

112TH CONGRESS  
1ST SESSION

**S.** \_\_\_\_\_

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

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IN THE SENATE OF THE UNITED STATES

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

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**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.**

4 This Act may be cited as the “American Health Secu-  
5 rity Act of 2011”.

6 **SEC. 2. FINDINGS; SENSE OF THE SENATE.**

7 (a) FINDINGS.—Congress finds as follows:

8 (1) While the United States of America spends  
9 on average nearly twice as much per capita on  
10 health care services as the next most costly nation,

1 the United States ranks 32d among all nations on  
2 life expectancy, and 41st on infant mortality.

3 (2) The number of uninsured Americans rose  
4 by more than 4,000,000 between 2008 and 2009 to  
5 a total of 51,000,000, or more than 1 of every 6  
6 Americans.

7 (3) This rise in the number of uninsured Amer-  
8 icans was the largest single-year increase since 1987  
9 and was the result of a continued decline in private  
10 health coverage, primarily in employer-sponsored in-  
11 surance.

12 (4) Small businesses around the country cannot  
13 afford to reinvest in their companies and create new  
14 jobs because their health care bills are going up 10  
15 or 15 percent every year.

16 (5) American businesses are at an economic dis-  
17 advantage, because their health care costs are so  
18 much higher than in other countries. Notably, auto-  
19 mobile manufacturers spend more on health care per  
20 automobile than on steel.

21 (b) SENSE OF THE SENATE CONCERNING URGENCY  
22 OF A MEDICARE-FOR-ALL TYPE SINGLE PAYER HEALTH  
23 CARE SYSTEM.—It is the sense of the Senate that the  
24 112th Congress should enact a Medicare-for-All Single

1 Payer Health Care System to make American companies  
2 more competitive and to stimulate job creation.

3 (c) SENSE OF THE SENATE CONCERNING THE STA-  
4 TUS OF HEALTH CARE.—It is the sense of the Senate that  
5 the 112th Congress should recognize and proclaim that  
6 health care is a human right.

7 (d) SENSE OF THE SENATE CONCERNING STATE  
8 FLEXIBILITY.—It is the sense of the Senate that in order  
9 to provide high quality health care coverage for all Ameri-  
10 cans while controlling costs in order to make American  
11 companies more competitive, individual States should be  
12 given maximum flexibility in designing health care pro-  
13 grams to improve the individual experience of care and  
14 the health of populations, and to reduce the per capita  
15 costs of care for each State.

16 (e) SENSE OF THE SENATE CONCERNING A NEW  
17 HEALTH CARE SYSTEM.—It is the sense of the Senate  
18 that—

19 (1) a new single payer health care system  
20 should build on achievements and commitments in  
21 the Patient Protection and Affordable Care Act  
22 (Public Law 111–148) and the Health Care and  
23 Education Reconciliation Act of 2010 (Public Law  
24 111–152), to strengthen primary care and public  
25 health, to raise the quality of patient care, to de-

1       velop new models of patient care, to develop the ca-  
2       pacity of the healthcare workforce, to increase trans-  
3       parency in the payment of health care system costs,  
4       and to strengthen enforcement against fraud and  
5       abuse;

6           (2) the possibilities of achieving efficiencies  
7       through integrated care are within reach with the  
8       spread of electronic support systems, health informa-  
9       tion exchanges, and the possibilities for virtual inte-  
10      gration and instant communication; and

11          (3) policies should be put in place to ensure  
12      higher quality, better prevention, and lower per cap-  
13      ita costs, including—

14           (A) global budget caps on total health care  
15      spending;

16           (B) measurement of and fixed account-  
17      ability for the health status and health needs of  
18      designated populations;

19           (C) improved standardized measures of  
20      care and per capita costs across sites and  
21      through time that are transparent; and

22           (D) changes in professional education cur-  
23      ricula to ensure that clinicians are enabled to  
24      change and improve their processes of care.

**1 SEC. 3. TABLE OF CONTENTS.****2 The table of contents of this Act is as follows:**

- Sec. 1. Short title.
- Sec. 2. Findings; sense of the Senate.
- Sec. 3. Table of contents.

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

- 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.
- Sec. 107. Repeal of provisions related to the State exchanges.

**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.
- 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.

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- Sec. 504. Elimination of utilization review programs; transition.  
 Sec. 505. Application of Center for Medicare and Medicaid Innovation to American Health Security Program.

TITLE VI—HEALTH SECURITY BUDGET; PAYMENTS; COST  
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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. 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.
- Sec. 813. Surcharge on high income individuals.

Subtitle C—Other Financing Provisions

- Sec. 821. Tax on Securities Transactions.

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.

13 (b) STATE HEALTH SECURITY PROGRAMS.—In order  
14 for a State to be eligible to receive payment under section  
15 604, a State shall establish a State health security pro-  
16 gram in accordance with this Act.

17 (c) STATE DEFINED.—

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

21 (2) ELECTION.—If the Governor of Puerto  
22 Rico, the Virgin Islands, Guam, American Samoa, or  
23 the Northern Mariana Islands certifies to the Presi-  
24 dent that the legislature of the Commonwealth or  
25 territory has enacted legislation desiring that the



1 Commonwealth or territory be included as a State  
2 under the provisions of this Act, such Common-  
3 wealth or territory shall be included as a “State”  
4 under this Act beginning January 1 of the first year  
5 beginning 90 days after the President receives the  
6 notification.

7 **SEC. 102. UNIVERSAL ENTITLEMENT.**

8 (a) IN GENERAL.—Every individual who is a resident  
9 of the United States and is a citizen or national of the  
10 United States or lawful resident alien (as defined in sub-  
11 section (d)) is entitled to benefits for health care services  
12 under this Act under the appropriate State health security  
13 program. In this section, the term “appropriate State  
14 health security program” means, with respect to an indi-  
15 vidual, the State health security program for the State in  
16 which the individual maintains a primary residence.

17 (b) TREATMENT OF CERTAIN NONIMMIGRANTS.—

18 (1) IN GENERAL.—The American Health Secu-  
19 rity Standards Board (in this Act referred to as the  
20 “Board”) may make eligible for benefits for health  
21 care services under the appropriate State health se-  
22 curity program under this Act such classes of aliens  
23 admitted to the United States as nonimmigrants as  
24 the Board may provide.

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

7           (c) TREATMENT OF OTHER INDIVIDUALS.—

8           (1) BY BOARD.—The Board also may make eli-  
9           gible for benefits for health care services under the  
10          appropriate State health security program under this  
11          Act other individuals not described in subsection (a)  
12          or (b), and regulate the nature of the eligibility of  
13          such individuals, in order—

14                 (A) to preserve the public health of com-  
15                 munities;

16                 (B) to compensate States for the addi-  
17                 tional health care financing burdens created by  
18                 such individuals; and

19                 (C) to prevent adverse financial and med-  
20                 ical consequences of uncompensated care,  
21          while inhibiting travel and immigration to the  
22          United States for the sole purpose of obtaining  
23          health care services.

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

4           (d) **LAWFUL RESIDENT ALIEN DEFINED.**—For pur-  
5           poses of this section, the term “lawful resident alien”  
6           means an alien lawfully admitted for permanent residence  
7           and any other alien lawfully residing permanently in the  
8           United States under color of law, including an alien with  
9           lawful temporary resident status under section 210, 210A,  
10          or 234A of the Immigration and Nationality Act (8 U.S.C.  
11          1160, 1161, or 1255a).

12          **SEC. 103. ENROLLMENT.**

13          (a) **IN GENERAL.**—Each State health security pro-  
14          gram shall provide a mechanism for the enrollment of indi-  
15          viduals entitled or eligible for benefits under this Act. The  
16          mechanism shall—

17               (1) include a process for the automatic enroll-  
18               ment of individuals at the time of birth in the  
19               United States and at the time of legal immigration  
20               into the United States or other acquisition of lawful  
21               resident status in the United States;

22               (2) provide for the enrollment, as of January 1,  
23               2013, of all individuals who are eligible to be en-  
24               rolled as of such date; and

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

4           (b) AVAILABILITY OF APPLICATIONS.—Each State  
5           health security program shall make applications for enroll-  
6           ment under the program available—

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

9           (2) at local offices of the Social Security Ad-  
10          ministration;

11          (3) at social services locations;

12          (4) at out-reach sites (such as provider and  
13          practitioner locations, especially community health  
14          centers); and

15          (5) at other locations (including post offices  
16          and schools) accessible to a broad cross-section of in-  
17          dividuals eligible to enroll.

18          (c) ISSUANCE OF HEALTH SECURITY CARDS.—In  
19          conjunction with an individual’s enrollment for benefits  
20          under this Act, the State health security program shall  
21          provide for the issuance of a health security card (to be  
22          referred to as a “smart card”) that shall be used for pur-  
23          poses of identification and processing of claims for bene-  
24          fits under the program. The State health security program  
25          may provide for issuance of such cards by employers for

1 purposes of carrying out enrollment pursuant to sub-  
2 section (a)(2).

3 **SEC. 104. PORTABILITY OF BENEFITS.**

4 (a) IN GENERAL.—To ensure continuous access to  
5 benefits for health care services covered under this Act,  
6 each State health security program—

7 (1) shall not impose any minimum period of  
8 residence in the State before residents of the State  
9 are entitled to, or eligible for, such benefits under  
10 the program;

11 (2) shall provide continuation of payment for  
12 covered health care services to individuals who have  
13 terminated their residence in the State and estab-  
14 lished their residence in another State, for the dura-  
15 tion of any waiting period imposed in the State of  
16 new residency for establishing entitlement to, or eli-  
17 gibility for, such services; and

18 (3) shall provide for the payment for health  
19 care services covered under this Act provided to indi-  
20 viduals while temporarily absent from the State  
21 based on the following principles:

22 (A) Payment for such health care services  
23 is at the rate that is approved by the State  
24 health security program in the State in which  
25 the services are provided, unless the States con-

1           cerned agree to apportion the cost between  
2           them in a different manner.

3                   (B) Payment for such health care services  
4           provided outside the United States is made on  
5           the basis of the amount that would have been  
6           paid by the State health security program for  
7           similar services rendered in the State, with due  
8           regard, in the case of hospital services, to the  
9           size of the hospital, standards of service, and  
10          other relevant factors.

11          (b) **CROSS-BORDER ARRANGEMENTS.**—A State  
12 health security program for a State may negotiate with  
13 such a program in an adjacent State a reciprocal arrange-  
14 ment for the coverage under such other program of health  
15 care services to enrollees residing in the border region.

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

17          Benefits shall first be available under this Act for  
18 items and services furnished on or after January 1, 2013.

19 **SEC. 106. RELATIONSHIP TO EXISTING FEDERAL HEALTH**  
20 **PROGRAMS.**

21          (a) **MEDICARE, MEDICAID AND STATE CHILDREN’S**  
22 **HEALTH INSURANCE PROGRAM (SCHIP).**—

23                   (1) **IN GENERAL.**—Notwithstanding any other  
24          provision of law, subject to paragraph (2)—

1           (A) no benefits shall be available under  
2 title XVIII of the Social Security Act for any  
3 item or service furnished after December 31,  
4 2012;

5           (B) no individual is entitled to medical as-  
6 sistance under a State plan approved under  
7 title XIX of such Act for any item or service  
8 furnished after such date;

9           (C) no individual is entitled to medical as-  
10 sistance under an SCHIP plan under title XXI  
11 of such Act for any item or service furnished  
12 after such date; and

13           (D) no payment shall be made to a State  
14 under section 1903(a) or 2105(a) of such Act  
15 with respect to medical assistance or child  
16 health assistance for any item or service fur-  
17 nished after such date.

18           (2) TRANSITION.—In the case of inpatient hos-  
19 pital services and extended care services during a  
20 continuous period of stay which began before Janu-  
21 ary 1, 2013, and which had not ended as of such  
22 date, for which benefits are provided under title  
23 XVIII, under a State plan under title XIX, or a  
24 State child health plan under title XXI, of the Social  
25 Security Act, the Secretary of Health and Human

1 Services and each State plan, respectively, shall pro-  
2 vide for continuation of benefits under such title or  
3 plan until the end of the period of stay.

4 (b) FEDERAL EMPLOYEES HEALTH BENEFITS PRO-  
5 GRAM.—No benefits shall be made available under chapter  
6 89 of title 5, United States Code, for any part of a cov-  
7 erage period occurring after December 31, 2012.

8 (c) TRICARE.—No benefits shall be made available  
9 under sections 1079 and 1086 of title 10, United States  
10 Code, for items or services furnished after December 31,  
11 2012.

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

18 (e) TREATMENT OF PREMIUM CREDITS, COST-SHAR-  
19 ING REDUCTIONS, AND SMALL EMPLOYER CREDITS.—

20 (1) IN GENERAL.—For each calendar year, the  
21 Secretary of the Treasury shall transfer to the  
22 American Health Security Trust Fund an amount  
23 equal to the sum of—

24 (A) the premium assistance credit amount  
25 which would have been allowable to taxpayers



1           residing in such State in such calendar year  
2           under section 36B of the Internal Revenue  
3           Code of 1986 (relating to refundable credit for  
4           coverage under a qualified health plan), as  
5           added by section 1401 of the Patient Protection  
6           and Affordable Care Act, if such section were in  
7           effect for such year,

8           (B) the amount of cost-sharing reductions  
9           which would have been required with respect to  
10          eligible insured residing in such State in such  
11          calendar year under section 1402 of the Patient  
12          Protection and Affordable Care Act if such sec-  
13          tion were in effect for such year, plus

14          (C) the amount of tax credits which would  
15          have been allowable to eligible small employers  
16          doing business in such State in such calendar  
17          year under section 45R of the Internal Revenue  
18          Code of 1986 if such section were in effect for  
19          such calendar year.

20          (2) DETERMINATION.—The amounts deter-  
21          mined under paragraph (1) shall be estimated by the  
22          Secretary of the Treasury in consultation with the  
23          Secretary of Health and Human Services.

1 **SEC. 107. REPEAL OF PROVISIONS RELATED TO THE STATE**  
2 **EXCHANGES.**

3 Title I of the Patient Protection and Affordable Care  
4 Act (Public Law 111–148) (and the amendments made  
5 by title I) is repealed.

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

10 **SEC. 201. COMPREHENSIVE BENEFITS.**

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

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

21 (2) PROFESSIONAL SERVICES.—Professional  
22 services of health care practitioners authorized to  
23 provide health care services under State law, includ-  
24 ing patient education and training in self-manage-  
25 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 an intellectual disability.

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 (f) TAFT HARTLEY AND MEW BENEFIT PLANS.—  
17 Notwithstanding any other provision of law, a health plan  
18 may be provided for under a collective bargaining agree-  
19 ment or a MEWA if such plan is limited to coverage that  
20 is supplemental to the coverage provided for under the  
21 State-based American Health Security Program and avail-  
22 able only to employees or their dependents or to retirees  
23 or their dependents.

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

2 (a) COMMUNITY-BASED PRIMARY HEALTH SERV-  
3 ICES.—In this title, the term “community-based primary  
4 health services” means ambulatory health services fur-  
5 nished—

6 (1) by a rural health clinic;

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

11 (3) in a school-based setting;

12 (4) by public educational agencies and other  
13 providers of services to children entitled to assist-  
14 ance under the Individuals with Disabilities Edu-  
15 cation Act for services furnished pursuant to a writ-  
16 ten Individualized Family Services Plan or Indi-  
17 vidual Education Plan under such Act; and

18 (5) public and private nonprofit entities receiv-  
19 ing Federal assistance under the Public Health  
20 Service Act.

21 (b) PREVENTIVE SERVICES.—

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

24 (A) which—

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

1 (ii) the Board determines to be effective in the maintenance and promotion of  
2 health or minimizing the effect of illness,  
3 disease, or medical condition; and

4 (B) which are provided consistent with the  
5 periodicity schedule established under para-  
6 graph (3).  
7

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

10 (A) Immunizations recommended by the  
11 Advisory Committee on Immunization Practices  
12 of the Centers for Disease Control and Preven-  
13 tion.

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

16 (C) Well-child care (including periodic  
17 physical examinations, hearing and vision  
18 screening, and developmental screening and ex-  
19 aminations) for individuals under 18 years of  
20 age, including evidence-informed preventive care  
21 and screenings included in the comprehensive  
22 guidelines of the Health Resources and Services  
23 Administration.

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

4 (E) Physical examinations.

5 (F) Family planning services.

6 (G) Routine eye examinations, eyeglasses,  
7 and contact lenses.

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

13 (I) Evidence-based items or services that  
14 have in effect a rating of “A” or “B” in the  
15 current recommendations of the United States  
16 Preventive Services Task Force.

17 (J) With respect to women, such additional  
18 preventive care and screenings not described in  
19 subparagraph (I) that are included in the com-  
20 prehensive guidelines of the Health Resources  
21 and Services Administration.

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



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

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

15 (1) Home health aide services.

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

18 (3) Medical social work services.

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

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

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

1 (d) HOME HEALTH SERVICES.—

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

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

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

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

23 (1) SERVICES DESCRIBED.—In this title, the  
24 term “mental health and substance abuse treatment  
25 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 if (with respect to services fur-  
7 nished to an individual described in section  
8 204(b)(1)) such services are furnished in con-  
9 formity with the plan of an organized system of  
10 care for mental health and substance abuse  
11 services in accordance with section 204(b)(2).

12 (B) INTENSIVE RESIDENTIAL SERVICES.—  
13 Intensive residential services (as defined in  
14 paragraph (2)).

15 (C) OUTPATIENT SERVICES.—Outpatient  
16 treatment services of mental illness or sub-  
17 stance abuse (other than intensive community-  
18 based services under subparagraph (D)) for an  
19 unlimited number of days during any calendar  
20 year furnished in accordance with standards es-  
21 tablished by the Secretary for the management  
22 of such services, and, in the case of services fur-  
23 nished to an individual described in section  
24 204(b)(1) who is not an inpatient of a hospital,  
25 in conformity with the plan of an organized sys-

1           tem of care for mental health and substance  
2           abuse services in accordance with section  
3           204(b)(2).

4           (D) INTENSIVE COMMUNITY-BASED SERV-  
5           ICES.—Intensive community-based services (as  
6           described in paragraph (3)).

7           (2) INTENSIVE RESIDENTIAL SERVICES DE-  
8           FINED.—

9           (A) IN GENERAL.—Subject to subpara-  
10          graphs (B) and (C), the term “intensive resi-  
11          dential services” means inpatient services pro-  
12          vided in any of the following facilities:

13                 (i) Residential detoxification centers.

14                 (ii) Crisis residential programs or  
15                 mental illness residential treatment pro-  
16                 grams.

17                 (iii) Therapeutic family or group  
18                 treatment homes.

19                 (iv) Residential centers for substance  
20                 abuse treatment.

21           (B) REQUIREMENTS FOR FACILITIES.—No  
22          service may be treated as an intensive residen-  
23          tial service under subparagraph (A) unless the  
24          facility at which the service is provided—

1 (i) is legally authorized to provide  
2 such service under the law of the State (or  
3 under a State regulatory mechanism pro-  
4 vided by State law) in which the facility is  
5 located or is certified to provide such serv-  
6 ice by an appropriate accreditation entity  
7 approved by the State in consultation with  
8 the Secretary; and

9 (ii) meets such other requirements as  
10 the Secretary may impose to ensure the  
11 quality of the intensive residential services  
12 provided.

13 (C) SERVICES FURNISHED TO AT-RISK  
14 CHILDREN.—In the case of services furnished  
15 to an individual described in section 204(b)(1),  
16 no service may be treated as an intensive resi-  
17 dential service under this subsection unless the  
18 service is furnished in conformity with the plan  
19 of an organized system of care for mental  
20 health and substance abuse services in accord-  
21 ance with section 204(b)(2).

22 (D) MANAGEMENT STANDARDS.—No serv-  
23 ice may be treated as an intensive residential  
24 service under subparagraph (A) unless the serv-  
25 ice is furnished in accordance with standards

1 established by the Secretary for the manage-  
2 ment of such services.

3 (3) INTENSIVE COMMUNITY-BASED SERVICES  
4 DEFINED.—

5 (A) IN GENERAL.—The term “intensive  
6 community-based services” means the items  
7 and services described in subparagraph (B) pre-  
8 scribed by a physician (or, in the case of serv-  
9 ices furnished to an individual described in sec-  
10 tion 204(b)(1), by an organized system of care  
11 for mental health and substance abuse services  
12 in accordance with such section) and provided  
13 under a program described in subparagraph  
14 (D) under the supervision of a physician (or, to  
15 the extent permitted under the law of the State  
16 in which the services are furnished, a non-phy-  
17 sician mental health professional) pursuant to  
18 an individualized, written plan of treatment es-  
19 tablished and periodically reviewed by a physi-  
20 cian (in consultation with appropriate staff par-  
21 ticipating in such program) which sets forth the  
22 physician’s diagnosis, the type, amount, fre-  
23 quency, and duration of the items and services  
24 provided under the plan, and the goals for  
25 treatment under the plan, but does not include

1 any item or service that is not furnished in ac-  
2 cordance with standards established by the Sec-  
3 retary for the management of such services.

4 (B) ITEMS AND SERVICES DESCRIBED.—  
5 The items and services described in this sub-  
6 paragraph are—

7 (i) partial hospitalization services con-  
8 sisting of the items and services described  
9 in subparagraph (C);

10 (ii) psychiatric rehabilitation services;

11 (iii) day treatment services for indi-  
12 viduals under 19 years of age;

13 (iv) in-home services;

14 (v) case management services, includ-  
15 ing collateral services designated as such  
16 case management services by the Sec-  
17 retary;

18 (vi) ambulatory detoxification services;

19 and

20 (vii) such other items and services as  
21 the Secretary may provide (but in no event  
22 to include meals and transportation),

23 that are reasonable and necessary for the diag-  
24 nosis or active treatment of the individual's  
25 condition, reasonably expected to improve or

1 maintain the individual's condition and func-  
2 tional level and to prevent relapse or hos-  
3 pitalization, and furnished pursuant to such  
4 guidelines relating to frequency and duration of  
5 services as the Secretary shall by regulation es-  
6 tablish (taking into account accepted norms of  
7 medical practice and the reasonable expectation  
8 of patient improvement).

9 (C) ITEMS AND SERVICES INCLUDED AS  
10 PARTIAL HOSPITALIZATION SERVICES.—For  
11 purposes of subparagraph (B)(i), partial hos-  
12 pitalization services consist of the following:

13 (i) Individual and group therapy with  
14 physicians or psychologists (or other men-  
15 tal health professionals to the extent au-  
16 thorized under State law).

17 (ii) Occupational therapy requiring  
18 the skills of a qualified occupational thera-  
19 pist.

20 (iii) Services of social workers, trained  
21 psychiatric nurses, behavioral aides, and  
22 other staff trained to work with psychiatric  
23 patients (to the extent authorized under  
24 State law).



1 (iv) Drugs and biologicals furnished  
2 for therapeutic purposes (which cannot, as  
3 determined in accordance with regulations,  
4 be self-administered).

5 (v) Individualized activity therapies  
6 that are not primarily recreational or di-  
7 versionary.

8 (vi) Family counseling (the primary  
9 purpose of which is treatment of the indi-  
10 vidual's condition).

11 (vii) Patient training and education  
12 (to the extent that training and edu-  
13 cational activities are closely and clearly  
14 related to the individual's care and treat-  
15 ment).

16 (viii) Diagnostic services.

17 (D) PROGRAMS DESCRIBED.—A program  
18 described in this subparagraph is a program  
19 (whether facility-based or freestanding) which is  
20 furnished by an entity—

21 (i) legally authorized to furnish such a  
22 program under State law (or the State reg-  
23 ulatory mechanism provided by State law)  
24 or certified to furnish such a program by  
25 an appropriate accreditation entity ap-

1                   proved by the State in consultation with  
2                   the Secretary; and

3                   (ii) meeting such other requirements  
4                   as the Secretary may impose to ensure the  
5                   quality of the intensive community-based  
6                   services provided.

7           (g) CARE COORDINATION SERVICES.—

8                   (1) IN GENERAL.—In this title, the term “care  
9                   coordination services” means services provided by  
10                  care coordinators (as defined in paragraph (2)) to  
11                  individuals described in paragraph (3) for the co-  
12                  ordination and monitoring of home and community-  
13                  based long term care services and services offered  
14                  through medical homes to ensure appropriate, cost-  
15                  effective utilization of such services in a comprehen-  
16                  sive and continuous manner, and includes—

17                           (A) transition management between inpa-  
18                           tient facilities and community-based services,  
19                           including assisting patients in identifying and  
20                           gaining access to appropriate ancillary services;  
21                           and

22                           (B) evaluating and recommending appro-  
23                           priate treatment services, in cooperation with  
24                           patients and other providers and in conjunction

1 with any quality review program or plan of care  
2 under section 205.

3 (2) CARE COORDINATOR.—

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

8 (i) is capable of performing directly,  
9 efficiently, and effectively the duties of a  
10 care coordinator described in paragraph  
11 (1); and

12 (ii) demonstrates capability in estab-  
13 lishing and periodically reviewing and re-  
14 vising plans of care, and in arranging for  
15 and monitoring the provision and quality  
16 of services under any plan.

17 (B) INDEPENDENCE.—State health secu-  
18 rity programs shall establish safeguards to en-  
19 sure that care coordinators have no financial in-  
20 terest in treatment decisions or placements.  
21 Care coordination may not be provided through  
22 any structure or mechanism through which  
23 quality review is performed.

24 (3) ELIGIBLE INDIVIDUALS.—An individual de-  
25 scribed in this paragraph is an individual described

1 in section 203 (relating to individuals qualifying for  
2 long term and chronic care services).

3 (h) DENTAL SERVICES.—

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

7 (A) Emergency dental treatment, including  
8 extractions, for bleeding, pain, acute infections,  
9 and injuries to the maxillofacial region.

10 (B) Prevention and diagnosis of dental dis-  
11 ease, including examinations of the hard and  
12 soft tissues of the oral cavity and related struc-  
13 tures, radiographs, dental sealants, fluorides,  
14 and dental prophylaxis.

15 (C) Treatment of dental disease, including  
16 non-cast fillings, periodontal maintenance serv-  
17 ices, and endodontic services.

18 (D) Space maintenance procedures to pre-  
19 vent orthodontic complications.

20 (E) Orthodontic treatment to prevent se-  
21 vere malocclusions.

22 (F) Full dentures.

23 (G) Medically necessary oral health care.

1 (H) Any items and services for special  
2 needs patients that are not described in sub-  
3 paragraphs (A) through (G) and that—

4 (i) are required to provide such pa-  
5 tients the items and services described in  
6 subparagraphs (A) through (G);

7 (ii) are required to establish oral func-  
8 tion (including general anesthesia for indi-  
9 viduals with physical or emotional limita-  
10 tions that prevent the provision of dental  
11 care without such anesthesia);

12 (iii) consist of orthodontic care for se-  
13 vere dentofacial abnormalities; or

14 (iv) consist of prosthetic dental de-  
15 vices for genetic or birth defects or fitting  
16 for such devices.

17 (I) Any dental care for individuals with a  
18 seizure disorder that is not described in sub-  
19 paragraphs (A) through (H) and that is re-  
20 quired because of an illness, injury, disorder, or  
21 other health condition that results from such  
22 seizure disorder.

23 (2) LIMITATIONS.—Dental services are subject  
24 to the following limitations:

25 (A) PREVENTION AND DIAGNOSIS.—

1 (i) EXAMINATIONS AND PROPHY-  
2 LAXIS.—The examinations and prophylaxis  
3 described in paragraph (1)(B) are covered  
4 only consistent with a periodicity schedule  
5 established by the Board, which schedule  
6 may provide for special treatment of indi-  
7 viduals less than 18 years of age and of  
8 special needs patients.

9 (ii) DENTAL SEALANTS.—The dental  
10 sealants described in such paragraph are  
11 not covered for individuals 18 years of age  
12 or older. Such sealants are covered for in-  
13 dividuals less than 10 years of age for pro-  
14 tection of the 1st permanent molars. Such  
15 sealants are covered for individuals 10  
16 years of age or older for protection of the  
17 2d permanent molars.

18 (B) TREATMENT OF DENTAL DISEASE.—  
19 Prior to January 1, 2018, the items and serv-  
20 ices described in paragraph (1)(C) are covered  
21 only for individuals less than 18 years of age  
22 and special needs patients. On or after such  
23 date, such items and services are covered for all  
24 individuals enrolled for benefits under this Act,

1           except that endodontic services are not covered  
2           for individuals 18 years of age or older.

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

7                   (i) are limited to posterior teeth;

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

13                  (iii) do not include a space maintainer  
14                  that is placed within 6 months of the ex-  
15                  pected eruption of the permanent posterior  
16                  tooth concerned.

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

18           (A) MEDICALLY NECESSARY ORAL HEALTH  
19           CARE.—The term “medically necessary oral  
20           health care” means oral health care that is re-  
21           quired as a direct result of, or would have a di-  
22           rect impact on, an underlying medical condi-  
23           tion. Such term includes oral health care di-  
24           rected toward control or elimination of pain, in-  
25           fection, or reestablishment of oral function.

1 (B) SPECIAL NEEDS PATIENT.—The term  
2 “special needs patient” includes an individual  
3 with a genetic or birth defect, a developmental  
4 disability, or an acquired medical disability.

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

10 (j) SERVICES IN INTERMEDIATE CARE FACILITIES  
11 FOR INDIVIDUALS WITH AN INTELLECTUAL DIS-  
12 ABILITY.—Except as may be provided by the Board—

13 (1) the term “intermediate care facility for indi-  
14 viduals with an intellectual disability” has the mean-  
15 ing given the term “intermediate care facility for in-  
16 dividuals with mental retardation” in section  
17 1905(d) of the Social Security Act (as in effect be-  
18 fore the enactment of this Act); and

19 (2) the term “services in intermediate care fa-  
20 cilities for individuals with an intellectual disability”  
21 means services described in section 1905(a)(15) of  
22 such Act (as so in effect) in an intermediate care fa-  
23 cility for individuals with an intellectual disability to  
24 an individual determined to require such services in  
25 accordance with standards specified by the Board



1 and comparable to the standards described in section  
2 1902(a)(31)(A) of such Act (as so in effect).

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

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

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

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

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

19 (i) bathing;

20 (ii) eating;

21 (iii) dressing;

22 (iv) toileting; and

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

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

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

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

15          (b) LIMIT ON SERVICES.—

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

1       dents of nursing facilities in the same area in which  
2       the services were provided.

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

11 **SEC. 204. EXCLUSIONS AND LIMITATIONS.**

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

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

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

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

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

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

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

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

22 (B) The system provides for the participa-  
23 tion and coordination of multiple agencies and  
24 providers that serve the needs of children in the  
25 area, including agencies and providers involved

1 with child welfare, education, juvenile justice,  
2 criminal justice, health care, mental health, and  
3 substance abuse prevention and treatment.

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

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

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

21 (F) The system provides for the manage-  
22 ment of the individualized treatment plans de-  
23 scribed in subparagraph (D) and for a flexible  
24 response to changes in treatment needs over  
25 time.

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

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

22           (e) SPECIFIC LIMITATIONS.—

23               (1) LIMITATIONS ON EYEGLASSES, CONTACT  
24 LENSES, HEARING AIDS, AND DURABLE MEDICAL  
25 EQUIPMENT.—Subject to section 201(e), the Board

1        may impose such limits relating to the costs and fre-  
2        quency of replacement of eyeglasses, contact lenses,  
3        hearing aids, and durable medical equipment to  
4        which individuals enrolled for benefits under this Act  
5        are entitled to have payment made under a State  
6        health security program as the Board deems appro-  
7        priate.

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

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

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

21            (i) required to correct a congenital  
22       anomaly;

23            (ii) required to restore or correct a  
24       part of the body which has been altered as

1 a result of accidental injury, disease, or  
2 surgery; or

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

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

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

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



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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

17               (A) IN GENERAL.—Participation agree-  
18               ments may be terminated, with appropriate no-  
19               tice—

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

23                       (ii) by a provider.

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

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

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

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

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

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

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

16           (b) MINIMUM PROVIDER STANDARDS.—

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

1           (2) NATIONAL MINIMUM STANDARDS.—The na-  
2           tional minimum standards under paragraph (1) shall  
3           be established for institutional providers of services,  
4           individual health care practitioners, and comprehen-  
5           sive health service organizations. Except as the  
6           Board may specify in order to carry out this title,  
7           a hospital, nursing facility, or other institutional  
8           provider of services shall meet standards for such a  
9           facility under the medicare program under title  
10          XVIII of the Social Security Act (42 U.S.C. 1395 et  
11          seq.). Such standards also may include, where ap-  
12          propriate, elements relating to—

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

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

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

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

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

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

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

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

4 (b) ENROLLMENT.—

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

10 (2) MINIMUM ENROLLMENT PERIOD.—Subject  
11 to paragraph (3), the minimum period of enrollment  
12 with a CHSO shall be 1 year, unless the enrolled in-  
13 dividual becomes ineligible to enroll with the organi-  
14 zation.

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

18 (c) REQUIREMENTS FOR CHSOs.—

19 (1) ACCESSIBLE SERVICES.—Each CHSO shall  
20 make all health services readily and promptly acces-  
21 sible to enrollees who live in the specified service  
22 area.

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



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

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

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

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

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

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

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

4            (6) QUALITY AND OTHER REPORTING REQUIRE-  
5        MENTS.—

6            (A) IN GENERAL.—The Board shall deter-  
7        mine appropriate measures to assess the quality  
8        of care furnished by the CHSO, such as meas-  
9        ures of—

10            (i) clinical processes and outcomes;

11            (ii) patient and, where practicable,  
12        caregiver experience of care; and

13            (iii) utilization (such as rates of hos-  
14        pital admissions for ambulatory care sen-  
15        sitive conditions).

16            (B) OTHER DUTIES.—The CHSO shall—

17            (i) define processes to promote evi-  
18        dence-based medicine and patient engage-  
19        ment, report on quality and cost measures,  
20        and coordinate care, such as through the  
21        use of telehealth, remote patient moni-  
22        toring, and other such enabling tech-  
23        nologies; and

24            (ii) demonstrate to the Board that the  
25        CHSO meets patient-centeredness criteria

1 specified by the Board, such as the use of  
2 patient and caregiver assessments or the  
3 use of individualized care plans.

4 (C) REPORTING REQUIREMENTS.—A  
5 CHSO shall submit data in a form and manner  
6 specified by the Board on measures the Board  
7 determines necessary for the CHSO to report to  
8 the State Health Security Program in order to  
9 evaluate the quality of care furnished by the  
10 CHSO. Such data may include care transitions  
11 across health care settings, including hospital  
12 discharge planning and post-hospital discharge  
13 follow-up by CHSO professionals, as the Board  
14 determines appropriate.

15 (D) QUALITY PERFORMANCE STAND-  
16 ARDS.—The Board shall establish quality per-  
17 formance standards to assess the quality of care  
18 furnished by CHSOs and shall seek to improve  
19 the quality of care furnished by CHSOs over  
20 time by specifying higher standards, new meas-  
21 ures, or both for purposes of assessing such  
22 quality of care.

23 (7) PREMIUMS.—Premiums or other charges by  
24 a CHSO for any services not paid for under this Act  
25 shall be reasonable.

1 (8) UTILIZATION AND BONUS INFORMATION.—

2 Each CHSO shall—

3 (A) comply with the requirements of sec-  
4 tion 1876(i)(8) of the Social Security Act (re-  
5 lating to prohibiting physician incentive plans  
6 that provide specific inducements to reduce or  
7 limit medically necessary services); and

8 (B) make available to its membership utili-  
9 zation information and data regarding financial  
10 performance, including bonus or incentive pay-  
11 ment arrangements to practitioners.

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

20 (10) BROAD MARKETING.—Each CHSO shall  
21 provide for the marketing of its services (including  
22 dissemination of marketing materials) to potential  
23 enrollees in a manner that is designed to enroll indi-  
24 viduals representative of the different population  
25 groups and geographic areas included within its

1 service area and meets such requirements as the  
2 Board or a State health security program may speci-  
3 fy.

4 (11) ADDITIONAL REQUIREMENTS.—Each  
5 CHSO shall meet—

6 (A) such requirements relating to min-  
7 imum enrollment;

8 (B) such requirements relating to financial  
9 solvency;

10 (C) such requirements relating to quality  
11 and availability of care; and

12 (D) such other requirements,

13 as the Board or a State health security program  
14 may specify.

15 (d) PROVISION OF EMERGENCY SERVICES TO NON-  
16 ENROLLEES.—A CHSO may furnish emergency services  
17 to persons who are not enrolled in the organization. Pay-  
18 ment by the State Health Security Program for such serv-  
19 ices, if they are covered services to eligible persons, shall  
20 be made to the organization unless the organization re-  
21 quests that it be made to the individual provider who fur-  
22 nished the services.

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

24 (a) APPLICATION TO AMERICAN HEALTH SECURITY  
25 PROGRAM.—Section 1877 of the Social Security Act, as

1 amended by subsections (b) and (c), shall apply under this  
2 Act in the same manner as it applies under title XVIII  
3 of the Social Security Act; except that in applying such  
4 section under this Act any references in such section to  
5 the Secretary or title XVIII of the Social Security Act are  
6 deemed references to the Board and the American Health  
7 Security Program under this Act, respectively.

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

12 “(M) Ambulance services.

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

14 (c) CONFORMING AMENDMENTS.—Section 1877 of  
15 such Act is further amended—

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

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

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

23 “(1) DENIAL OF PAYMENT.—No payment may  
24 be made under a State health security program for  
25 a designated health service for which a claim is pre-

1       sented in violation of subsection (a)(1)(B). No indi-  
2       vidual, third party payor, or other entity is liable for  
3       payment for designated health services for which a  
4       claim is presented in violation of such subsection.”;  
5       and

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

10       **TITLE IV—ADMINISTRATION**  
11       **Subtitle A—General Administrative**  
12       **Provisions**

13       **SEC. 401. AMERICAN HEALTH SECURITY STANDARDS**  
14       **BOARD.**

15       (a) **ESTABLISHMENT.**—There is hereby established  
16       an American Health Security Standards Board.

17       (b) **APPOINTMENT AND TERMS OF MEMBERS.**—

18               (1) **IN GENERAL.**—The Board shall be com-  
19       posed of—

20               (A) the Secretary of Health and Human  
21       Services; and

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

1       The President shall first nominate individuals under  
2       subparagraph (B) on a timely basis so as to provide  
3       for the operation of the Board by not later than  
4       January 1, 2012.

5               (2) SELECTION OF APPOINTED MEMBERS.—  
6       With respect to the individuals appointed under  
7       paragraph (1)(B):

8               (A) The members shall be chosen on the  
9               basis of backgrounds in health policy, health ec-  
10              onomics, the health professions, and the admin-  
11              istration of health care institutions.

12              (B) The members shall provide a balanced  
13              point of view with respect to the various health  
14              care interests and at least 2 of them shall rep-  
15              resent the interests of individual consumers.

16              (C) At least 1 member shall have a nurs-  
17              ing background.

18              (D) Not more than 3 members shall be  
19              from the same political party.

20              (E) To the greatest extent feasible, the  
21              members shall represent the various geographic  
22              regions of the United States and shall reflect  
23              the racial, ethnic, and gender composition of  
24              the population of the United States.



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

10          (c) VACANCIES.—

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

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 an appointed member of the Board for a  
22           second term in the same manner as the original ap-  
23           pointment. A member who has served for 2 consecu-  
24           tive 6-year terms shall not be eligible for reappoint-



1 (G) methods for determining amounts of  
2 payments to providers of covered services, con-  
3 sistent with subtitle B of title VI;

4 (H) the determination of medical necessity  
5 and appropriateness with respect to coverage of  
6 certain services;

7 (I) assisting State health security pro-  
8 grams with planning for capital expenditures  
9 and service delivery;

10 (J) planning for health professional edu-  
11 cation funding (as specified in title VI);

12 (K) allocating funds provided under title  
13 VII; and

14 (L) encouraging States to develop regional  
15 planning mechanisms (described in section  
16 404(a)(3)).

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

21 (g) UNIFORM REPORTING STANDARDS; ANNUAL RE-  
22 PORT; STUDIES.—

23 (1) UNIFORM REPORTING STANDARDS.—

24 (A) IN GENERAL.—The Board shall estab-  
25 lish uniform State reporting requirements and

1 national standards to ensure an adequate na-  
2 tional data base regarding health services prac-  
3 titioners, services and finances of State health  
4 security programs, approved plans, providers,  
5 and the costs of facilities and practitioners pro-  
6 viding services. Such standards shall include, to  
7 the maximum extent feasible, health outcome  
8 measures.

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

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

17 (A) The status of implementation of the  
18 Act.

19 (B) Enrollment under this Act.

20 (C) Benefits under this Act.

21 (D) Expenditures and financing under this  
22 Act.

23 (E) Cost-containment measures and  
24 achievements under this Act.

25 (F) Quality assurance.

1 (G) Health care utilization patterns, in-  
2 cluding any changes attributable to the pro-  
3 gram.

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

6 (I) Differences in the health status of the  
7 populations of the different States, including in-  
8 come and racial characteristics.

9 (J) Necessary changes in the education of  
10 health personnel.

11 (K) Plans for improving service to medi-  
12 cally underserved populations.

13 (L) Transition problems as a result of im-  
14 plementation of this Act.

15 (M) Opportunities for improvements under  
16 this Act.

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

20 (A) make statistical and other studies, on  
21 a nationwide, regional, State, or local basis, of  
22 any aspect of the operation of this Act, includ-  
23 ing studies of the effect of the Act upon the  
24 health of the people of the United States and

1 the effect of comprehensive health services upon  
2 the health of persons receiving such services;

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

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

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

21 (E) develop, in collaboration with the phar-  
22 maceutical profession, and test, improved ad-  
23 ministrative practices or improved methods for  
24 the reimbursement of independent pharmacies

1           for the cost of furnishing drugs as a covered  
2           service; and

3                   (F) conduct or solicit other studies as it  
4           may consider necessary or promising for the  
5           evaluation, or for the improvement, of the oper-  
6           ation of this Act.

7           (4) REPORT ON USE OF EXISTING FEDERAL  
8           HEALTH CARE FACILITIES.—Not later than 1 year  
9           after the date of the enactment of this Act, the  
10          Board shall recommend to Congress one or more  
11          proposals for the treatment of health care facilities  
12          of the Federal Government.

13          (h) EXECUTIVE DIRECTOR.—

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

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

1 Health and Human Services, any of its functions or  
2 duties under this Act other than—

3 (A) the issuance of regulations; or

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

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

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

14 (1) in section 12(1), by inserting after “Cor-  
15 poration;” the first place it appears the following:  
16 “the Chair of the American Health Security Stand-  
17 ards Board;”;

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

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

22 “SPECIAL PROVISIONS CONCERNING AMERICAN HEALTH  
23 SECURITY STANDARDS BOARD

24 “SEC. 8M. The Inspector General of the American  
25 Health Security Standards Board, in addition to the other  
26 authorities vested by this Act, shall have the same author-



1 ity, with respect to the Board and the American Health  
2 Security Program under this Act, as the Inspector General  
3 for the Department of Health and Human Services has  
4 with respect to the Secretary of Health and Human Serv-  
5 ices and the medicare and medicaid programs, respec-  
6 tively.”.

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

9 (k) ACCESS TO INFORMATION.—The Secretary of  
10 Health and Human Services shall make available to the  
11 Board all information available from sources within the  
12 Department or from other sources, pertaining to the du-  
13 ties of the Board.

14 **SEC. 402. AMERICAN HEALTH SECURITY ADVISORY COUN-**  
15 **CIL.**

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

20 (b) MEMBERSHIP.—The Council shall be composed  
21 of—

22 (1) the Chair of the Board, who shall serve as  
23 Chair of the Council; and

24 (2) 20 members, not otherwise in the employ of  
25 the United States, appointed by the Board without

1 regard to the provisions of title 5, United States  
2 Code, governing appointments in the competitive  
3 service.

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

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

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

22 (2) the terms of the members first taking office  
23 shall expire, as designated by the Board at the time  
24 of appointment, at the end of the first year with re-  
25 spect to 5 members, at the end of the second year

1 with respect to 5 members, at the end of the third  
2 year with respect to 5 members, and at the end of  
3 the fourth year with respect to 5 members after the  
4 date of enactment of this Act.

5 (d) VACANCIES.—

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

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

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

19 (e) QUALIFICATIONS.—

20 (1) PUBLIC HEALTH REPRESENTATIVES.—  
21 Members of the Council who are representative of  
22 State health security programs and public health  
23 professionals shall be individuals who have extensive  
24 experience in the financing and delivery of care  
25 under public health programs.

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

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

15          (f) DUTIES.—

16           (1) IN GENERAL.—It shall be the duty of the  
17          Council—

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

23           (B) to study the operation of this Act and  
24           the utilization of health services under it, with  
25           a view to recommending any changes in the ad-

1           ministration of the Act or in its provisions  
2           which may appear desirable.

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

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

15          (h) MEETINGS.—The Council shall meet as fre-  
16          quently as the Board deems necessary, but not less than  
17          4 times each year. Upon request by 7 or more members  
18          it shall be the duty of the Chair to call a meeting of the  
19          Council.

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

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

4 **SEC. 403. CONSULTATION.**

5 The Secretary and the Board shall consult with Fed-  
6 eral agencies and private entities, such as professional so-  
7 cieties, national associations, nationally recognized asso-  
8 ciations of experts, medical schools and academic health  
9 centers, consumer groups, and labor and business organi-  
10 zations in the formulation of guidelines, regulations, policy  
11 initiatives, and information gathering to ensure the broad-  
12 est and most informed input in the administration of this  
13 Act. Nothing in this Act shall prevent the Secretary from  
14 adopting guidelines developed by such a private entity if,  
15 in the Secretary's and Board's judgment, such guidelines  
16 are generally accepted as reasonable and prudent and con-  
17 sistent with this Act.

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

19 (a) SUBMISSION OF PLANS.—

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

24 (2) REGIONAL PROGRAMS.—A State may join  
25 with 1 or more neighboring States to submit to the

1 Board a plan for a regional health security program  
2 instead of separate State health security programs.

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

9 (4) STATES THAT FAIL TO SUBMIT A PLAN.—  
10 In the case of a State that fails to submit a plan as  
11 required under this subsection, the American Health  
12 Security Standards Board Authority shall develop a  
13 plan for a State health security program in such  
14 State.

15 (b) REVIEW AND APPROVAL OF PLANS.—

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

23 (A) Payment for required health services  
24 for eligible individuals in the State in accord-  
25 ance with this Act.

1 (B) Adequate administration, including the  
2 designation of a single State agency responsible  
3 for the administration (or supervision of the ad-  
4 ministration) of the program.

5 (C) The establishment of a State health se-  
6 curity budget.

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

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

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

17 (i) ensures participation of consumers  
18 of health services and providers of health  
19 services; and

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



1 (G) The licensure and regulation of all  
2 health providers and facilities to ensure compli-  
3 ance with Federal and State laws and to pro-  
4 mote quality of care.

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

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

13 (J) Publication of an annual report on the  
14 operation of the State health security program,  
15 which report shall include information on cost,  
16 progress towards achieving full enrollment, pub-  
17 lic access to health services, quality review,  
18 health outcomes, health professional training,  
19 the needs of medically underserved populations,  
20 and the information required in the annual re-  
21 port under section 401(g)(2).

22 (K) Provision of a fraud and abuse preven-  
23 tion and control unit that the Inspector General  
24 determines meets the requirements of section  
25 412(a).

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

3                   (2) CONSEQUENCES OF FAILURE TO COMPLY.—

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

16                  (c) STATE HEALTH SECURITY ADVISORY COUN-  
17                  CILS.—

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

24                  (2) MEMBERSHIP.—Each State Health Security  
25                  Advisory Council shall be composed of at least 11 in-

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

14 (3) DUTIES.—

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

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

1           grams, with particular emphasis placed on as-  
2           sisting those applicants with broad consumer  
3           representation.

4           (d) STATE USE OF FISCAL AGENTS.—

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

12 (3) meet 1 of the following requirements:

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

18 (B) If it is in a State the constitution of  
19 which does not provide for the criminal prosecu-  
20 tion of individuals by a statewide authority and  
21 has formal procedures, approved by the Board,  
22 that—

23 (i) assure its referral of suspected  
24 criminal violations relating to the State  
25 health insurance plan to the appropriate

1 authority or authorities in the States for  
2 prosecution; and

3 (ii) assure its assistance of, and co-  
4 ordination with, such authority or authori-  
5 ties in such prosecutions.

6 (C) It shall have a formal working relation-  
7 ship with the office of the State Attorney Gen-  
8 eral and have formal procedures (including pro-  
9 cedures for its referral of suspected criminal  
10 violations to such office) which are approved by  
11 the Board and which provide effective coordina-  
12 tion of activities between the fraud unit and  
13 such office with respect to the detection, inves-  
14 tigation, and prosecution of suspected criminal  
15 violations relating to the State health insurance  
16 plan.

17 (c) FUNCTIONS.—The fraud unit shall—

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

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

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

13          (d) RESOURCES.—The fraud unit shall—

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

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

17               (3) provide sufficient resources (as specified by  
18               the Board),

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

21          (e) COOPERATIVE AGREEMENTS.—The fraud unit  
22          shall have cooperative agreements (as specified by the  
23          Board) with—

24               (1) similar fraud units in other States;

25               (2) the Inspector General; and



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

2 (f) REPORTS.—The fraud unit shall submit to the In-  
3 spector General an application and annual reports con-  
4 taining such information as the Inspector General deter-  
5 mines to be necessary to determine whether the unit meets  
6 the previous requirements of this section.

## 7 **TITLE V—QUALITY ASSESSMENT**

### 8 **SEC. 501. AMERICAN HEALTH SECURITY QUALITY COUNCIL.**

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

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

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

22 (2) STANDARDS OF QUALITY, PERFORMANCE  
23 MEASURES, AND MEDICAL REVIEW CRITERIA.—The  
24 Council shall review and evaluate each standard of  
25 quality, performance measure, and medical review

1 criterion developed under part B of title IX of the  
2 Public Health Service Act. The Council shall deter-  
3 mine whether the standard, measure, or criterion is  
4 appropriate for use in assessing or reviewing the  
5 quality of services provided by State health security  
6 programs, health care institutions, or health care  
7 professionals.

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

22 (4) REPORTING.—The Council shall report to  
23 the Board annually on the conduct of activities  
24 under such title and shall report to the Board annu-  
25 ally specifically on findings from outcomes research

1 and development of practice guidelines that may af-  
2 fect the Board's determination of coverage of serv-  
3 ices under section 401(f)(1)(G).

4 (5) OTHER FUNCTIONS.—The Council shall  
5 perform the functions of the Council described in  
6 section 502.

7 (c) APPOINTMENT AND TERMS OF MEMBERS.—

8 (1) IN GENERAL.—The Council shall be com-  
9 posed of 10 members appointed by the President.  
10 The President shall first appoint individuals on a  
11 timely basis so as to provide for the operation of the  
12 Council by not later than January 1, 2012.

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

23 (3) TERMS OF MEMBERS.—Individuals ap-  
24 pointed to the Council shall serve for a term of 5  
25 years, except that the terms of 4 of the individuals

1 initially appointed shall be, as designated by the  
2 President at the time of their appointment, for 1, 2,  
3 3, and 4 years.

4 (d) VACANCIES.—

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

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

14 (3) REAPPOINTMENT.—The President may re-  
15 appoint a member of the Council for a second term  
16 in the same manner as the original appointment. A  
17 member who has served for 2 consecutive 5-year  
18 terms shall not be eligible for reappointment until 2  
19 years after the member has ceased to serve.

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

23 (f) COMPENSATION.—Members of the Council who  
24 are not employees of the Federal Government shall be en-  
25 titled to compensation at a level equivalent to level II of

1 the Executive Schedule, in accordance with section 5313  
2 of title 5, United States Code.

3 **SEC. 502. DEVELOPMENT OF CERTAIN METHODOLOGIES,**  
4 **GUIDELINES, AND STANDARDS.**

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

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

20 (c) **REMEDIAL ACTIONS.**—The Council shall develop  
21 standards for education and sanctions with respect to  
22 outliers so as to ensure the quality of health care services  
23 provided under this Act. The Council shall develop criteria  
24 for referral of providers to the State licensing board if edu-

1 cation proves ineffective in correcting provider practice be-  
2 havior.

3 (d) DISSEMINATION.—The Council shall disseminate  
4 to the State—

5 (1) the methodologies adopted under subsection

6 (a);

7 (2) the guidelines developed under subsection

8 (b); and

9 (3) the standards developed under subsection

10 (c);

11 for use by the States under section 503.

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

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

18 (a) REQUIREMENT.—In order to meet the require-  
19 ment of section 404(b)(1)(H), each State health security  
20 program shall establish 1 or more qualified entities to con-  
21 duct quality reviews of persons providing covered services  
22 under the program, in accordance with standards estab-  
23 lished under subsection (b)(1) (except as provided in sub-  
24 section (b)(2)) and subsection (d).

25 (b) FEDERAL STANDARDS.—

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

3           (A) the adoption of practice guidelines  
4 (whether developed by the Federal Government  
5 or other entities);

6           (B) the identification of outliers (con-  
7 sistent with methodologies adopted under sec-  
8 tion 502(a));

9           (C) the development of remedial programs  
10 and monitoring for outliers; and

11           (D) the application of sanctions (consistent  
12 with the standards developed under section  
13 502(c)).

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

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

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

9 **SEC. 504. ELIMINATION OF UTILIZATION REVIEW PRO-**  
10 **GRAMS; TRANSITION.**

11 (a) INTENT.—It is the intention of this title to re-  
12 place by January 1, 2015, random utilization controls with  
13 a systematic review of patterns of practice that com-  
14 promise the quality of care.

15 (b) SUPERSEDING CASE REVIEWS.—

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

24 (2) TRANSITION.—Before January 1, 2015, the  
25 Board and the States may employ existing utiliza-



1           tion review standards and mechanisms as may be  
2           necessary to effect the transition to pattern of prac-  
3           tice-based reviews.

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

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

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

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

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

19 **SEC. 505. APPLICATION OF CENTER FOR MEDICARE AND**  
20 **MEDICAID INNOVATION TO AMERICAN**  
21 **HEALTH SECURITY PROGRAM.**

22           Section 1115A of the Social Security Act (42 U.S.C.  
23 1315a) is amended by adding at the end the following new  
24 subsection:

1           “(h) APPLICATION TO AMERICAN HEALTH SECURITY  
2 PROGRAM.—Notwithstanding any other provision of law  
3 (including the preceding provisions of this section), on and  
4 after January 1, 2013, the duties described in this section  
5 shall be adapted to apply to the American Health Security  
6 Program under the American Health Security Act of  
7 2011. For purposes of carrying out the preceding sen-  
8 tence, effective on such date, the following rules shall  
9 apply:

10           “(1) There is created, in consultation with the  
11 American Health Security Standards Board estab-  
12 lished under section 401 of the American Health Se-  
13 curity Act of 2011, within the Department of Health  
14 and Human Services a Center for American Health  
15 Security Innovation (in this subsection referred to as  
16 the ‘Center’) to carry out this subsection. The pur-  
17 pose of the Center is to accelerate the implementa-  
18 tion of new models of care under the American  
19 Health Security Program that would improve patient  
20 care, improve population health, and lower costs in  
21 a manner consistent with the requirements of such  
22 Program.

23           “(2) Any references in this section to the ‘Sec-  
24 retary’ or the ‘Centers for Medicare & Medicaid

1 Services’ are deemed references to the ‘American  
2 Health Security Standards Board’.

3 “(3) Any references in this section to title  
4 XVIII, XIX, or XXI of this Act are deemed ref-  
5 erences to the American Health Security Program.

6 “(4) Any references in this section to the ‘Chief  
7 Actuary of the Centers for Medicare & Medicaid  
8 Services’ are deemed references to the ‘Chief Actu-  
9 ary of the Department of Health and Human Serv-  
10 ices’.

11 “(5) Any references in this section to the ‘Cen-  
12 ter for Medicare and Medicaid Innovation’ or the  
13 ‘CMI’ are deemed references to the Center for  
14 American Health Security Innovation.

15 “(6) For purposes of carrying out this sub-  
16 section, the American Health Security Standards  
17 Board shall provide for the transfer, from the Amer-  
18 ican Health Security Trust Fund under section 801  
19 of the American Health Security Act of 2011, of  
20 such sums as the Board determines necessary, to the  
21 Center.”.

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 2012), 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 In addition to the cost of covered health services, the

1 national health security budget shall consist of at  
2 least 4 components:

3 (A) A component for quality assessment  
4 activities (described in title V).

5 (B) A component for health professional  
6 education expenditures.

7 (C) A component for administrative costs.

8 (D) A component for operating and other  
9 expenditures not described in subparagraphs  
10 (A) through (C) (in this title referred to as the  
11 “operating component”), consisting of amounts  
12 not included in the other components. A State  
13 may provide for the allocation of this compo-  
14 nent between capital expenditures and other ex-  
15 penditures.

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

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

24 (B) assures that the health professional  
25 education expenditure component is sufficient

1 to provide for the amount of health professional  
2 education expenditures sufficient to meet the  
3 need for covered health care services (consistent  
4 with the national health security spending  
5 growth limit under subsection (b)(2)).

6 (b) BASIS FOR TOTAL EXPENDITURES.—

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

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

25 (c) DEFINITIONS.—In this title:

1           (1) CAPITAL EXPENDITURES.—The term “cap-  
2           ital expenditures” means expenses for the purchase,  
3           lease, construction, or renovation of capital facilities  
4           and for equipment and includes return on equity  
5           capital.

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

11 **SEC. 602. COMPUTATION OF INDIVIDUAL AND STATE CAPI-**  
12 **TATION AMOUNTS.**

13           (a) CAPITATION AMOUNTS.—

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

1 (A) a national average per capita cost for  
2 all covered health care services (computed  
3 under subsection (b));

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

6 (C) the risk adjustment factor (established  
7 under subsection (d)) for the risk group.

8 (2) STATE CAPITATION AMOUNT.—

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

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

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



1 (b) COMPUTATION OF NATIONAL AVERAGE PER CAP-  
2 ITA COST.—

3 (1) FOR 2012.—For 2012, the national average  
4 per capita cost under this paragraph is equal to—

5 (A) the average per capita health care ex-  
6 penditures in the United States in 2010 (as es-  
7 timated by the Board);

8 (B) increased to 2011 by the Board's esti-  
9 mate of the actual amount of such per capita  
10 expenditures during 2011; and

11 (C) updated to 2012 by the national health  
12 security spending growth limit specified in sec-  
13 tion 601(b)(2) for 2012.

14 (2) FOR SUCCEEDING YEARS.—For each suc-  
15 ceeding year, the national average per capita cost  
16 under this subsection is equal to the national aver-  
17 age per capita cost computed under this subsection  
18 for the previous year adjusted by the national health  
19 security spending growth limit (specified in section  
20 601(b)(2)) for the year involved.

21 (c) STATE ADJUSTMENT FACTORS.—

22 (1) IN GENERAL.—Subject to the succeeding  
23 paragraphs of this subsection, the Board shall de-  
24 velop for each State a factor to adjust the national

1 average per capita costs to reflect differences be-  
2 tween the State and the United States in—

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

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

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

16 (D) any other factor relating to operating  
17 costs required to ensure equitable distribution  
18 of funds among the States.

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

1 (A) differences among States in health  
2 professional education programs in operation as  
3 of the date of the enactment of this Act; and

4 (B) differences among States in their rel-  
5 ative need for expenditures for health profes-  
6 sional education, taking into account the health  
7 professional education expenditures proposed in  
8 State health security budgets under section  
9 603(a).

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

17 (4) PHASE-IN.—In applying State adjustment  
18 factors under this subsection during the 5-year pe-  
19 riod beginning with 2012, the Board shall phase-in,  
20 over such period, the use of factors described in  
21 paragraph (1) in a manner so that the adjustment  
22 factor for a State is based on a blend of such factors  
23 and a factor that reflects the relative actual average  
24 per capita costs of health services of the different  
25 States as of the time of enactment of this Act.

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

6           (d) ADJUSTMENTS FOR RISK GROUP CLASSIFICA-  
7           TION.—

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

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

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

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

2 (a) ESTABLISHMENT AND SUBMISSION OF BUDG-  
3 ETS.—

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

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

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

16 (ii) Within the operating component—

17 (I) expenditures for operating  
18 costs of hospitals and other facility-  
19 based services in the State;

20 (II) expenditures for payment to  
21 comprehensive health service organiza-  
22 tions;

23 (III) expenditures for payment of  
24 services provided by health care prac-  
25 titioners; and

1 (IV) expenditures for other cov-  
2 ered items and services.

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

6 (B) The total revenues required to meet  
7 the State health security expenditures.

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

11 (3) FINAL BUDGET.—The final budget for a  
12 year shall—

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

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

19 (4) ADJUSTMENT IN ALLOCATIONS PER-  
20 MITTED.—

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

1 (B) NOTICE.—No such change may be  
2 made unless the State has provided prior notice  
3 of the change to the Board.

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

7 (b) EXPENDITURE LIMITS.—

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

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

22 (3) WORKER ASSISTANCE.—A State health se-  
23 curity program may provide that, for budgets for  
24 years before 2015, up to 1 percent of the budget  
25 may be used for purposes of programs providing as-

1       sistance to workers who are currently performing  
2       functions in the administration of the health insur-  
3       ance system and who may experience economic dis-  
4       location as a result of the implementation of the pro-  
5       gram.

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

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

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

18              (1) the State capitation amount (computed  
19              under section 602(a)(2)) for the State for the year;  
20              and

21              (2) the Federal contribution percentage (estab-  
22              lished under subsection (b)).

23      (b) FEDERAL CONTRIBUTION PERCENTAGE.—The  
24      Board shall establish a formula for the establishment of  
25      a Federal contribution percentage for each State. Such



1 formula shall take into consideration a State's per capita  
2 income and revenue capacity and such other relevant eco-  
3 nomic indicators as the Board determines to be appro-  
4 priate. In addition, during the 5-year period beginning  
5 with 2012, the Board may provide for a transition adjust-  
6 ment to the formula in order to take into account current  
7 expenditures by the State (and local governments thereof)  
8 for health services covered under the State health security  
9 program. The weighted-average Federal contribution per-  
10 centage for all States shall equal 86 percent and in no  
11 event shall such percentage be less than 81 percent nor  
12 more than 91 percent.

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

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

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

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

1 **SEC. 605. ACCOUNT FOR HEALTH PROFESSIONAL EDU-**  
2 **CATION EXPENDITURES.**

3 (a) SEPARATE ACCOUNT.—Each State health secu-  
4 rity program shall—

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

7 (2) specify the general manner, consistent with  
8 subsection (b), in which such expenditures are to be  
9 distributed among different types of institutions and  
10 the different areas of the State.

11 (b) DISTRIBUTION RULES.—The distribution of  
12 funds to hospitals and other health care facilities from the  
13 account shall conform to the following principles:

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

21 (2) The distribution of funds from the account  
22 shall take into account the potentially higher costs  
23 of placing health professional students in clinical  
24 education programs in health professional shortage  
25 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 reductions in registered nursing staffing pat-  
24 terns or changes in emergency room or primary  
25 care services or availability.

1           (E) Change in the consumer price index  
2           and other price indices.

3           (F) The cost of reasonable compensation  
4           to health care practitioners.

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

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

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

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

21          (K) Technological advances or changes.

22          (L) Costs of the institution or facility asso-  
23          ciated with meeting Federal and State regula-  
24          tions.

1 (M) The costs associated with necessary  
2 public outreach activities.

3 (N) Incentives to facilities that maintain  
4 costs below previous reasonable budgeted levels  
5 without reducing the care provided.

6 (O) With respect to facilities that provide  
7 mental health services and substance abuse  
8 treatment services, any additional costs involved  
9 in the treatment of dually diagnosed individ-  
10 uals.

11 The portion of such a budget that relates to expendi-  
12 tures for health professional education shall be con-  
13 sistent with the State health security budget for  
14 such expenditures.

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

23 (c) ADJUSTMENTS IN APPROVED BUDGETS.—

24 (1) ADJUSTMENTS TO GLOBAL BUDGETS THAT  
25 CONTRACT WITH COMPREHENSIVE HEALTH SERVICE

1 ORGANIZATIONS.—Each State health security pro-  
2 gram shall develop an administrative mechanism for  
3 reducing operating funds to institutions or facilities  
4 in proportion to payments made to such institutions  
5 or facilities for services contracted for by a com-  
6 prehensive health service organization.

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

13 (d) DONATIONS PERMISSIBLE.—The States health  
14 security programs may permit institutions and facilities  
15 to raise funds from private sources to pay for newly con-  
16 structed facilities, major renovations, and equipment. The  
17 expenditure of such funds, whether for operating or cap-  
18 ital expenditures, does not obligate the State health secu-  
19 rity program to provide for continued support for such ex-  
20 penditures unless included in an approved global budget.

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

22 **BASED ON PROSPECTIVE FEE SCHEDULE.**

23 (a) FEE FOR SERVICE.—

24 (1) IN GENERAL.—Every independent health  
25 care practitioner is entitled to be paid, for the provi-

1 sion of covered health services under the State  
2 health security program, a fee for each billable cov-  
3 ered service.

4 (2) GLOBAL FEE PAYMENT METHODOLOGIES.—

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

15 (3) BILLING DEADLINES; ELECTRONIC BILL-  
16 ING.—A State health security program may deny  
17 payment for any service of an independent health  
18 care practitioner for which it did not receive a bill  
19 and appropriate supporting documentation (which  
20 had been previously specified) within 30 days after  
21 the date the service was provided. Such a program  
22 may require that bills for services for which payment  
23 may be made under this section, or for any class of  
24 such services, be submitted electronically.



1           (b) PAYMENT RATES BASED ON NEGOTIATED PRO-  
2 SPECTIVE FEE SCHEDULES.—With respect to any pay-  
3 ment method for a class of services of practitioners, the  
4 State health security program shall establish, on a pro-  
5 spective basis, a payment schedule. The State health secu-  
6 rity program may establish such a schedule after negotia-  
7 tions with organizations representing the practitioners in-  
8 volved. Such fee schedules shall be designed to provide in-  
9 centives for practitioners to choose primary care medicine,  
10 including general internal medicine, family medicine, gyne-  
11 cology, and pediatrics, over medical specialization. Noth-  
12 ing in this section shall be construed as preventing a State  
13 from adjusting the payment schedule amounts on a quar-  
14 terly or other periodic basis depending on whether expend-  
15 itures under the schedule will exceed the budgeted amount  
16 with respect to such expenditures.

17           (c) BILLABLE COVERED SERVICE DEFINED.—In this  
18 section, the term “billable covered service” means a service  
19 covered under section 201 for which a practitioner is enti-  
20 tled to compensation by payment of a fee determined  
21 under this section.

1 **SEC. 613. PAYMENTS TO COMPREHENSIVE HEALTH SERV-**  
2 **ICE ORGANIZATIONS.**

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

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

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

10 (b) BASIC CAPITATION AMOUNT.—

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

19 (2) ADJUSTMENT FOR SPECIAL HEALTH  
20 NEEDS.—The State health security program shall  
21 adjust such average amounts to take into account  
22 the special health needs, including a disproportionate  
23 number of medically underserved individuals, of pop-  
24 ulations served by the organization.

25 (3) ADJUSTMENT FOR SERVICES NOT PRO-  
26 VIDED.—The State health security program shall ad-

1 just such average amounts to take into account the  
2 cost of covered health care services that are not pro-  
3 vided by the comprehensive health service organiza-  
4 tion under section 303(a).

5 **SEC. 614. PAYMENTS FOR COMMUNITY-BASED PRIMARY**  
6 **HEALTH SERVICES.**

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

10 (1) be based on a global budget described in  
11 section 611;

12 (2) be based on the basic primary care capita-  
13 tion amount described in subsection (c) for each in-  
14 dividual enrolled with the provider of such services;  
15 or

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

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

21 (1) an additional amount, as set by the State  
22 health security program, to cover the costs incurred  
23 by a provider which serves persons not covered by  
24 this Act whose health care is essential to overall  
25 community health and the control of communicable

1 disease, and for whom the cost of such care is other-  
2 wise uncompensated;

3 (2) an additional amount, as set by the State  
4 health security program, to cover the reasonable  
5 costs incurred by a provider that furnishes case  
6 management services (as defined in section  
7 1915(g)(2) of the Social Security Act), transpor-  
8 tation services, and translation services; and

9 (3) an additional amount, as set by the State  
10 health security program, to cover the costs incurred  
11 by a provider in conducting health professional edu-  
12 cation programs in connection with the provision of  
13 such services.

14 (c) BASIC PRIMARY CARE CAPITATION AMOUNT.—

15 (1) IN GENERAL.—The basic primary care capi-  
16 tation amount described in this subsection for an en-  
17 rollee with a provider of community-based primary  
18 health services shall be determined by the State  
19 health security program on the basis of the average  
20 amount of expenditures that is estimated would be  
21 made under the State health security program for  
22 such an enrollee, based on actuarial characteristics  
23 (as defined by the State health security program).

24 (2) ADJUSTMENT FOR SPECIAL HEALTH  
25 NEEDS.—The State health security program shall

1       adjust such average amounts to take into account  
2       the special health needs, including a disproportionate  
3       number of medically underserved individuals, of pop-  
4       ulations served by the provider.

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

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

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

15       (a) ESTABLISHMENT OF LIST.—

16           (1) IN GENERAL.—The Board shall establish a  
17       list of approved prescription drugs and biologicals  
18       that the Board determines are necessary for the  
19       maintenance or restoration of health or of employ-  
20       ability or self-management and eligible for coverage  
21       under this Act.

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

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

10           (c) CHARGES BY INDEPENDENT PHARMACIES.—  
11 Each State health security program shall provide for pay-  
12 ment for a prescription drug or biological or insulin fur-  
13 nished by an independent pharmacy based on the drug's  
14 cost to the pharmacy (not in excess of the applicable prod-  
15 uct price established under subsection (b)) plus a dis-  
16 pensing fee. In accordance with standards established by  
17 the Board, each State health security program, after con-  
18 sultation with representatives of the pharmaceutical pro-  
19 fession, shall establish schedules of dispensing fees, de-  
20 signed to afford reasonable compensation to independent  
21 pharmacies after taking into account variations in their  
22 cost of operation resulting from regional differences, dif-  
23 ferences in the volume of prescription drugs dispensed, dif-  
24 ferences in services provided, the need to maintain expend-

1 itures within the budgets established under this title, and  
2 other relevant factors.

3 **SEC. 616. PAYMENTS FOR APPROVED DEVICES AND EQUIP-**  
4 **MENT.**

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

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

19 (c) PRICES.—For each such listed item covered under  
20 this Act, the Board shall from time to time determine a  
21 product price or prices which shall constitute the max-  
22 imum to be recognized under this Act as the cost of the  
23 item to a provider thereof. The Board may conduct nego-  
24 tiations, on behalf of State health security programs, with

1 equipment and device manufacturers and distributors in  
2 determining the applicable product price or prices.

3 (d) EXCLUSIONS.—The Board may exclude from cov-  
4 erage under this Act ineffective, unsafe, or overpriced  
5 products where better alternatives are determined to be  
6 available.

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

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

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

16 (2) consistent with the State health security  
17 budget.

18 **SEC. 618. PAYMENT INCENTIVES FOR MEDICALLY UNDER-**  
19 **SERVED AREAS.**

20 (a) MODEL PAYMENT METHODOLOGIES.—In addi-  
21 tion to the payment amounts otherwise provided in this  
22 title, the Board shall establish model payment methodolo-  
23 gies and other incentives that promote the provision of  
24 covered health care services in medically underserved



1 areas, particularly in rural and inner-city underserved  
2 areas.

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

9 **SEC. 619. AUTHORITY FOR ALTERNATIVE PAYMENT METH-**  
10 **ODOLOGIES.**

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

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

23 (2) the program submits periodic reports to the  
24 Board showing the operation and effectiveness of the  
25 alternative methodology, in order for the Board to

1 evaluate the appropriateness of applying the alter-  
2 native methodology to other States.

3 **Subtitle C—Mandatory Assignment**  
4 **and Administrative Provisions**

5 **SEC. 631. MANDATORY ASSIGNMENT.**

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

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

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

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

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

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

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

21 **SEC. 701. ROLE OF BOARD; ESTABLISHMENT OF PRIMARY**  
22 **CARE PROFESSIONAL OUTPUT GOALS.**

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

24 (1) coordinating health professional education  
25 policies and goals, in consultation with the Secretary  
26 of Health and Human Services (in this title referred

1 to as the “Secretary”), to achieve the national goals  
2 specified in subsection (b);

3 (2) overseeing the health professional education  
4 expenditures of the State health security programs  
5 from the account established under section 602(c);

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

11 (4) developing, coordinating, and promoting  
12 other policies that expand the number of primary  
13 care practitioners, registered nurses, midlevel practi-  
14 tioners, and dentists; and

15 (5) recommending the appropriate training,  
16 education, and patient advocacy enhancements of  
17 primary care health professionals, including reg-  
18 istered nurses, to achieve uniform high quality care  
19 and patient safety.

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

22 (1) GRADUATE MEDICAL EDUCATION.—By not  
23 later than 5 years after the date of the enactment  
24 of this Act, at least 50 percent of the residents in  
25 medical residency education programs (as defined in

1 subsection (e)(2)) are primary care residents (as de-  
2 fined in subsection (e)(4)).

3 (2) REGISTERED NURSES.—To ensure an ade-  
4 quate supply of registered nurses, there shall be a  
5 number, specified by the Board, of registered nurses  
6 employed in the health care system as of January 1,  
7 2015.

8 (3) MIDDLELEVEL PRIMARY CARE PRACTI-  
9 TIONERS.—To ensure an adequate supply of primary  
10 care practitioners, there shall be a number, specified  
11 by the Board, of midlevel primary care practitioners  
12 (as defined in subsection (e)(3)) employed in the  
13 health care system as of January 1, 2015.

14 (4) DENTISTRY.—To ensure an adequate sup-  
15 ply of dental care practitioners, there shall be a  
16 number, specified by the Board, of dentists (as de-  
17 fined in subsection (e)(1)) employed in the health  
18 care system as of January 1, 2015.

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

22 (1) IN GENERAL.—The Board, in consultation  
23 with the National Health Care Workforce Commis-  
24 sion, shall establish a method of applying the na-  
25 tional goal in subsection (b)(1) to program goals for

1 each medical residency education program or to  
2 medical residency education consortia.

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

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

14 (A) includes at least 1 medical school with  
15 a teaching hospital and related teaching set-  
16 tings; and

17 (B) has an affiliation with qualified com-  
18 munity-based primary health service providers  
19 described in section 202(a) and with at least 1  
20 comprehensive health service organization es-  
21 tablished under section 303.

22 (4) ENFORCEMENT THROUGH STATE HEALTH  
23 SECURITY BUDGETS.—The Board shall develop a  
24 formula for reducing payments to State health secu-  
25 rity programs (that provide for payments to a med-

1 ical residency education program) that failed to meet  
2 the goal for the program established under this sub-  
3 section.

4 (d) METHOD FOR ATTAINMENT OF NATIONAL GOAL  
5 FOR MIDDLELEVEL PRIMARY CARE PRACTITIONERS.—To as-  
6 sist in attaining the national goal identified in subsection  
7 (b)(3), the Board, in consultation with the National  
8 Health Care Workforce Commission, shall—

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

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

19 (e) DEFINITIONS.—In this title:

20 (1) DENTIST.—The term “dentist” means a  
21 practitioner who performs the evaluation, diagnosis,  
22 prevention or treatment (nonsurgical, surgical, or re-  
23 lated procedures) of diseases, disorders or conditions  
24 of the oral cavity, maxillofacial area or the adjacent  
25 and associated structures and their impact on the

1 human body, within the scope of his or her edu-  
2 cation, training and experience, in accordance with  
3 the ethics of the profession and applicable law.

4 (2) MEDICAL RESIDENCY EDUCATION PRO-  
5 GRAM.—The term “medical residency education pro-  
6 gram” means a program that provides education  
7 and training to graduates of medical schools in order  
8 to meet requirements for licensing and certification  
9 as a physician, and includes the medical school su-  
10 pervising the program and includes the hospital or  
11 other facility in which the program is operated.

12 (3) MIDLEVEL PRIMARY CARE PRACTI-  
13 TIONER.—The term “midlevel primary care practi-  
14 tioner” means a clinical nurse practitioner, certified  
15 nurse midwife, physician assistance, or other non-  
16 physician practitioner, specified by the Board, as au-  
17 thORIZED to practice under State law.

18 (4) PRIMARY CARE RESIDENT.—The term “pri-  
19 mary care resident” means (in accordance with cri-  
20 teria established by the Board) a resident being  
21 trained in a distinct program of family practice med-  
22 icine, general practice, general internal medicine, or  
23 general pediatrics.



1 **SEC. 702. GRANTS FOR HEALTH PROFESSIONS EDUCATION,**  
2 **NURSE EDUCATION, AND THE NATIONAL**  
3 **HEALTH SERVICE CORPS.**

4 (a) TRANSFERS TO PUBLIC HEALTH SERVICE.—The  
5 Board shall make transfers from the American Health Se-  
6 curity Trust Fund to the Public Health Service under sub-  
7 part II of part D of title III, title VII, and title VIII of  
8 the Public Health Service Act for the support of the Na-  
9 tional Health Service Corps, health professions education,  
10 and nursing education, including education of clinical  
11 nurse practitioners, certified registered nurse anesthetists,  
12 certified nurse midwives, and physician assistants.

13 (b) RANGE OF FUNDS.—The amount of transfers  
14 under subsection (a) for any fiscal year for title VII and  
15 VIII shall be an amount (specified by the Board each  
16 year) not less than  $\frac{3}{100}$  percent of the amounts the Board  
17 estimates will be expended from the Trust Fund in the  
18 fiscal year.

19 (c) MAINTENANCE.—The Board shall make no trans-  
20 fer of funds under this section for any fiscal year for which  
21 the total appropriations for the programs authorized by  
22 the provisions referred to in subsection (a) are less than  
23 the total amount appropriated for such programs in fiscal  
24 year 2010.

1       **Subtitle B—Direct Health Care**  
2                                   **Delivery**

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

4       (a) TRANSFERS TO PUBLIC HEALTH SERVICE.—

5 From the amounts provided under subsection (c), the  
6 Board shall make transfers from the American Health Se-  
7 curity Trust Fund to the Public Health Service for the  
8 following purposes (other than payment for services cov-  
9 ered under title II):

10           (1) For payments to States under the maternal  
11 and child health block grants under title V of the  
12 Social Security Act (42 U.S.C. 701 et seq.).

13           (2) For prevention and treatment of tuber-  
14 culosis under section 317 of the Public Health Serv-  
15 ice Act (42 U.S.C. 247b).

16           (3) For the prevention and treatment of sexu-  
17 ally transmitted diseases under section 318 of the  
18 Public Health Service Act (42 U.S.C. 247c).

19           (4) Preventive health block grants under part A  
20 of title XIX of the Public Health Service Act (42  
21 U.S.C. 300w et seq.).

22           (5) Grants to States for community mental  
23 health services under subpart I of part B of title  
24 XIX of the Public Health Service Act (42 U.S.C.  
25 300x et seq.).

1           (6) Grants to States for prevention and treat-  
2           ment of substance abuse under subpart II of part B  
3           of title XIX of the Public Health Service Act (42  
4           U.S.C. 300x-21 et seq.).

5           (7) Grants for HIV health care services under  
6           parts A, B, and C of title XXVI of the Public  
7           Health Service Act (42 U.S.C. 300ff-11 et seq.).

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

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

16          (c) FUNDS SUPPLEMENTAL TO OTHER FUNDS.—The  
17          funds provided under this section with respect to provision  
18          of services are in addition to, and not in replacement of,  
19          funds made available under the programs referred to in  
20          subsection (a) and shall be administered in accordance  
21          with the terms of such programs.

22          (d) REQUIRED REPORTS ON HEALTH STATUS.—The  
23          Secretary shall require each State receiving funds under  
24          this section to submit annual reports to the Secretary on  
25          the health status of the population and measurable objec-

1 tives for improving the health of the public in the State.

2 Such reports shall include the following:

3 (1) A comparison of the measures of the State  
4 and local public health system compared to relevant  
5 objectives set forth in “Healthy People 2020” or  
6 subsequent national objectives set by the Secretary.

7 (2) A description of health status measures to  
8 be improved within the State (at the State and local  
9 levels) through expanded public health functions and  
10 health promotion and disease prevention programs.

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

14 (4) Information regarding how Federal funding  
15 has improved population-based prevention activities  
16 and programs.

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

19 (6) A description of the relationship between  
20 the State’s public health system, community-based  
21 health promotion and disease prevention providers,  
22 and the State health security program.

23 (e) LIMITATION ON FUND TRANSFERS.—The Board  
24 shall make no transfer of funds under this section for any  
25 fiscal year for which the total appropriations for such pro-

1 grams are less than the total amount appropriated for  
2 such programs in fiscal year 2010.

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

11 (1) Data collection, analysis, and assessment of  
12 public health data, vital statistics, and personal  
13 health data to assess community health status and  
14 outcomes reporting. This function includes the ac-  
15 quisition and installation of hardware and software,  
16 and personnel training and technical assistance to  
17 operate and support automated and integrated infor-  
18 mation systems.

19 (2) Activities to protect the environment and to  
20 ensure the safety of housing, workplaces, food, and  
21 water.

22 (3) Investigation and control of adverse health  
23 conditions, and threats to the health status of indi-  
24 viduals and the community. This function includes  
25 the identification and control of outbreaks of infec-

1       tious disease, patterns of chronic disease and injury,  
2       and cooperative activities to reduce the levels of vio-  
3       lence.

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

7               (5) The provision of public health laboratory  
8       services to complement private clinical laboratory  
9       services, including—

10               (A) screening tests for metabolic diseases  
11       in newborns;

12               (B) toxicology assessments of blood lead  
13       levels and other environmental toxins;

14               (C) tuberculosis and other diseases requir-  
15       ing partner notification; and

16               (D) testing for infectious and food-borne  
17       diseases.

18               (6) Training and education for the public  
19       health professions.

20               (7) Research on effective and cost-effective pub-  
21       lic health practices. This function includes the devel-  
22       opment, testing, evaluation, and publication of re-  
23       sults of new prevention and public health control  
24       interventions.

1           (8) Integration and coordination of the preven-  
2           tion programs and services of community-based pro-  
3           viders, local and State health departments, and  
4           other sectors of State and local government that af-  
5           fect health.

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

8           (a) TRANSFERS TO SECTION 330 PROGRAM OF THE  
9 PUBLIC HEALTH SERVICE ACT.—The Board shall make  
10 transfers from the American Health Security Trust Fund  
11 to the Public Health Service for the program authorized  
12 under section 330 of the Public Health Service Act (42  
13 U.S.C. 254b).

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

21           (c) RANGE OF FUNDS.—The amount of transfers  
22 under subsection (b) for any fiscal year shall be an amount  
23 (specified by the Board each year) not less than  $\frac{6}{100}$  per-  
24 cent of the amounts the Board estimates will be expended  
25 from the Trust Fund 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 2010.

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

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

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

15 **“SEC. 340J. 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 (b) TECHNICAL AMENDMENTS.—Part D of title III  
2 of the Public Health Service Act (42 U.S.C. 254b et seq.)  
3 is amended—

4 (1) by redesignating subpart XI, as added by  
5 section 10333 of the Patient Protection and Afford-  
6 able Care Act (Public Law 111–148), as subpart  
7 XII; and

8 (2) by redesignating section 340H of the Public  
9 Health Service Act (42 U.S.C. 256i), as added by  
10 section 10333 of the Patient Protection and Afford-  
11 able Care Act (Public Law 111–148), as section  
12 340I.

## 13 **Subtitle C—Primary Care and** 14 **Outcomes Research**

### 15 **SEC. 721. SET-ASIDE FOR OUTCOMES RESEARCH.**

16 (a) GRANTS FOR OUTCOMES RESEARCH.—The  
17 Board shall make transfers from the American Health Se-  
18 curity Trust Fund to the Agency for Healthcare Research  
19 and Quality under title IX of the Public Health Service  
20 Act (42 U.S.C. 299 et seq.) for the purpose of carrying  
21 out activities under such title. The Secretary shall assure  
22 that there is a special emphasis placed on pediatric out-  
23 comes research.

24 (b) RANGE OF FUNDS.—The amount of transfers  
25 under subsection (a) for any fiscal year shall be an amount

1 (specified by the Board each year) not less than  $\frac{1}{100}$  per-  
2 cent and not to exceed  $\frac{2}{100}$  percent of the amounts the  
3 Board estimates will be expended from the Trust Fund  
4 in the fiscal year.

5 (c) FUNDS SUPPLEMENTAL TO OTHER FUNDS.—The  
6 funds provided under this section with respect to provision  
7 of services are in addition to, and not in replacement of,  
8 funds made available to the Agency for Healthcare Re-  
9 search and Quality under section 947 of the Public Health  
10 Service Act (42 U.S.C. 299c–6). The Board shall make  
11 no transfer of funds under this section for any fiscal year  
12 for which the total appropriations under such section are  
13 less than the total amount appropriated under such sec-  
14 tion and title in fiscal year 2010.

15 (d) CONFORMING AMENDMENT.—Section 947(b) of  
16 the Public Health Service Act (42 U.S.C. 299c–6(b)) is  
17 amended by inserting after “of the fiscal years 2001  
18 through 2005” the following: “and of fiscal year 2012 and  
19 each subsequent year”.

20 **SEC. 722. OFFICE OF PRIMARY CARE AND PREVENTION RE-**  
21 **SEARCH.**

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

24 (1) by redesignating parts G through I as parts  
25 H through J, respectively; and

1 (2) by inserting after part F the following new  
2 part:

3 **“PART G—RESEARCH ON PRIMARY CARE AND**  
4 **PREVENTION**

5 **“SEC. 486E. OFFICE OF PRIMARY CARE AND PREVENTION**  
6 **RESEARCH.**

7 “(a) ESTABLISHMENT.—There is established within  
8 the Office of the Director of NIH an office to be known  
9 as the Office of Primary Care and Prevention Research  
10 (in this part referred to as the ‘Office’). The Office shall  
11 be headed by a director, who shall be appointed by the  
12 Director of NIH.

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

14 “(1) identify projects of research on primary  
15 care and prevention, for children as well as adults,  
16 that should be conducted or supported by the na-  
17 tional research institutes, with particular emphasis  
18 on—

19 “(A) clinical patient care, with special em-  
20 phasis on pediatric clinical care and diagnosis;

21 “(B) diagnostic effectiveness;

22 “(C) primary care education;

23 “(D) health and family planning services;

24 “(E) medical effectiveness outcomes of pri-  
25 mary care procedures and interventions; and

1                   “(F) the use of multidisciplinary teams of  
2                   health care practitioners;

3                   “(2) identify multidisciplinary research related  
4                   to primary care and prevention that should be so  
5                   conducted;

6                   “(3) promote coordination and collaboration  
7                   among entities conducting research identified under  
8                   any of paragraphs (1) and (2);

9                   “(4) encourage the conduct of such research by  
10                  entities receiving funds from the national research  
11                  institutes;

12                  “(5) recommend an agenda for conducting and  
13                  supporting such research;

14                  “(6) promote the sufficient allocation of the re-  
15                  sources of the national research institutes for con-  
16                  ducting and supporting such research; and

17                  “(7) prepare the report required under section  
18                  486G.

19                  “(c) PRIMARY CARE AND PREVENTION RESEARCH  
20                  DEFINED.—For purposes of this part, the term ‘primary  
21                  care and prevention research’ means research on improve-  
22                  ment of the practice of family medicine, general internal  
23                  medicine, and general pediatrics, and includes research re-  
24                  lating to—

1           “(1) obstetrics and gynecology, dentistry, or  
2           mental health or substance abuse treatment when  
3           provided by a primary care physician or other pri-  
4           mary care practitioner; and

5           “(2) primary care provided by multidisciplinary  
6           teams.

7   **“SEC. 486F. NATIONAL DATA SYSTEM AND CLEARINGHOUSE**  
8                   **ON PRIMARY CARE AND PREVENTION RE-**  
9                   **SEARCH.**

10          “(a) DATA SYSTEM.—The Director of NIH, in con-  
11          sultation with the Director of the Office, shall establish  
12          a data system for the collection, storage, analysis, re-  
13          trieval, and dissemination of information regarding pri-  
14          mary care and prevention research that is conducted or  
15          supported by the national research institutes. Information  
16          from the data system shall be available through informa-  
17          tion systems available to health care professionals and pro-  
18          viders, researchers, and members of the public.

19          “(b) CLEARINGHOUSE.—The Director of NIH, in  
20          consultation with the Director of the Office and with the  
21          National Library of Medicine, shall establish, maintain,  
22          and operate a program to provide, and encourage the use  
23          of, information on research and prevention activities of the  
24          national research institutes that relate to primary care  
25          and prevention research.

1 **“SEC. 486G. BIENNIAL REPORT.**

2 “(a) IN GENERAL.—With respect to primary care  
3 and prevention research, the Director of the Office shall,  
4 not later than 1 year after the date of the enactment of  
5 this part, and biennially thereafter, prepare a report—

6 “(1) describing and evaluating the progress  
7 made during the preceding 2 fiscal years in research  
8 and treatment conducted or supported by the Na-  
9 tional Institutes of Health;

10 “(2) summarizing and analyzing expenditures  
11 made by the agencies of such Institutes (and by  
12 such Office) during the preceding 2 fiscal years; and

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

16 “(b) INCLUSION IN BIENNIAL REPORT OF DIRECTOR  
17 OF NIH.—The Director of the Office shall submit each  
18 report prepared under subsection (a) to the Director of  
19 NIH for inclusion in the report submitted to the President  
20 and the Congress under section 403.

21 **“SEC. 486H. AUTHORIZATION OF APPROPRIATIONS.**

22 “For the Office of Primary Care and Prevention Re-  
23 search, there are authorized to be appropriated  
24 \$150,000,000 for fiscal year 2012, \$180,000,000 for fis-  
25 cal year 2013, and \$216,000,000 for fiscal year 2014.”.

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

4 (1) in paragraph (23), by striking “and” after  
5 the semicolon at the end;

6 (2) in paragraph (24), by striking the period at  
7 the end and inserting “; and”; and

8 (3) by inserting after paragraph (24) the fol-  
9 lowing new paragraph:

10 “(25) after consultation with the Director of  
11 the Office of Primary Care and Prevention Re-  
12 search, shall ensure that resources of the National  
13 Institutes of Health are sufficiently allocated for  
14 projects on primary care and prevention research  
15 that are identified under section 486E(b).”.

## 16 **Subtitle D—School-Related Health** 17 **Services**

### 18 **SEC. 731. AUTHORIZATIONS OF APPROPRIATIONS.**

19 (a) FUNDING FOR SCHOOL-RELATED HEALTH SERV-  
20 ICES.—For the purpose of carrying out this subtitle, there  
21 are authorized to be appropriated \$100,000,000 for fiscal  
22 year 2014, \$275,000,000 for fiscal year 2015,  
23 \$350,000,000 for fiscal year 2016, and \$400,000,000 for  
24 each of the fiscal years 2017 and 2018.



1 (b) RELATION TO OTHER FUNDS.—The authoriza-  
2 tions of appropriations established in subsection (a) are  
3 in addition to any other authorizations of appropriations  
4 that are available for the purpose described in such sub-  
5 section.

6 **SEC. 732. ELIGIBILITY FOR DEVELOPMENT AND OPER-**  
7 **ATION GRANTS.**

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

10 (1) State health agencies that apply on behalf  
11 of local community partnerships and other commu-  
12 nities in need of health services for school-aged chil-  
13 dren within the State.

14 (2) Local community partnerships in States in  
15 which health agencies have not applied.

16 (b) LOCAL COMMUNITY PARTNERSHIPS.—

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

20 (A) a local health care provider with expe-  
21 rience in delivering services to school-aged chil-  
22 dren;

23 (B) 1 or more local public schools; and

24 (C) at least 1 community based organiza-  
25 tion located in the community to be served that

1           has a history of providing services to school-  
2           aged children in the community who are at-risk.

3           (2) PARTICIPATION.—A partnership described  
4           in paragraph (1) shall, to the maximum extent fea-  
5           sible, involve broad based community participation  
6           from parents and adolescent children to be served,  
7           health and social service providers, teachers and  
8           other public school and school board personnel, de-  
9           velopment and service organizations for adolescent  
10          children, and interested business leaders. Such par-  
11          ticipation may be evidenced through an expanded  
12          partnership, or an advisory board to such partner-  
13          ship.

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

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

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

21   **SEC. 733. PREFERENCES.**

22          (a) IN GENERAL.—In making grants under sections  
23          734 and 735, the Secretary shall give preference to appli-  
24          cants whose communities to be served show the most sub-  
25          stantial level of need for such services among school-aged

1 children, as measured by indicators of community health  
2 including the following:

3 (1) High levels of poverty.

4 (2) The presence of a medically underserved  
5 population.

6 (3) The presence of a health professional short-  
7 age area.

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

19 (b) LINKAGE TO COMMUNITY HEALTH CENTERS.—

20 In making grants under sections 734 and 735, the Sec-  
21 retary shall give preference to applicants that demonstrate  
22 a linkage to community health centers.

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

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

5 (b) USE OF FUNDS.—A project for which a grant  
6 may be made under subsection (a) may include the cost  
7 of the following:

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

10 (2) Recruitment, compensation, and training of  
11 health and administrative staff.

12 (3) The development of agreements, and the ac-  
13 quisition and development of equipment and infor-  
14 mation services, necessary to support information  
15 exchange between school health service sites and  
16 health plans, health providers, and other entities au-  
17 thorized to collect information under this Act.

18 (4) Other activities necessary to assume oper-  
19 ational status.

20 (c) APPLICATION FOR GRANT.—

21 (1) IN GENERAL.—Applicants shall submit ap-  
22 plications in a form and manner prescribed by the  
23 Secretary.

24 (2) APPLICATIONS BY STATE HEALTH AGEN-  
25 CIES.—

1           (A) In the case of applicants that are State  
2 health agencies, the application shall contain  
3 assurances that the State health agency is ap-  
4 plying for funds—

5                   (i) on behalf of at least 1 local com-  
6 munity partnership; and

7                   (ii) on behalf of at least 1 other com-  
8 munity identified by the State as in need  
9 of the services funded under this subtitle  
10 but without a local community partnership.

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

19           (C) A State applying on behalf of local  
20 community partnerships and other communities  
21 may retain not more than 10 percent of grants  
22 awarded under this subtitle for administrative  
23 costs.

1 (d) CONTENTS OF APPLICATION.—In order to receive  
2 a grant under this section, an applicant shall include in  
3 the application the following information:

4 (1) An assessment of the need for school health  
5 services in the communities to be served, using the  
6 latest available health data and health goals and ob-  
7 jectives established by the Secretary.

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

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

15 (4) A description of a quality assurance pro-  
16 gram which complies with standards that the Sec-  
17 retary may prescribe.

18 (e) NUMBER OF GRANTS.—Not more than 1 planning  
19 grant may be made to a single applicant. A planning grant  
20 may not exceed 2 years in duration.

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

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

1 (b) USE OF GRANT.—The costs for which a grant  
2 may be made under this section include the following:

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

6 (2) The cost of furnishing services whose pur-  
7 pose is to increase the capacity of individuals to uti-  
8 lize available health services, including transpor-  
9 tation, community and patient outreach, patient  
10 education, translation services, and such other serv-  
11 ices as the Secretary determines to be appropriate in  
12 carrying out such purpose.

13 (3) Training, recruitment and compensation of  
14 health professionals and other staff.

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

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

19 (6) Other activities deemed necessary by the  
20 Secretary.

21 (c) APPLICATION FOR GRANT.—Applicants shall sub-  
22 mit applications in a form and manner prescribed by the  
23 Secretary. In order to receive a grant under this section,  
24 an applicant shall include in the application the following  
25 information:

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

3           (2) The amounts and sources of funding that  
4           the applicant will expend, including estimates of the  
5           amount of payments the applicant will receive from  
6           sources other than the grant.

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

9           (d) ADDITIONAL CONTENTS OF APPLICATION.—In  
10          order to receive a grant under this section, an applicant  
11          shall meet the following conditions:

12           (1) The applicant furnishes the following serv-  
13          ices:

14           (A) Diagnosis and treatment of simple ill-  
15          nesses and minor injuries.

16           (B) Preventive health services, including  
17          health screenings.

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

20           (D) Referrals and followups in situations  
21          involving illness or injury.

22           (E) Health and social services, counseling  
23          services, and necessary referrals, including re-  
24          ferrals regarding mental health and substance  
25          abuse and oral health services.



1 (F) Such other services as the Secretary  
2 determines to be appropriate.

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

6 (3) The applicant does not impose charges on  
7 students or their families for services (including col-  
8 lection of any cost-sharing for services under the  
9 comprehensive benefit package that otherwise would  
10 be required).

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

22 (5) In the case of an applicant which serves a  
23 population that includes a substantial proportion of  
24 individuals of limited English speaking ability, the  
25 applicant has developed a plan to meet the needs of

1 such population to the extent practicable in the lan-  
2 guage and cultural context most appropriate to such  
3 individuals.

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

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

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

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

14 **SEC. 736. FEDERAL ADMINISTRATIVE COSTS.**

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

18 **SEC. 737. DEFINITIONS.**

19 For purposes of this subtitle:

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

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

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

4           (4) The term “health professional shortage  
5           area” means a health professional shortage area des-  
6           ignated under section 332 of the Public Health Serv-  
7           ice Act.

8           (5) The term “medically underserved popu-  
9           lation” has the meaning given such term in section  
10          330 of the Public Health Service Act.

11          (6) The term “school-aged children” has the  
12          meaning given such term in section 732(c).

13 **TITLE VIII—FINANCING PROVI-**  
14 **SIONS; AMERICAN HEALTH**  
15 **SECURITY TRUST FUND**

16 **SEC. 800. AMENDMENT OF 1986 CODE; SECTION 15 NOT TO**  
17 **APPLY.**

18          (a) AMENDMENT OF 1986 CODE.—Except as other-  
19 wise expressly provided, whenever in this title an amend-  
20 ment or repeal is expressed in terms of an amendment  
21 to, or repeal of, a section or other provision, the reference  
22 shall be considered to be made to a section or other provi-  
23 sion of the Internal Revenue Code of 1986.

24          (b) SECTION 15 NOT TO APPLY.—The amendments  
25 made by subtitle B shall not be treated as a change in

1 a rate of tax for purposes of section 15 of the Internal  
2 Revenue Code of 1986.

3 **Subtitle A—American Health**  
4 **Security Trust Fund**

5 **SEC. 801. AMERICAN HEALTH SECURITY TRUST FUND.**

6 (a) IN GENERAL.—There is hereby created on the  
7 books of the Treasury of the United States a trust fund  
8 to be known as the American Health Security Trust Fund  
9 (in this section referred to as the “Trust Fund”). The  
10 Trust Fund shall consist of such gifts and bequests as  
11 may be made and such amounts as may be deposited in,  
12 or appropriated to, such Trust Fund as provided in this  
13 Act.

14 (b) APPROPRIATIONS INTO TRUST FUND.—

15 (1) TAXES.—There are hereby appropriated to  
16 the Trust Fund for each fiscal year (beginning with  
17 fiscal year 2013), out of any moneys in the Treasury  
18 not otherwise appropriated, amounts equivalent to  
19 100 percent of the aggregate increase in tax liabil-  
20 ities under the Internal Revenue Code of 1986 which  
21 is attributable to the application of the amendments  
22 made by this title. The amounts appropriated by the  
23 preceding sentence shall be transferred from time to  
24 time (but not less frequently than monthly) from the  
25 general fund in the Treasury to the Trust Fund,

1 such amounts to be determined on the basis of esti-  
2 mates by the Secretary of the Treasury of the taxes  
3 paid to or deposited into the Treasury; and proper  
4 adjustments shall be made in amounts subsequently  
5 transferred to the extent prior estimates were in ex-  
6 cess of or were less than the amounts that should  
7 have been so transferred.

8 (2) CURRENT PROGRAM RECEIPTS.—Notwith-  
9 standing any other provision of law, there are hereby  
10 appropriated to the Trust Fund for each fiscal year  
11 (beginning with fiscal year 2013) the amounts that  
12 would otherwise have been appropriated to carry out  
13 the following programs:

14 (A) The Medicare program, under parts A,  
15 B, and D of title XVIII of the Social Security  
16 Act (other than amounts attributable to any  
17 premiums under such parts).

18 (B) The Medicaid program, under State  
19 plans approved under title XIX of such Act.

20 (C) The Federal employees health benefit  
21 program, under chapter 89 of title 5, United  
22 States Code.

23 (D) The TRICARE program (formerly  
24 known as the CHAMPUS program), under  
25 chapter 55 of title 10, United States Code.

1           (E) The maternal and child health pro-  
2           gram (under title V of the Social Security Act),  
3           vocational rehabilitation programs, programs  
4           for drug abuse and mental health services  
5           under the Public Health Service Act, programs  
6           providing general hospital or medical assistance,  
7           and any other Federal program identified by  
8           the Board, in consultation with the Secretary of  
9           the Treasury, to the extent the programs pro-  
10          vide for payment for health services the pay-  
11          ment of which may be made under this Act.

12          (c) INCORPORATION OF PROVISIONS.—The provisions  
13          of subsections (b) through (i) of section 1817 of the Social  
14          Security Act shall apply to the Trust Fund under this Act  
15          in the same manner as they applied to the Federal Hos-  
16          pital Insurance Trust Fund under part A of title XVIII  
17          of such Act, except that the American Health Security  
18          Standards Board shall constitute the Board of Trustees  
19          of the Trust Fund.

20          (d) TRANSFER OF FUNDS.—Any amounts remaining  
21          in the Federal Hospital Insurance Trust Fund or the Fed-  
22          eral Supplementary Medical Insurance Trust Fund after  
23          the settlement of claims for payments under title XVIII  
24          have been completed, shall be transferred into the Amer-  
25          ican Health Security Trust Fund.

1 **Subtitle B—Taxes Based on Income**  
2 **and Wages**

3 **SEC. 811. PAYROLL TAX ON EMPLOYERS.**

4 (a) IN GENERAL.—Section 3111 (relating to tax on  
5 employers) is amended by redesignating subsections (c)  
6 and (d) as subsection (d) and (e), respectively, and by in-  
7 serting after subsection (b) the following new subsection:

8 “(c) HEALTH CARE.—In addition to other taxes,  
9 there is hereby imposed on every employer an excise tax,  
10 with respect to having individuals in his employ, equal to  
11 6.7 percent of the wages (as defined in section 3121(a))  
12 paid by him with respect to employment (as defined in  
13 section 3121(b)).”.

14 (b) SELF-EMPLOYMENT INCOME.—Section 1401 (re-  
15 lating to rate of tax on self-employment income) is amend-  
16 ed by redesignating subsection (c) as subsection (d) and  
17 inserting after subsection (b) the following new subsection:

18 “(c) HEALTH CARE.—In addition to other taxes,  
19 there shall be imposed for each taxable year, on the self-  
20 employment income of every individual, a tax equal to 6.7  
21 percent of the amount of the self-employment income for  
22 such taxable year.”.

23 (c) COMPARABLE TAXES FOR RAILROAD SERV-  
24 ICES.—

1           (1) TAX ON EMPLOYERS.—Section 3221 is  
2           amended by redesignating subsections (c) and (d) as  
3           subsection (d) and (e), respectively, and by insert-  
4           ing after subsection (b) the following new subsection:  
5           “(c) HEALTH CARE.—In addition to other taxes,  
6           there is hereby imposed on every employer an excise tax,  
7           with respect to having individuals in his employ, equal to  
8           6.7 percent of the compensation paid by such employer  
9           for services rendered to such employer.”.

10           (2) TAX ON EMPLOYEE REPRESENTATIVES.—  
11           Section 3211 (relating to tax on employee represent-  
12           atives) is amended by redesignating subsection (c) as  
13           subsection (d) and inserting after subsection (b) the  
14           following new paragraph:

15           “(c) HEALTH CARE.—In addition to other taxes,  
16           there is hereby imposed on the income of each employee  
17           representative a tax equal to 6.7 percent of the compensa-  
18           tion received during the calendar year by such employee  
19           representative for services rendered by such employee rep-  
20           resentative.”.

21           (3) NO APPLICABLE BASE.—Subparagraph (A)  
22           of section 3231(e)(2) is amended by adding at the  
23           end thereof the following new clause:





1 **“SEC. 59B. HEALTH CARE INCOME TAX.**

2 “(a) IMPOSITION OF TAX.—In the case of an indi-  
3 vidual, there is hereby imposed a tax (in addition to any  
4 other tax imposed by this subtitle) equal to the applicable  
5 amount with respect to the taxpayer for the taxable year.

6 “(b) APPLICABLE AMOUNT.—For purposes of this  
7 section—

8 “(1) IN GENERAL.—In the case of a taxpayer  
9 not described in paragraph (2), the applicable  
10 amount with respect to any taxable year shall be de-  
11 termined in accordance with the following table:

| <b>“If taxable income is:</b>             | <b>The applicable amount is:</b>                     |
|---|--|
| Not over \$200,000 .....                  | 2.2% of taxable income                               |
| Over \$200,000 but not over<br>\$400,000. | \$4,400, plus 3.2% of the excess over<br>\$200,000   |
| Over \$400,000 but not over<br>\$600,000. | \$10,800, plus 4.2% of the excess over<br>\$400,000  |
| Over \$600,000 .....                      | \$19,200, plus 5.2% of the excess over<br>\$600,000. |

12 “(2) JOINT RETURNS AND SURVIVING  
13 SPOUSES.—In the case of a joint return or a sur-  
14 viving spouse (as defined in section 2(a)), the appli-  
15 cable amount with respect to any taxable year shall  
16 be determined in accordance with the following  
17 table:

| <b>“If taxable income is:</b>             | <b>The applicable amount is:</b>                     |
|---|--|
| Not over \$250,000 .....                  | 2.2% of taxable income                               |
| Over \$250,000 but not over<br>\$400,000. | \$5,500, plus 3.2% of the excess over<br>\$250,000   |
| Over \$400,000 but not over<br>\$600,000. | \$10,300, plus 4.2% of the excess over<br>\$400,000  |
| Over \$600,000 .....                      | \$18,700, plus 5.2% of the excess over<br>\$600,000. |

1           “(3) INFLATION ADJUSTMENT.—

2                   “(A) IN GENERAL.—In the case of any  
3 taxable year beginning after 2013, each of the  
4 dollar amounts in the tables contained in para-  
5 graphs (1) and (2) shall be increased by an  
6 amount equal to—

7                           “(i) such dollar amount, multiplied by

8                                   “(ii) the cost-of-living adjustment de-  
9 termined under section 1(f)(3) for the cal-  
10 endar year in which the taxable year be-  
11 gins, determined by substituting ‘calendar  
12 year 2012’ for ‘calendar year 1992’ in sub-  
13 paragraph (B) thereof.

14                   “(B) ROUNDING.—If any amount after ad-  
15 justment under subparagraph (A) is not a mul-  
16 tiple of \$1,000, such amount shall be rounded  
17 to the next lowest multiple of \$1,000.

18           “(c) NO CREDITS AGAINST TAX; NO EFFECT ON  
19 MINIMUM TAX.—The tax imposed by this section shall not  
20 be treated as a tax imposed by this chapter for purposes  
21 of determining—

22                   “(1) the amount of any credit allowable under  
23 this chapter, or

24                   “(2) the amount of the minimum tax imposed  
25 by section 55.

1 “(d) SPECIAL RULES.—

2 “(1) TAX TO BE WITHHELD, ETC.—For pur-  
3 poses of this title, the tax imposed by this section  
4 shall be treated as imposed by section 1.

5 “(2) REIMBURSEMENT OF TAX BY EMPLOYER  
6 NOT INCLUDIBLE IN GROSS INCOME.—The gross in-  
7 come of an employee shall not include any payment  
8 by his employer to reimburse the employee for the  
9 tax paid by the employee under this section.

10 “(3) OTHER RULES.—The rules of section  
11 59A(d) shall apply to the tax imposed by this sec-  
12 tion.”.

13 (b) CLERICAL AMENDMENT.—The table of parts for  
14 subchapter A of chapter 1 is amended by adding at the  
15 end the following new item:

“PART VIII—HEALTH CARE RELATED TAXES”.

16 (c) EFFECTIVE DATE.—The amendments made by  
17 this section shall apply to taxable years beginning after  
18 December 31, 2012.

19 **SEC. 813. SURCHARGE ON HIGH INCOME INDIVIDUALS.**

20 (a) IN GENERAL.—Part VIII of subchapter A of  
21 chapter 1, as added by this title, is amended by adding  
22 at the end the following new subpart:

23 **“Subpart B—Surcharge on High Income Individuals**

“Sec. 59C. Surcharge on high income individuals.

1 **“SEC. 59C. SURCHARGE ON HIGH INCOME INDIVIDUALS.**

2       “(a) GENERAL RULE.—In the case of a taxpayer  
3 other than a corporation, there is hereby imposed (in addi-  
4 tion to any other tax imposed by this subtitle) a tax equal  
5 to 5.4 percent of so much of the modified adjusted gross  
6 income of the taxpayer as exceeds \$1,000,000.

7       “(b) TAXPAYERS NOT MAKING A JOINT RETURN.—  
8 In the case of any taxpayer other than a taxpayer making  
9 a joint return under section 6013 or a surviving spouse  
10 (as defined in section 2(a)), subsection (a) shall be applied  
11 by substituting ‘\$500,000’ for ‘\$1,000,000’.

12       “(c) MODIFIED ADJUSTED GROSS INCOME.—For  
13 purposes of this section, the term ‘modified adjusted gross  
14 income’ means adjusted gross income reduced by any de-  
15 duction (not taken into account in determining adjusted  
16 gross income) allowed for investment interest (as defined  
17 in section 163(d)). In the case of an estate or trust, ad-  
18 justed gross income shall be determined as provided in sec-  
19 tion 67(e).

20       “(d) SPECIAL RULES.—

21               “(1) NONRESIDENT ALIEN.—In the case of a  
22 nonresident alien individual, only amounts taken  
23 into account in connection with the tax imposed  
24 under section 871(b) shall be taken into account  
25 under this section.

1           “(2) CITIZENS AND RESIDENTS LIVING  
2 ABROAD.—The dollar amount in effect under sub-  
3 section (a) (after the application of subsection (b))  
4 shall be decreased by the excess of—

5           “(A) the amounts excluded from the tax-  
6 payer’s gross income under section 911, over

7           “(B) the amounts of any deductions or ex-  
8 clusions disallowed under section 911(d)(6)  
9 with respect to the amounts described in sub-  
10 paragraph (A).

11           “(3) CHARITABLE TRUSTS.—Subsection (a)  
12 shall not apply to a trust all the unexpired interests  
13 in which are devoted to one or more of the purposes  
14 described in section 170(c)(2)(B).

15           “(4) NOT TREATED AS TAX IMPOSED BY THIS  
16 CHAPTER FOR CERTAIN PURPOSES.—The tax im-  
17 posed under this section shall not be treated as tax  
18 imposed by this chapter for purposes of determining  
19 the amount of any credit under this chapter or for  
20 purposes of section 55.”.

21           (b) CLERICAL AMENDMENT.—The table of subparts  
22 for part VIII of subchapter A of chapter 1, as added by  
23 this title, is amended by inserting after the item relating  
24 to subpart A the following new item:

“SUBPART B. SURCHARGE ON HIGH INCOME INDIVIDUALS.”.

1 (c) SECTION 15 NOT TO APPLY.—The amendment  
2 made by subsection (a) shall not be treated as a change  
3 in a rate of tax for purposes of section 15 of the Internal  
4 Revenue Code of 1986.

5 (d) EFFECTIVE DATE.—The amendments made by  
6 this section shall apply to taxable years beginning after  
7 December 31, 2012.

## 8 **Subtitle C—Other Financing** 9 **Provisions**

### 10 **SEC. 821. TAX ON SECURITIES TRANSACTIONS.**

11 (a) IN GENERAL.—Chapter 36 is amended by insert-  
12 ing after subchapter B the following new subchapter:

### 13 **“Subchapter C—Tax on Securities** 14 **Transactions**

“Sec. 4475. Tax on securities transactions.

### 15 **“SEC. 4475. TAX ON SECURITIES TRANSACTIONS.**

16 “(a) IMPOSITION OF TAX.—There is hereby imposed  
17 a tax on each covered transaction with respect to any secu-  
18 rity.

19 “(b) RATE OF TAX.—

20 “(1) IN GENERAL.—Except as otherwise pro-  
21 vided in this subsection, the rate of such tax shall  
22 be equal to 0.02 percent of the fair market value of  
23 the security.

1           “(2) SWAPS.—In the case of a security de-  
2           scribed in subsection (d)(1)(D), the rate of such tax  
3           shall be equal to 0.02 percent of the fair market  
4           value of the underlying property with respect to, or  
5           the notional principal amount of, the security-based  
6           swap involved in such transaction.

7           “(3) SHORT-TERM DEBT INSTRUMENTS.—In  
8           the case of a covered transaction with respect to a  
9           security described in subsection (d)(1)(C) which has  
10          a fixed maturity date not more than 1 year from the  
11          date of issue, the rate of such tax shall be equal to  
12          0.02 percent of the fair market value of such secu-  
13          rity.

14          “(c) COVERED TRANSACTION.—For purposes of this  
15          section, the term ‘covered transaction’ means—

16                 “(1) except as provided in paragraph (2), any  
17                 purchase if—

18                         “(A) such purchase occurs on a trading fa-  
19                         cility located in the United States, or

20                         “(B) the purchaser or seller is a United  
21                         States person, or

22                 “(2) any transaction with respect to a security  
23                 described in subsection (d)(1)(D), if any party with  
24                 rights under such security is a United States person  
25                 or if such transaction is facilitated by a United



1 States person, including a trading facility located in  
2 the United States or a broker.

3 “(d) SECURITY AND OTHER DEFINITIONS.—For pur-  
4 poses of this section—

5 “(1) IN GENERAL.—The term ‘security’ has the  
6 meaning given such term by section 2(a)(1) of the  
7 Securities Act of 1933 (15 U.S.C. 77b(a)(1)).

8 “(2) SECURITY-BASED SWAP.—The term ‘secu-  
9 rity-based swap’ means any option, forward contract,  
10 short position, notional principal contract, credit de-  
11 fault swap, or any similar financial instrument.

12 “(3) SPECIFIED INDEX.—The term ‘specified  
13 index’ means any 1 or more of any combination of—

14 “(A) a fixed rate, price, or amount, or

15 “(B) a variable rate, price, or amount,

16 which is based on any current objectively deter-  
17 minable information which is not within the control  
18 of any of the parties to the contract or instrument  
19 and is not unique to any of the parties’ cir-  
20 cumstances.

21 “(e) EXCEPTIONS TO IMPOSITION OF TAX.—

22 “(1) EXCEPTION FOR INITIAL ISSUES.—No tax  
23 shall be imposed under subsection (a) on any cov-  
24 ered transaction with respect to the initial issuance

1 of any security described in subparagraph (A), (B),  
2 or (C) of subsection (d)(1).

3 “(2) EXCEPTION FOR RETIREMENT ACCOUNTS,  
4 ETC.—No tax shall be imposed under subsection (a)  
5 on any covered transaction with respect to any secu-  
6 rity which is held in any plan, account, or arrange-  
7 ment described in section 220, 223, 401(a), 403(a),  
8 403(b), 408, 408A, 529, or 530 (including assets  
9 held in a segregated asset account described in sec-  
10 tion 817 as part of any such plan, account, or ar-  
11 rangement).

12 “(3) EXCEPTION FOR CERTAIN MUTUAL FUND  
13 TRANSACTIONS.—No tax shall be imposed under  
14 subsection (a) on any covered transaction—

15 “(A) with respect to the purchase of any  
16 interest in a regulated investment company (as  
17 defined in section 851) which issues only stock  
18 which is redeemable on the demand of the stock  
19 holder,

20 “(B) by a regulated investment company  
21 (as so defined) which is 100 percent owned by  
22 1 or more plans, accounts, or arrangements de-  
23 scribed in paragraph (2), and

24 “(C) to the extent such tax is properly al-  
25 locable to any class of shares of a regulated in-

1 vestment company (as so defined) which is 100  
2 percent owned by 1 or more plans, accounts, or  
3 arrangements described in paragraph (2).

4 “(f) BY WHOM PAID.—

5 “(1) IN GENERAL.—The tax imposed by this  
6 section shall be paid by—

7 “(A) in the case of a transaction which oc-  
8 curs on a trading facility located in the United  
9 States, such trading facility,

10 “(B) in the case of a transaction not de-  
11 scribed in subparagraph (A) which is executed  
12 by a broker, such broker,

13 “(C) in the case of a transaction not de-  
14 scribed in subparagraph (A) or (B), with re-  
15 spect to a security described in section  
16 (d)(1)(D), the party identified by the Secretary,  
17 or

18 “(D) in any other case, the purchaser with  
19 respect to the transaction.

20 “(2) WITHHOLDING IF PURCHASER IS NOT A  
21 UNITED STATES PERSON.—See section 1447 for  
22 withholding by seller if purchaser is a foreign per-  
23 son.

24 “(g) ADMINISTRATION.—The Secretary shall carry  
25 out this section in consultation with the Securities and Ex-

1 change Commission and the Commodity Futures Trading  
2 Commission.

3 “(h) GUIDANCE; REGULATIONS.—The Secretary  
4 shall—

5 “(1) provide guidance regarding such informa-  
6 tion reporting concerning covered transactions as the  
7 Secretary deems appropriate, and

8 “(2) prescribe such regulations as are necessary  
9 or appropriate to prevent avoidance of the purposes  
10 of this section, including the use of non-United  
11 States persons in such transactions or the improper  
12 allocation of taxes to classes of shares described in  
13 subsection (e)(3)(C).”.

14 (b) CREDIT FOR FIRST \$100,000 OF STOCK TRANS-  
15 ACTIONS PER YEAR.—Subpart C of part IV of subchapter  
16 A of chapter 1 is amended by inserting after section 36A  
17 the following new section:

18 **“SEC. 36B. CREDIT FOR SECURITIES TRANSACTION TAXES.**

19 “(a) ALLOWANCE OF CREDIT.—In the case of any  
20 purchaser with respect to a covered transaction, there  
21 shall be allowed as a credit against the tax imposed by  
22 this subtitle for the taxable year an amount equal to the  
23 lesser of—

24 “(1) the aggregate amount of tax imposed  
25 under section 4475 on covered transactions during

1 the taxable year with respect to which the taxpayer  
2 is the purchaser, or

3 “(2) \$250 (\$500 in the case of a joint return).

4 “(b) AGGREGATION RULE.—For purposes of this sec-  
5 tion, all persons treated as a single employer under sub-  
6 section (a) or (b) of section 52, or subsection (m) or (o)  
7 of section 414, shall be treated as one taxpayer.

8 “(c) DEFINITIONS.—For purposes of this section,  
9 any term used in this section which is also used in section  
10 4475 shall have the same meaning as when used in section  
11 4475.”.

12 (c) WITHHOLDING.—Subchapter A of chapter 3 is  
13 amended by adding at the end the following new section:

14 **“SEC. 1447. WITHHOLDING ON SECURITIES TRANSACTIONS.**

15 “(a) IN GENERAL.—In the case of any outbound se-  
16 curities transaction, the transferor shall deduct and with-  
17 hold a tax equal to the tax imposed under section 4475  
18 with respect to such transaction.

19 “(b) OUTBOUND SECURITIES TRANSACTION.—For  
20 purposes of this section, the term ‘outbound securities  
21 transaction’ means any covered transaction to which sec-  
22 tion 4475(a) applies if—

23 “(1) such transaction does not occur on a trad-  
24 ing facility located in the United States, and

1           “(2) the purchaser with respect to such trans-  
2           action in not a United States person.”.

3           (d) CONFORMING AMENDMENTS.—

4           (1) Section 6211(b)(4)(A) is amended by insert-  
5           ing “36B,” after “36A,”.

6           (2) Section 1324(b)(2) of title 31, United  
7           States Code, is amended by inserting “36B,” after  
8           “36A,”.

9           (3) The table of subchapters for chapter 36 is  
10          amended by inserting after the item relating to sub-  
11          chapter B the following new item:

“Subchapter C. Tax on securities transactions.”.

12          (4) The table of sections for subchapter A of  
13          chapter 3 is amended by adding at the end the fol-  
14          lowing new item:

“Sec. 1447. Withholding on securities transactions.”.

15          (5) The table of sections for subpart C of part  
16          IV of subchapter A of chapter 1 is amended by in-  
17          serting after the item relating to section 36A the fol-  
18          lowing new item:

“Sec. 36B. Credit for securities transaction taxes.”.

19          (e) EFFECTIVE DATE.—The amendments made by  
20          this section shall apply to transactions occurring more  
21          than 180 days after the date of the enactment of this Act.

1 **TITLE IX—CONFORMING AMEND-**  
2 **MENTS TO THE EMPLOYEE**  
3 **RETIREMENT INCOME SECUR-**  
4 **RITY ACT OF 1974**

5 **SEC. 901. ERISA INAPPLICABLE TO HEALTH COVERAGE AR-**  
6 **RANGEMENTS UNDER STATE HEALTH SECUR-**  
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 2011.”.

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 “(10) Subsection (a) of this section shall not apply  
2 to State health security programs established pursuant to  
3 section 101(b) of the American Health Security Act of  
4 2011.”.

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. 522. (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 2011.

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 522(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 521 the following new items:

“Sec. 522. 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, 2014.

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.

