) For prevention and treatment of tuber-
 24 culosis under section 317 of the Public Health Serv-
 25 ice Act.

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

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

6 (5) 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 (6) 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 (7) Grants for HIV health care services under
13 parts A, B, and C of title XXVI of the Public
14 Health Service Act.

15 (8) Public health formula grants described in
16 subsection (d).

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

23 (c) FUNDS SUPPLEMENTAL TO OTHER FUNDS.—The
24 funds provided under this section with respect to provision
25 of services are in addition to, and not in replacement of,

1 funds made available under the programs referred to in
2 subsection (a) and shall be administered in accordance
3 with the terms of such programs.

4 (d) REQUIRED REPORTS ON HEALTH STATUS.—The
5 Secretary shall require each State receiving funds under
6 this section to submit annual reports to the Secretary on
7 the health status of the population and measurable objec-
8 tives for improving the health of the public in the State.
9 Such reports shall include the following:

10 (1) A comparison of the measures of the State
11 and local public health system compared to relevant
12 objectives set forth in “Healthy People 2000” or
13 subsequent national objectives set by the Secretary.

14 (2) A description of health status measures to
15 be improved within the State (at the State and local
16 levels) through expanded public health functions and
17 health promotion and disease prevention programs.

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

21 (4) Information regarding how Federal funding
22 has improved population-based prevention activities
23 and programs.

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

1 (6) A description of the relationship between
2 the State's public health system, community-based
3 health promotion and disease prevention providers,
4 and the State health security program.

5 (e) LIMITATION ON FUND TRANSFERS.—The Board
6 shall make no transfer of funds under this section for any
7 fiscal year for which the total appropriations for such pro-
8 grams are less than the total amount appropriated for
9 such programs in fiscal year 2008.

10 (f) PUBLIC HEALTH FORMULA GRANTS.—The Sec-
11 retary shall provide stable funds to States through for-
12 mula grants for the purpose of carrying out core public
13 health functions to monitor and protect the health of com-
14 munities from communicable diseases and exposure to
15 toxic environmental pollutants, occupational hazards,
16 harmful products, and poor health outcomes. Such func-
17 tions include the following:

18 (1) Data collection, analysis, and assessment of
19 public health data, vital statistics, and personal
20 health data to assess community health status and
21 outcomes reporting. This function includes the ac-
22 quisition and installation of hardware and software,
23 and personnel training and technical assistance to
24 operate and support automated and integrated infor-
25 mation systems.

1 (2) Activities to protect the environment and to
2 assure the safety of housing, workplaces, food, and
3 water.

4 (3) Investigation and control of adverse health
5 conditions, and threats to the health status of indi-
6 viduals and the community. This function includes
7 the identification and control of outbreaks of infec-
8 tious disease, patterns of chronic disease and injury,
9 and cooperative activities to reduce the levels of vio-
10 lence.

11 (4) Health promotion and disease prevention
12 activities for which there is a significant need and a
13 high priority of the Public Health Service.

14 (5) The provision of public health laboratory
15 services to complement private clinical laboratory
16 services, including—

17 (A) screening tests for metabolic diseases
18 in newborns;

19 (B) toxicology assessments of blood lead
20 levels and other environmental toxins;

21 (C) tuberculosis and other diseases requir-
22 ing partner notification; and

23 (D) testing for infectious and food-borne
24 diseases.

1 (6) Training and education for the public
2 health professions.

3 (7) Research on effective and cost-effective pub-
4 lic health practices. This function includes the devel-
5 opment, testing, evaluation, and publication of re-
6 sults of new prevention and public health control
7 interventions.

8 (8) Integration and coordination of the preven-
9 tion programs and services of community-based pro-
10 viders, local and State health departments, and
11 other sectors of State and local government that af-
12 fect health.

13 **SEC. 712. SET-ASIDE FOR PRIMARY HEALTH CARE DELIV-**
14 **ERY.**

15 (a) TRANSFERS TO SECTION 330 PROGRAM OF THE
16 PUBLIC HEALTH SERVICE ACT.—The Board shall make
17 transfers from the American Health Security Trust Fund
18 to the Public Health Service for the program authorized
19 under section 330 of the Public Health Service Act (42
20 U.S.C. 254b) in the following amounts for the fiscal year
21 indicated:

22 (1) For fiscal year 2010, \$2,988,821,592.

23 (2) For fiscal year 2011, \$3,862,107,440.

24 (3) For fiscal year 2012, \$4,990,553,440.

25 (4) For fiscal year 2013, \$6,448,713,307.

1 (5) For fiscal year 2014, \$7,332,924,155.

2 (6) For fiscal year 2015, \$8,332,924,155.

3 (7) For fiscal year 2016 and each subsequent
4 fiscal year, the amount transferred for the preceding
5 fiscal year adjusted by the product of—

6 (A) one plus the average percentage in-
7 crease in costs incurred per patient served by
8 entities receiving funding under such section;
9 and

10 (B) one plus the average percentage in-
11 crease in the total number of patients served by
12 entities receiving funding under such section.

13 (b) TRANSFERS TO PUBLIC HEALTH SERVICE.—
14 From the amounts provided under subsection (d), the
15 Board shall make transfers from the American Health Se-
16 curity Trust Fund to the Public Health Service for the
17 program of primary care service expansion grants under
18 subpart V of part D of title III of the Public Health Serv-
19 ice Act (as added by section 713 of this Act).

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

1 (d) FUNDS SUPPLEMENTAL TO OTHER FUNDS.—
 2 The funds provided under this section with respect to pro-
 3 vision of services are in addition to, and not in replace-
 4 ment of, funds made available under the sections 340A,
 5 1001, and 2655 of the Public Health Service Act. The
 6 Board shall make no transfer of funds under this section
 7 for any fiscal year for which the total appropriations for
 8 such sections are less than the total amount appropriated
 9 under such sections in fiscal year 2008.

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

11 Part D of title III of the Public Health Service Act
 12 (42 U.S.C. 254b et seq.) is amended by adding at the end
 13 thereof the following new subpart:

14 **“Subpart XI—Primary Care Expansion**

15 **“SEC. 340H. EXPANDING PRIMARY CARE DELIVERY CAPAC-**
 16 **ITY IN URBAN AND RURAL AREAS.**

17 “(a) GRANTS FOR PRIMARY CARE CENTERS.—From
 18 the amounts described in subsection (c), the American
 19 Health Security Standards Board shall make grants to
 20 public and nonprofit private entities for projects to plan
 21 and develop primary care centers which will serve medi-
 22 cally underserved populations (as defined in section
 23 330(b)(3)) in urban and rural areas and to deliver primary
 24 care services to such populations in such areas. The funds
 25 provided under such a grant may be used for the same

1 purposes for which a grant may be made under subsection
2 (c), (e), (f), (g), (h), or (i) of section 330.

3 “(b) PROCESS OF AWARDING GRANTS.—The provi-
4 sions of subsection (k)(1) of section 330 shall apply to
5 a grant under this section in the same manner as they
6 apply to a grant under the corresponding subsection of
7 such section. The provisions of subsection (r)(2)(A) of
8 such section shall apply to grants for projects to plan and
9 develop primary care centers under this section in the
10 same manner as they apply to grants under such section.

11 “(c) FUNDING AS SET-ASIDE FROM TRUST FUND.—
12 Funds in the American Health Security Trust Fund (es-
13 tablished under section 801 of the act) shall be available
14 to carry out this section.

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

17 “(1) a health center (as defined in section
18 330(a)(1));

19 “(2) an entity qualified to receive a grant under
20 section 330, 1001, or 2651; or

21 “(3) a Federally-qualified health center (as de-
22 fined in section 1905(l)(2)(B) of the Social Security
23 Act).”.

1 **Subtitle C—Primary Care and**
2 **Outcomes Research**

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

4 (a) GRANTS FOR OUTCOMES RESEARCH.—The
5 Board shall make transfers from the American Health Se-
6 curity Trust Fund to the Agency for Health Care Policy
7 and Research under title IX of the Public Health Service
8 Act for the purpose of carrying out activities under such
9 title. The Secretary shall assure that there is a special em-
10 phasis placed on pediatric outcomes research.

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

17 (c) FUNDS SUPPLEMENTAL TO OTHER FUNDS.—The
18 funds provided under this section with respect to provision
19 of services are in addition to, and not in replacement of,
20 funds made available to the Agency for Health Care Policy
21 and Research under 937 of the Public Health Service Act.
22 The Board shall make no transfer of funds under this sec-
23 tion for any fiscal year for which the total appropriations
24 under such section are less than the total amount appro-
25 priated under such section and title in fiscal year 2008.

1 (d) CONFORMING AMENDMENT.—Section 937(b) of
 2 the Public Health Service Act (42 U.S.C. 299e–6(b)) is
 3 amended by inserting after “of the fiscal years 2001
 4 through 2005” the following: “and of fiscal year 2010 and
 5 each subsequent year”.

6 **SEC. 722. OFFICE OF PRIMARY CARE AND PREVENTION RE-**
 7 **SEARCH.**

8 (a) IN GENERAL.—Title IV of the Public Health
 9 Service Act is amended—

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

12 (2) by inserting after part F the following new
 13 part:

14 **“PART G—RESEARCH ON PRIMARY CARE AND**
 15 **PREVENTION**

16 **“SEC. 486E. 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, for children as well as adults,
3 that should be conducted or supported by the na-
4 tional research institutes, with particular emphasis
5 on—

6 “(A) clinical patient care, with special em-
7 phasis on pediatric clinical care and diagnosis;

8 “(B) diagnostic effectiveness;

9 “(C) primary care education;

10 “(D) health and family planning services;

11 “(E) medical effectiveness outcomes of pri-
12 mary care procedures and interventions; and

13 “(F) the use of multidisciplinary teams of
14 health care practitioners;

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

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

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

24 “(5) recommend an agenda for conducting and
25 supporting such research;

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. 486G. 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 1 year after the date of the enactment of
16 this part, and biennially thereafter, prepare a report—

17 “(1) describing and evaluating the progress
18 made during the preceding 2 fiscal years in research
19 and treatment conducted or supported by the Na-
20 tional 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 2 fiscal years; 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 **“SEC. 486H. AUTHORIZATION OF APPROPRIATIONS.**

10 “For the Office of Primary Care and Prevention Re-
11 search, there are authorized to be appropriated
12 \$150,000,000 for fiscal year 2010, \$180,000,000 for fis-
13 cal year 2011, and \$216,000,000 for fiscal year 2012.”.

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

17 (1) in paragraph (22), by striking “and” after
18 the semicolon at the end;

19 (2) in paragraph (23), by striking the period at
20 the end and inserting “; and”; and

21 (3) by inserting after paragraph (23) the fol-
22 lowing new paragraph:

23 “(24) after consultation with the Director of
24 the Office of Primary Care and Prevention Re-
25 search, shall ensure that resources of the National

1 Institutes of Health are sufficiently allocated for
2 projects on primary care and prevention research
3 that are identified under section 486E(b).”.

4 **Subtitle D—School-Related Health** 5 **Services**

6 **SEC. 731. AUTHORIZATIONS OF APPROPRIATIONS.**

7 (a) FUNDING FOR SCHOOL-RELATED HEALTH SERV-
8 ICES.—For the purpose of carrying out this subtitle, there
9 are authorized to be appropriated \$100,000,000 for fiscal
10 year 2012, \$275,000,000 for fiscal year 2013,
11 \$350,000,000 for fiscal year 2014, and \$400,000,000 for
12 each of the fiscal years 2015 and 2016.

13 (b) RELATION TO OTHER FUNDS.—The authoriza-
14 tions of appropriations established in subsection (a) are
15 in addition to any other authorizations of appropriations
16 that are available for the purpose described in such sub-
17 section.

18 **SEC. 732. ELIGIBILITY FOR DEVELOPMENT AND OPER-** 19 **ATION GRANTS.**

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

22 (1) State health agencies that apply on behalf
23 of local community partnerships and other commu-
24 nities in need of health services for school-aged chil-
25 dren within the State.

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

3 (b) LOCAL COMMUNITY PARTNERSHIPS.—

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

7 (A) a local health care provider with expe-
8 rience in delivering services to school-aged chil-
9 dren;

10 (B) 1 or more local public schools; and

11 (C) at least 1 community based organiza-
12 tion located in the community to be served that
13 has a history of providing services to school-
14 aged children in the community who are at-risk.

15 (2) PARTICIPATION.—A partnership described
16 in paragraph (1) shall, to the maximum extent fea-
17 sible, involve broad based community participation
18 from parents and adolescent children to be served,
19 health and social service providers, teachers and
20 other public school and school board personnel, de-
21 velopment and service organizations for adolescent
22 children, and interested business leaders. Such par-
23 ticipation may be evidenced through an expanded
24 partnership, or an advisory board to such partner-
25 ship.

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

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

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

8 **SEC. 733. PREFERENCES.**

9 (a) IN GENERAL.—In making grants under sections
10 734 and 735, the Secretary shall give preference to appli-
11 cants whose communities to be served show the most sub-
12 stantial level of need for such services among school-aged
13 children, as measured by indicators of community health
14 including the following:

15 (1) High levels of poverty.

16 (2) The presence of a medically underserved
17 population.

18 (3) The presence of a health professional short-
19 age area.

20 (4) High rates of indicators of health risk
21 among school-aged children, including a high propor-
22 tion of such children receiving services through the
23 Individuals with Disabilities Education Act, adoles-
24 cent pregnancy, sexually transmitted disease (includ-
25 ing infection with the human immunodeficiency

1 virus), preventable disease, communicable disease,
2 intentional and unintentional injuries, community
3 and gang violence, unemployment among adolescent
4 children, juvenile justice involvement, and high rates
5 of drug and alcohol exposure.

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

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

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

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

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

19 (2) Recruitment, compensation, and training of
20 health and administrative staff.

21 (3) The development of agreements, and the ac-
22 quisition and development of equipment and infor-
23 mation services, necessary to support information
24 exchange between school health service sites and

1 health plans, health providers, and other entities au-
2 thorized to collect information under this Act.

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

5 (c) APPLICATION FOR GRANT.—

6 (1) IN GENERAL.—Applicants shall submit ap-
7 plications in a form and manner prescribed by the
8 Secretary.

9 (2) APPLICATIONS BY STATE HEALTH AGEN-
10 CIES.—

11 (A) In the case of applicants that are State
12 health agencies, the application shall contain
13 assurances that the State health agency is ap-
14 plying for funds—

15 (i) on behalf of at least 1 local com-
16 munity partnership; and

17 (ii) on behalf of at least 1 other com-
18 munity identified by the State as in need
19 of the services funded under this subtitle
20 but without a local community partnership.

21 (B) In the case of the communities identi-
22 fied in applications submitted by State health
23 agencies that do not yet have local community
24 partnerships (including the community identi-
25 fied under subparagraph (A)(ii)), the State

1 shall describe the steps that will be taken to aid
2 the communities in developing a local commu-
3 nity partnership.

4 (C) A State applying on behalf of local
5 community partnerships and other communities
6 may retain not more than 10 percent of grants
7 awarded under this subtitle for administrative
8 costs.

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

12 (1) An assessment of the need for school health
13 services in the communities to be served, using the
14 latest available health data and health goals and ob-
15 jectives established by the Secretary.

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

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

23 (4) A description of a quality assurance pro-
24 gram which complies with standards that the Sec-
25 retary may prescribe.

1 (e) NUMBER OF GRANTS.—Not more than 1 planning
2 grant may be made to a single applicant. A planning grant
3 may not exceed 2 years in duration.

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

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

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

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

14 (2) The cost of furnishing services whose pur-
15 pose is to increase the capacity of individuals to uti-
16 lize available health services, including transpor-
17 tation, community and patient outreach, patient
18 education, translation services, and such other serv-
19 ices as the Secretary determines to be appropriate in
20 carrying out such purpose.

21 (3) Training, recruitment and compensation of
22 health professionals and other staff.

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

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

3 (6) Other activities deemed necessary by the
4 Secretary.

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

10 (1) A description of the services to be furnished
11 by the applicant.

12 (2) The amounts and sources of funding that
13 the applicant will expend, including estimates of the
14 amount of payments the applicant will receive from
15 sources other than the grant.

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

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

21 (1) The applicant furnishes the following serv-
22 ices:

23 (A) Diagnosis and treatment of simple ill-
24 nesses and minor injuries.

1 (B) Preventive health services, including
2 health screenings.

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

5 (D) Referrals and followups in situations
6 involving illness or injury.

7 (E) Health and social services, counseling
8 services, and necessary referrals, including re-
9 ferrals regarding mental health and substance
10 abuse.

11 (F) Such other services as the Secretary
12 determines to be appropriate.

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

16 (3) The applicant does not impose charges on
17 students or their families for services (including col-
18 lection of any cost-sharing for services under the
19 comprehensive benefit package that otherwise would
20 be required).

21 (4) The applicant has reviewed and will periodi-
22 cally review the needs of the population served by
23 the applicant in order to ensure that its services are
24 accessible to the maximum number of school-aged
25 children in the area, and that, to the maximum ex-

1 tent possible, barriers to access to services of the ap-
2 plicant are removed (including barriers resulting
3 from the area's physical characteristics, its eco-
4 nomic, social and cultural grouping, the health care
5 utilization patterns of such children, and available
6 transportation).

7 (5) In the case of an applicant which serves a
8 population that includes a substantial proportion of
9 individuals of limited English speaking ability, the
10 applicant has developed a plan to meet the needs of
11 such population to the extent practicable in the lan-
12 guage and cultural context most appropriate to such
13 individuals.

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

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

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

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

1 **SEC. 736. FEDERAL ADMINISTRATIVE COSTS.**

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

5 **SEC. 737. DEFINITIONS.**

6 For purposes of this subtitle:

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

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

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

14 (4) The term “health professional shortage
15 area” means a health professional shortage area des-
16 ignated under section 332 of the Public Health Serv-
17 ice Act.

18 (5) The term “medically underserved popu-
19 lation” has the meaning given such term in section
20 330 of the Public Health Service Act.

21 (6) The term “school-aged children” has the
22 meaning given such term in section 732(c).

1 **TITLE VIII—FINANCING PROVI-**
2 **SIONS; AMERICAN HEALTH**
3 **SECURITY TRUST FUND**

4 **SEC. 800. AMENDMENT OF 1986 CODE; SECTION 15 NOT TO**
5 **APPLY.**

6 (a) AMENDMENT OF 1986 CODE.—Except as other-
7 wise expressly provided, whenever in this title an amend-
8 ment or repeal is expressed in terms of an amendment
9 to, or repeal of, a section or other provision, the reference
10 shall be considered to be made to a section or other provi-
11 sion of the Internal Revenue Code of 1986.

12 (b) SECTION 15 NOT TO APPLY.—The amendments
13 made by subtitle B shall not be treated as a change in
14 a rate of tax for purposes of section 15 of the Internal
15 Revenue Code of 1986.

16 **Subtitle A—American Health**
17 **Security Trust Fund**

18 **SEC. 801. AMERICAN HEALTH SECURITY TRUST FUND.**

19 (a) IN GENERAL.—There is hereby created on the
20 books of the Treasury of the United States a trust fund
21 to be known as the American Health Security Trust Fund
22 (in this section referred to as the “Trust Fund”). The
23 Trust Fund shall consist of such gifts and bequests as
24 may be made and such amounts as may be deposited in,

1 or appropriated to, such Trust Fund as provided in this
2 Act.

3 (b) APPROPRIATIONS INTO TRUST FUND.—

4 (1) TAXES.—There are hereby appropriated to
5 the Trust Fund for each fiscal year (beginning with
6 fiscal year 2011), out of any moneys in the Treasury
7 not otherwise appropriated, amounts equivalent to
8 100 percent of the aggregate increase in tax liabil-
9 ities under the Internal Revenue Code of 1986 which
10 is attributable to the application of the amendments
11 made by this title. The amounts appropriated by the
12 preceding sentence shall be transferred from time to
13 time (but not less frequently than monthly) from the
14 general fund in the Treasury to the Trust Fund,
15 such amounts to be determined on the basis of esti-
16 mates by the Secretary of the Treasury of the taxes
17 paid to or deposited into the Treasury; and proper
18 adjustments shall be made in amounts subsequently
19 transferred to the extent prior estimates were in ex-
20 cess of or were less than the amounts that should
21 have been so transferred.

22 (2) CURRENT PROGRAM RECEIPTS.—Notwith-
23 standing any other provision of law, there are hereby
24 appropriated to the Trust Fund for each fiscal year
25 (beginning with fiscal year 2011) the amounts that

1 would otherwise have been appropriated to carry out
2 the following programs:

3 (A) The medicare program, under parts A,
4 B, and D of title XVIII of the Social Security
5 Act (other than amounts attributable to any
6 premiums under such parts).

7 (B) The medicaid program, under State
8 plans approved under title XIX of such Act.

9 (C) The Federal employees health benefit
10 program, under chapter 89 of title 5, United
11 States Code.

12 (D) The TRICARE program (formerly
13 known as the CHAMPUS program), under
14 chapter 55 of title 10, United States Code.

15 (E) The maternal and child health pro-
16 gram (under title V of the Social Security Act),
17 vocational rehabilitation programs, programs
18 for drug abuse and mental health services
19 under the Public Health Service Act, programs
20 providing general hospital or medical assistance,
21 and any other Federal program identified by
22 the Board, in consultation with the Secretary of
23 the Treasury, to the extent the programs pro-
24 vide for payment for health services the pay-
25 ment of which may be made under this Act.

1 (c) INCORPORATION OF PROVISIONS.—The provisions
 2 of subsections (b) through (i) of section 1817 of the Social
 3 Security Act shall apply to the Trust Fund under this Act
 4 in the same manner as they applied to the Federal Hos-
 5 pital Insurance Trust Fund under part A of title XVIII
 6 of such Act, except that the American Health Security
 7 Standards Board shall constitute the Board of Trustees
 8 of the Trust Fund.

9 (d) TRANSFER OF FUNDS.—Any amounts remaining
 10 in the Federal Hospital Insurance Trust Fund or the Fed-
 11 eral Supplementary Medical Insurance Trust Fund after
 12 the settlement of claims for payments under title XVIII
 13 have been completed, shall be transferred into the Amer-
 14 ican Health Security Trust Fund.

15 **Subtitle B—Taxes Based on Income** 16 **and Wages**

17 **SEC. 811. PAYROLL TAX ON EMPLOYERS.**

18 (a) IN GENERAL.—Section 3111 (relating to tax on
 19 employers) is amended by redesignating subsection (c) as
 20 subsection (d) and inserting after subsection (b) the fol-
 21 lowing new subsection:

22 “(c) HEALTH CARE.—In addition to other taxes,
 23 there is hereby imposed on every employer an excise tax,
 24 with respect to having individuals in his employ, equal to
 25 8.7 percent of the wages (as defined in section 3121(a))

1 paid by him with respect to employment (as defined in
2 section 3121(b)).”.

3 (b) SELF-EMPLOYMENT INCOME.—Section 1401 (re-
4 lating to rate of tax on self-employment income) is amend-
5 ed by redesignating subsection (c) as subsection (d) and
6 inserting after subsection (b) the following new subsection:

7 “(c) HEALTH CARE.—In addition to other taxes,
8 there shall be imposed for each taxable year, on the self-
9 employment income of every individual, a tax equal to 8.7
10 percent of the amount of the self-employment income for
11 such taxable year.”.

12 (c) COMPARABLE TAXES FOR RAILROAD SERV-
13 ICES.—

14 (1) TAX ON EMPLOYERS.—Section 3221 is
15 amended by redesignating subsection (c) as sub-
16 sections (d) and inserting after subsection (b) the
17 following new subsection:

18 “(c) HEALTH CARE.—In addition to other taxes,
19 there is hereby imposed on every employer an excise tax,
20 with respect to having individuals in his employ, equal to
21 8.7 percent of the compensation paid by such employer
22 for services rendered to such employer.”.

23 (2) TAX ON EMPLOYEE REPRESENTATIVES.—
24 Section 3211 (relating to tax on employee represent-
25 atives) is amended by redesignating subsection (c) as

1 subsection (d) and inserting after subsection (b) the
2 following new paragraph:

3 “(c) HEALTH CARE.—In addition to other taxes,
4 there is hereby imposed on the income of each employee
5 representative a tax equal to 8.7 percent of the compensa-
6 tion received during the calendar year by such employee
7 representative for services rendered by such employee rep-
8 resentative.”.

9 (3) NO APPLICABLE BASE.—Subparagraph (A)
10 of section 3231(e)(2) is amended by adding at the
11 end thereof the following new clause:

12 “(iv) HEALTH CARE TAXES.—Clause
13 (i) shall not apply to the taxes imposed by
14 sections 3221(c) and 3211(c).”.

15 (4) TECHNICAL AMENDMENT.—

16 (A) Subsection (d) of section 3211, as re-
17 designated by paragraph (2), is amended by
18 striking “and (b)” and inserting “, (b), and
19 (c)”.

20 (B) Subsection (d) of section 3221, as re-
21 designated by paragraph (1), is amended by
22 striking “and (b)” and inserting “, (b), and
23 (c)”.

1 (d) EFFECTIVE DATE.—The amendments made by
 2 this section shall apply to remuneration paid after Decem-
 3 ber 31, 2010.

4 **SEC. 812. HEALTH CARE INCOME TAX.**

5 (a) GENERAL RULE.—Subchapter A of chapter 1 (re-
 6 lating to determination of tax liability) is amended by add-
 7 ing at the end thereof the following new part:

8 **“PART VIII—HEALTH CARE INCOME TAX ON**
 9 **INDIVIDUALS**

“Sec. 59B. Health care income tax.

10 **“SEC. 59B. HEALTH CARE INCOME TAX.**

11 “(a) IMPOSITION OF TAX.—In the case of an indi-
 12 vidual, there is hereby imposed a tax (in addition to any
 13 other tax imposed by this subtitle) equal to 2.2 percent
 14 of the taxable income of the taxpayer for the taxable year.

15 “(b) NO CREDITS AGAINST TAX; NO EFFECT ON
 16 MINIMUM TAX.—The tax imposed by this section shall not
 17 be treated as a tax imposed by this chapter for purposes
 18 of determining—

19 “(1) the amount of any credit allowable under
 20 this chapter, or

21 “(2) the amount of the minimum tax imposed
 22 by section 55.

23 “(c) SPECIAL RULES.—

1 “(1) TAX TO BE WITHHELD, ETC.—For pur-
2 poses of this title, the tax imposed by this section
3 shall be treated as imposed by section 1.

4 “(2) REIMBURSEMENT OF TAX BY EMPLOYER
5 NOT INCLUDIBLE IN GROSS INCOME.—The gross in-
6 come of an employee shall not include any payment
7 by his employer to reimburse the employee for the
8 tax paid by the employee under this section.

9 “(3) OTHER RULES.—The rules of section
10 59A(d) shall apply to the tax imposed by this sec-
11 tion.”.

12 (b) CLERICAL AMENDMENT.—The table of parts for
13 subchapter A of chapter 1 is amended by adding at the
14 end the following new item:

 “PART VIII—HEALTH CARE INCOME TAX ON INDIVIDUALS”.

15 (c) EFFECTIVE DATE.—The amendments made by
16 this section shall apply to taxable years beginning after
17 December 31, 2010.

1 **TITLE IX—CONFORMING AMEND-**
 2 **MENTS TO THE EMPLOYEE**
 3 **RETIREMENT INCOME SECU-**
 4 **RITY ACT OF 1974**

5 **SEC. 901. ERISA INAPPLICABLE TO HEALTH COVERAGE AR-**
 6 **RANGEMENTS UNDER STATE HEALTH SECU-**
 7 **RITY PROGRAMS.**

8 Section 4 of the Employee Retirement Income Secu-
 9 rity Act of 1974 (29 U.S.C. 1003) is amended—

10 (1) in subsection (a), by striking “(b) or (c)”
 11 and inserting “(b), (c), or (d)”; and

12 (2) by adding at the end the following new sub-
 13 section:

14 “(d) The provisions of this title shall not apply to
 15 any arrangement forming a part of a State health security
 16 program established pursuant to section 101(b) of the
 17 American Health Security Act of 2009.”.

18 **SEC. 902. EXEMPTION OF STATE HEALTH SECURITY PRO-**
 19 **GRAMS FROM ERISA PREEMPTION.**

20 Section 514(b) of the Employee Retirement Income
 21 Security Act of 1974 (29 U.S.C. 1144(b)) (as amended
 22 by sections 904(b)(3)(B) and 1002(b) of this Act) is
 23 amended by adding at the end the following new para-
 24 graph:

1 “(8) Subsection (a) of this section shall not apply to
 2 State health security programs established pursuant to
 3 section 101(b) of the American Health Security Act of
 4 2009.”.

5 **SEC. 903. PROHIBITION OF EMPLOYEE BENEFITS DUPLICA-**
 6 **TIVE OF BENEFITS UNDER STATE HEALTH**
 7 **SECURITY PROGRAMS; COORDINATION IN**
 8 **CASE OF WORKERS’ COMPENSATION.**

9 (a) IN GENERAL.—Part 5 of subtitle B of title I of
 10 the Employee Retirement Income Security Act of 1974 is
 11 amended by adding at the end the following new section:

12 “PROHIBITION OF EMPLOYEE BENEFITS DUPLICATIVE OF
 13 STATE HEALTH SECURITY PROGRAM BENEFITS; CO-
 14 ORDINATION IN CASE OF WORKERS’ COMPENSATION

15 “SEC. 519. (a) Subject to subsection (b), no employee
 16 benefit plan may provide benefits which duplicate payment
 17 for any items or services for which payment may be made
 18 under a State health security program established pursu-
 19 ant to section 101(b) of the American Health Security Act
 20 of 2009.

21 “(b)(1) Each workers compensation carrier that is
 22 liable for payment for workers compensation services fur-
 23 nished in a State shall reimburse the State health security
 24 plan for the State in which the services are furnished for
 25 the cost of such services.

26 “(2) In this subsection:

1 “(A) The term ‘workers compensation carrier’
2 means an insurance company that underwrites work-
3 ers compensation medical benefits with respect to 1
4 or more employers and includes an employer or fund
5 that is financially at risk for the provision of work-
6 ers compensation medical benefits.

7 “(B) The term ‘workers compensation medical
8 benefits’ means, with respect to an enrollee who is
9 an employee subject to the workers compensation
10 laws of a State, the comprehensive medical benefits
11 for work-related injuries and illnesses provided for
12 under such laws with respect to such an employee.

13 “(C) The term ‘workers compensation services’
14 means items and services included in workers com-
15 pensation medical benefits and includes items and
16 services (including rehabilitation services and long-
17 term-care services) commonly used for treatment of
18 work-related injuries and illnesses.”.

19 (b) CONFORMING AMENDMENT.—Section 4(b) of
20 such Act (29 U.S.C. 1003(b)) is amended by adding at
21 the end the following: “Paragraph (3) shall apply subject
22 to section 519(b) (relating to reimbursement of State
23 health security plans by workers compensation carriers).”.

1 (c) CLERICAL AMENDMENT.—The table of contents
 2 in section 1 of such Act is amended by inserting after the
 3 item relating to section 518 the following new items:

“Sec. 519. Prohibition of employee benefits duplicative of state health security
 program benefits; coordination in case of workers’ compensa-
 tion.”.

4 **SEC. 904. REPEAL OF CONTINUATION COVERAGE REQUIRE-**
 5 **MENTS UNDER ERISA AND CERTAIN OTHER**
 6 **REQUIREMENTS RELATING TO GROUP**
 7 **HEALTH PLANS.**

8 (a) IN GENERAL.—Part 6 of subtitle B of title I of
 9 the Employee Retirement Income Security Act of 1974
 10 (29 U.S.C. 1161 et seq.) is repealed.

11 (b) CONFORMING AMENDMENTS.—

12 (1) Section 502(a) of such Act (29 U.S.C.
 13 1132(a)) is amended—

14 (A) by striking paragraph (7); and

15 (B) by redesignating paragraphs (8), (9),
 16 and (10) as paragraphs (7), (8), and (9), re-
 17 spectively.

18 (2) Section 502(c)(1) of such Act (29 U.S.C.
 19 1132(c)(1)) is amended by striking “paragraph (1)
 20 or (4) of section 606,”.

21 (3) Section 514(b) of such Act (29 U.S.C.
 22 1144(b)) is amended—

1 (A) in paragraph (7), by striking “section
2 206(d)(3)(B)(i),” and all that follows and in-
3 serting “section 206(d)(3)(B)(i).”; and

4 (B) by striking paragraph (8).

5 (4) The table of contents in section 1 of the
6 Employee Retirement Income Security Act of 1974
7 is amended by striking the items relating to part 6
8 of subtitle B of title I of such Act.

9 **SEC. 905. EFFECTIVE DATE OF TITLE.**

10 The amendments made by this title shall take effect
11 January 1, 2012.

12 **TITLE X—ADDITIONAL**
13 **CONFORMING AMENDMENTS**

14 **SEC. 1001. REPEAL OF CERTAIN PROVISIONS IN INTERNAL**
15 **REVENUE CODE OF 1986.**

16 The provisions of titles III and IV of the Health In-
17 surance Portability and Accountability Act of 1996, other
18 than subtitles D and H of title III and section 342, are
19 repealed and the provisions of law that were amended or
20 repealed by such provisions are hereby restored as if such
21 provisions had not been enacted.

