I

103D CONGRESS
1ST SESSION

H. R. 1691

To provide universal access for all Americans to basic health care services and long-term care services.

IN THE HOUSE OF REPRESENTATIVES

APRIL 5, 1993

Mr. ANDREWS of Maine introduced the following bill; which was referred jointly to the Committees on Energy and Commerce, Ways and Means, Education and Labor, Rules, Armed Services, Veterans' Affairs, and Post Office and Civil Service

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A BILL

To provide universal access for all Americans to basic health care services and long-term care services.

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

SECTION 1. SHORT TITLE; TABLE OF CONTENTS.

(a) SHORT TITLE.—This Act may be cited as the ''National Health Security Act of 1993''.

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

SEC. 2. STATEMENT OF PRINCIPLES.

The principles of this Act are—

(1) to provide universal access to basic health care services for all Americans regardless of their financial and medical conditions;

(2) to establish the institutional and political capacity to control the Nation's escalating health care costs and eliminate administrative waste;

(3) to ensure the portability of health care coverage to all regions of the country;

(4) to build on the strengths of American federalism, with the Federal Government contributing progressive financing and specifying minimum national standards while State governments supply additional funding and administer the program with the flexibility needed to address the specific concerns of each region;

(5) to maintain the proven advantages of the American health care delivery system, including private practice, the freedom to choose among practitioners, and superiority in biomedical technology;

(6) to encourage the effective use of preventive and primary care;

(7) to enhance the autonomy of practitioners by limiting the intrusiveness of government intervention in the actual delivery of care;

(8) to promote the role of competition among practitioners and to encourage innovation that results in higher quality and more efficient care;

(9) to reduce the incentives providers face to perform medically unnecessary or inappropriate services;

(10) to reinforce the public accountability of the health care system, permitting explicit and open de-

liberation about the allocation of society's resources to health care; and

(11) to provide that all Americans share in the responsibility of maintaining an efficient health care system.

SEC. 3. GENERAL DEFINITIONS.

(a) IN GENERAL.—For purposes of this Act:

(1) The term ''Board'' means the Federal Health Board established in section 301.

(2) The term ''Advisory Council'' means the Federal Health Care Advisory Council established in section 302.

(3) The term ''Priorities Council'' means the Federal Health Priorities Council established in section 303.

(4) The term ''State program'' means a State health care program approved under section 311.

(5) The term ''State'' includes the District of Columbia, the Commonwealth of Puerto Rico, the United States Virgin Islands, Guam, American Samoa, and the Commonwealth of the Northern Mariana Islands.

(6) The term ''Trust Fund'' means the Federal Health Trust Fund established in section 423.

(b) OTHER DEFINITIONS.—Except as otherwise provided, the definitions contained in section 1861 of the Social Security Act (42 U.S.C. 1395x), as in effect on the day before the date of the enactment of this Act, shall apply in this Act.

TITLE I—ELIGIBILITY AND ENROLLMENT

SEC. 101. ELIGIBILITY AND ENTITLEMENT.

(a) IN GENERAL.—Every individual who is a resident of the United States and is a citizen or national of the United States or lawful resident alien (as defined in subsection (d)) is entitled to health care services and long-term care services covered under this Act in the State in which the individual maintains a primary residence.

(b) TREATMENT OF CERTAIN NONIMMIGRANTS.—

(1) IN GENERAL.—The Board may make eligible for health care services and long-term care services covered under this Act such classes of aliens admitted to the United States as nonimmigrants as the Board may provide.

(2) CONSIDERATION.—In providing for eligibility under paragraph (1), the Board shall consider reciprocity in health care and long-term care services offered to United States citizens who are nonimmigrants in other foreign states, and such

other factors as the Board determines to be appropriate.

(c) TREATMENT OF OTHER INDIVIDUALS.—The Board may make eligible for health care services and long-term care services covered under this Act other individuals not described in subsection (a) or (b), and regulate the nature of the eligibility of such individuals for the purposes of fulfilling the following criteria:

(1) Preserving the public health of communities.

(2) Compensating States for the additional health care financing burdens created by such individuals.

(3) Preventing adverse financial and medical consequences of uncompensated care.

(4) Inhibiting travel and immigration to the United States for the sole purpose of obtaining health care services or long-term care services covered under this Act.

(d) LAWFUL RESIDENT ALIEN DEFINED.—For purposes of this section, the term ''lawful resident alien'' means an alien lawfully admitted for permanent residence and any other alien lawfully residing permanently in the United States under color of law, including an alien with lawful temporary resident status under section 210, 210A,

or 245A of the Immigration and Nationality Act (8 U.S.C. 1160, 1161, or 1255a).

SEC. 102. ENROLLMENT.

(a) IN GENERAL.—Each State program shall provide a mechanism for enrollment of individuals entitled to benefits under this Act and, in conjunction with such enrollment, the issuance of a State health insurance card which may be used for purposes of identification and processing of claims for benefits under this Act.

(b) ENROLLMENT AT BIRTH OR IMMIGRATION.—The mechanism under subsection (a) shall include a process for the automatic enrollment of individuals at the time of birth in the State or at the establishment of permanent residence in the State, including at the time of immigration into the United States, other acquisition of lawful resident status in the United States, or eligibility for other individuals established under section 101(c).

SEC. 103. PORTABILITY.

To ensure continuous access to health care services and long-term care services covered under this Act, each State program—

(1) shall utilize a uniform claims form as developed by the Board;

(2) shall not impose any minimum period of residence in the State, or waiting period, in excess

of 3 months before residents of the State are entitled to such services;

(3) shall provide continuation of payment for such services to individuals who have terminated their residence in the State and established their residence in another State, for the duration of any waiting period imposed in the State of new residency for establishing entitlement to such services; and

(4) shall provide for the payment for health care services covered under this Act provided to individuals while temporarily absent from the State based on the following principles:

(A) Payment for such health care services is at the rate that is approved by the State program in the State in which the services are provided, unless the States concerned agree to apportion the cost between them in a different manner.

(B)(i) Except as provided in clause (ii), payment for such health care services provided outside the United States is made on the basis of the amount that would have been paid by the State program for similar services rendered in the State, with due regard, in the case of hos-

pital services, to the size of the hospital, standards of service, and other relevant factors.

(ii) Payment for services described under clause (i) which are elective services may be subject to prior consent of the agency that administers and operates the State program if such elective services are available on a substantially similar basis in the State.

(iii) For the purposes of this subparagraph, the term ''elective services'' means health care services covered under this Act other than services that are provided in an emergency or in any other circumstance in which medical care is required without delay.

TITLE II—BENEFITS

Subtitle A—Health Care Services

SEC. 201. COVERED HEALTH CARE SERVICES.

(a) IN GENERAL.—Every eligible individual is entitled to have payment made for the health care services covered under this Act by a participating provider if the service is necessary or appropriate for the maintenance of health or for the diagnosis or treatment of, or rehabilitation following, injury, disability, or disease.

(b) SPECIFIC SERVICES.—Subject to limitations described in section 202, health care services covered under this Act are as follows:

(1) Inpatient and outpatient hospital care, including 24-hour per day emergency services.

(2) Diagnostic and screening tests.

(3) Medical and other health services furnished by health care professionals who are authorized to provide such services under State law, including medically necessary dental care.

(4) Preventive health care, including care for well-defined causes of illness and injury (such as breast, cervical, and colon cancer), immunizations (for children, according to an immunization schedule issued by the American Academy of Pediatrics), prenatal and postnatal care (according to guidelines of the American College of Obstetrics and Gynecology, and including prenatal and postnatal care coordination, and nutrition education), family planning services, and well-baby and well-child care (including physical examinations and vision, dental, hearing, and developmental examinations).

(5) Prescription drugs, biologicals, and devices.

(6) Substance abuse treatment services, including comprehensive residential treatment services for

pregnant women and women with children seeking treatment for substance abuse.

(7) Inpatient and outpatient mental health services to provide an active preventive, diagnostic, therapeutic, or rehabilitative service with respect to emotional or mental disorders.

(8) Hospice care for patients certified to be terminally ill, provided under a State approved program.

(9) Habilitation and rehabilitation services, including physical, speech, and occupational therapies.

(10) Home medical equipment and prosthetic devices prescribed by a licensed practitioner.

(11) Experimental treatment as deemed necessary by the review of the Board and the State Advisory Boards.

SEC. 202. LIMITATIONS AND EXCLUSIONS.

(a) NO LIMITS IN GENERAL.—Except as provided in this section, section 203, and section 221, a State program may not limit the amount, duration, or scope of health care services covered under this Act.

(b) SPECIFIC EXCLUSIONS.—Health care services excluded from coverage under this Act include the following:

(1) Cosmetic surgery, except medically necessary reconstruction.

(2) Certain amenities in inpatient facilities, such as private rooms and other amenities determined by the Board, unless medically necessary.

SEC. 203. PATIENT COST-SHARING.

(a) IN GENERAL.—Except as provided in this section, a State program may not impose cost-sharing for services under this Act.

(b) ESTABLISHMENT OF COST-SHARING SCHEDULE.—

(1) IN GENERAL.—Co-payments and out-of-pocket limits shall be established by the Board consistent with paragraph (2). The Board shall base its determinations on the following principles:

(A) Assurance of administrative simplicity and efficiency.

(B) Maintenance of the fiscal integrity of the public health insurance program.

(C) Deterrence of unnecessary use of services.

(D) Encouragement of healthy behaviors.

(E) Encouragement of the use of preventive services.

(F) Maximization of economic fairness.

(G) Minimization of financial barriers to appropriate medical care.

(2) SPECIFICS.—In establishing co-payments and out-of-pocket limits under paragraph (1)—

(A) there shall be no cost-sharing imposed with respect to preventive health care (described in section 201(b)(4)), and

(B) there shall no deductible for any services.

(3) STUDIES OF MODIFICATIONS.—

(A) IN GENERAL.—The Priorities Council shall study—

(i) whether the out-of-pocket limits should be modified to take into account family size and family composition,

(ii) whether the use of co-payments is a cost-effective means of containing health care costs and whether the use of co-payments is an excessive administrative burden on health care providers and fiscal providers (designated under section 311(b)(2)),

(iii) the effects of the continuation of duplicative private insurance (as allowed in section 602), upon the quality, access, and cost of the public health insurance program,

(iv) whether cost sharing requirements should be different for individuals that engage in certain practices deemed to increase the likelihood such individuals will utilize more health care resources than individuals who do not engage in such practices.

(B) SPECIFIC RECOMMENDATIONS.—The Priorities Council within 2 years of the date described in section 901(b)(1) shall issue recommendations regarding the studies described in subparagraph (A). The recommendations must balance the following goals:

(i) Preserve the fiscal integrity of the public health insurance program.

(ii) Minimize the shifting between individuals and families of the burden of financing the public program.

(iii) Encourage behaviors by governments, intermediaries, providers, and individuals that lead to reduced costs to the health care system.

(3) REGULATIONS BASED ON RECOMMENDATIONS.—

(A) IN GENERAL.—The Board is authorized to promulgate regulations, as it deems appropriate, for implementing the recommendations of the Priorities Council.

(B) MODIFICATIONS.—The Board is also authorized to promulgate regulations to make periodic adjustments for inflation to income categories, co-payments, and deductibles.

(C) EFFECT OF REGULATIONS.—The regulations incorporating these modifications to the cost sharing and out-of-pocket limits described in this section shall have the force of law, unless within 60 days of the promulgation of the regulations, the Congress enacts a disapproval resolution under the procedures described in section 501.

Subtitle B—Long-Term Care Services

SEC. 211. COVERED LONG-TERM CARE SERVICES.

(a) IN GENERAL.—The Board, by regulation, shall set standards for eligibility, long-term care services covered, cost-sharing, income protection, and case coordination, subject to the criteria described in the following subsections.

(b) ELIGIBILITY.—

(1) IN GENERAL.—The Board shall determine the standards for eligibility for institutional and for home and community-based long-term care services based on an individual's ability to perform activities of daily living (ADLs) and instrumental activities of daily living (IADLs), and comparable cognitive or behavioral impairments.

(2) DETERMINATION.—Eligibility for long-term care services shall be based on a determination by a case manager of the individual's ability to perform the minimum level of ADLs and IADLs, according to the standard set by the Board.

(3) STANDARD.—The Board shall, pursuant to recommendations by the Advisory Council and the Long-Term Care Services Assessment Commission, periodically make recommendations about the efficacy of using deficits in ADLs and IADLs, or measures of comparable cognitive or behavioral impairment, or both, to determine eligibility for long-term care services.

(c) SERVICES COVERED.—

(1) IN GENERAL.—The Board shall determine the long-term care services to be covered under this Act to meet the long-term care needs of the eligible population.

(2) MINIMUM SERVICES.—At a minimum, long-term care services to be covered under this Act, subject to standards set by the Board, shall include:

(A) Home and community-based services, such as nursing care and rehabilitative and restorative care.

(B) Nursing home care.

(C) Hospice care.

(D) Home medical equipment.

(E) Services for individuals with developmental disabilities and mental illness.

(d) COST SHARING.—The Board shall establish an income-related cost-sharing schedule for individuals eligible for long-term care services covered under this Act, taking into account such factors as what out-of-nursing home expenses would have been.

(e) INCOME PROTECTION.—

(1) IN GENERAL.—The Board shall reduce the cost sharing to ensure that the income and assets of the individual using long-term care services covered under this Act are sufficient to enable such individual to retain a personal needs allowance sufficient—

(A) to cover all items needed in addition to those provided by the long-term care facility,

(B) to maintain such individual's primary residence, and

(C) to maintain such individual's independence once the individual no longer needs long-term care services.

(2) SPOUSAL PROTECTION, ETC.—The Board shall reduce the cost sharing to ensure that the income of the spouse, dependent, parent, or guardian of the individual using long-term care services covered under this Act is not reduced below levels determined appropriate by the Board, but in no case less than the spousal protection levels under title XIX of the Social Security Act, as in effect on the day before the date of the enactment of this Act.

(f) CASE MANAGEMENT.—

(1) IN GENERAL.—The Board shall set standards for case coordination of long-term care services covered under this Act.

(2) CASE COORDINATOR.—

(A) IN GENERAL.—Under the case coordination system, services shall be made available to individuals through a case coordinator who will be responsible for matching services to each individual's needs, and coordinating the delivery of services.

(B) SPECIFIC RESPONSIBILITIES.—The specific responsibilities of the case coordinator include:

(i) The assessment and periodic reassessment of an individual's need for services, and the availability and efficacy of informal services.

(ii) The development of plan of care for the individual.

(iii) The authorization and coordination of services designed to meet an individual's unmet needs.

(g) EFFECT OF REGULATIONS.—The regulations incorporating the standards described in subsection (a) shall have the force of law, unless within 60 days of the promulgation of the regulations, the Congress enacts a disapproval resolution under the procedures described in section 501.

SEC. 212. LONG-TERM CARE SERVICES ASSESSMENT COMMISSION.

(a) ESTABLISHMENT.—Due to the seriousness of the current problems in long-term care, the Director of the Congressional Office of Technology Assessment (hereafter in this section referred to as the ''Director'') shall provide for the appointment of a special task force, to be known

as the ''Long-Term Care Services Assessment Commission'' (hereafter in this section referred to as the ''Commission'').

(b) MEMBERSHIP.—The Commission shall consist of 10 individuals appointed for a seven-year term, beginning on October 1, 1994. The membership of the Commission shall include long-term care service providers, other health and social service professionals, individuals skilled in the conduct and interpretation of biomedical, health services, and health economics research, and representatives of consumers, the elderly, and the disabled. The Director shall fill any vacancy in the membership of the Commission in the same manner as the original appointment. The vacancy shall not affect the power of the remaining members to execute the duties of the Commission.

(c) COMPENSATION.—All members of the Commission shall be reimbursed by the Board for travel and per diem in lieu of subsistence expenses during the performance of duties of the Commission in accordance with subchapter I of chapter 57 of title 5, United States Code.

(d) ORGANIZATION.—The Commission shall cease to exist at the end of the 7-year term described in subsection (b).

(e) FACA NOT APPLICABLE.—The provisions of the Federal Advisory Committee Act shall not apply to the Commission.

(f) DUTIES.—

(1) IN GENERAL.—The Commission shall make recommendations to the Board not later than January 31 of 1995 (and of each subsequent year) regarding—

(A) the adequacy and appropriateness of the long-term care services covered under this Act,

(B) the criteria for eligibility for long-term care services,

(C) the effect of the cost sharing requirements for long-term care services,

(D) the financial protections provided individuals in the use of such services and the ability of the patient and any spouse, dependent, parent, or guardian of the patient in the community to remain financially independent once the patient no longer needs long-term care services,

(E) the effect of the long-term care services covered under this Act on the availability

and use of informal long-term care services and private long-term care insurance, and

(F) the overall functioning of the provision of long-term care services covered under this Act, once fully implemented.

(2) REVIEW.—The Commission shall review and analyze any long-term care services regulations or proposed regulations of the Board and report to the Congress its assessment of the appropriateness of the regulations in meeting the statutory criteria established under this Act.

(g) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated such sums as are necessary for the establishment and operation of the Commission to carry out the purposes of this Act.

Subtitle C—Modification of Services

SEC. 221. MODIFICATION OF SERVICES COVERED UNDER THIS ACT.

(a) RECOMMENDATIONS BY PRIORITIES COUNCIL.—Not later than January 31 of 1998 (and of each subsequent year), the Priorities Council shall issue a report to the Board describing any changes, additions, deletions, or clarifications the Priority Council recommends for the

health care services and long-term care services covered under this Act.

(b) BOARD REGULATIONS.—

(1) IN GENERAL.—The Board is authorized to promulgate regulations, as the Board deems appropriate, for implementing the recommendations of the Priorities Council. Such regulations are to be promulgated within 1 year of the submission of the Priorities Council's report.

(2) EFFECT.—The regulations incorporating modifications in the health care services and long-term care services covered under this Act shall have the force of law, unless within 60 days of the promulgation of the regulations, the Congress enacts a disapproval resolution under the procedures described in section 501.

TITLE III—FEDERAL AND STATE ADMINISTRATION

Subtitle A—Federal Administration

SEC. 301. FEDERAL HEALTH BOARD.

(a) IN GENERAL.—There is hereby established a Federal Health Board.

(b) APPOINTMENT AND TERMS OF MEMBERS.—

(1) APPOINTMENT.—The Board shall be composed of 9 individuals appointed by the President,

with the advice and consent of the Senate, not later than October 1, 1994, and shall be chosen on the basis of backgrounds in health policy, health economics, the healing professions, and the administration of health care institutions. At least 1 member of the Board shall represent consumer interests, and due regard must be given to geographic, urban, and rural representation. No more than 5 members may be affiliated with a single political party.

(2) TERMS OF MEMBERS.—The individuals appointed shall serve for a term of 9 years (or until a successor is appointed), except that the terms of individuals initially appointed shall be (as specified by the President) for such fewer number of years as will provide for the expiration of terms on a staggered basis.

(3) REMOVAL FOR CAUSE ONLY.—Upon confirmation, members of the Board may not be removed except for cause upon notice and hearing.

(c) VACANCIES.—

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

(2) VACANCY APPOINTMENTS.—Any member appointed to fill a vacancy shall serve for the remainder of the term for which the predecessor of the member was appointed.

(3) REAPPOINTMENT.—The President may reappoint an appointed member of the Board for a second term in the same manner as the original appointment.

(d) CHAIRPERSON AND VICE CHAIRPERSON.—The Board shall select a Chairperson and a Vice Chairperson from among the members of the Board.

(e) COMPENSATION.—Members of the Board shall be compensated at a level comparable to level II of the Executive Schedule, in accordance with section 5313 of title 5, United States Code.

(f) STAFF.—The Board shall employ such staff as the Board may determine necessary.

(g) APPLICABILITY OF CIVIL SERVICE PROVISIONS.—The staff of the Board may be appointed without regard to the provisions of title 5, United States Code, governing appointments in the competitive service and be compensated without regard to the provisions of chapter 51, and subchapter III of chapter 53 of title 5 relating to classification and General Schedule pay rates, except that no individual may receive pay less than 120 percent

of the minimum rate of basic pay payable for GS–15 of the General Schedule or more than the rate of basic pay payable for level IV of the Executive Schedule.

(h) DUTIES.—

(1) IN GENERAL.—The Board is responsible for the overall administration of this Act, including such duties specifically designated by this Act.

(2) ADDITIONAL DUTIES.—The duties of the Board also include—

(A) facilitating the exchange of information among States,

(B) establishing, evaluating, and updating national minimum quality standards,

(C) establishing uniform reporting requirements,

(D) developing a uniform claims form,

(E) reviewing and approving interstate consortia,

(F) assisting States in developing systems to minimize fragmented care, and

(G) developing and evaluating activities combating fraud and abuse within the health care system.

(i) REPORTS.—

(1) INITIAL REPORT.—Not later than January 1, 1996, the Board shall report to the Congress regarding the implementation of the program established under this Act, including any recommendations for further implementing legislation.

(2) ANNUAL REPORTS.—Beginning January 1, 1997, the Board shall annually report to Congress on the status of expenditures under this Act and the long-range plans and goals of the Board for the organization and delivery of health care services and long-term care services under this Act.

SEC. 302. FEDERAL HEALTH ADVISORY COUNCIL.

(a) APPOINTMENT.—Not later than January 1, 1995, the Board shall provide for appointment of a Federal Health Advisory Council to advise the Board on its activities.

(b) MEMBERSHIP.—Such Advisory Council shall consist of 15 members who are representatives of consumers, providers, unions, health care experts, senior citizen groups, public health officials, experts in long-term care, rural health care and mental illness, and other individuals with an interest in the health care system. Such members shall serve for terms of 3 years, except that, in the initial appointment, 5 members shall be each appointed for terms of 1-year, 2-years, and 3-years.

(c) VACANCIES.—

(1) IN GENERAL.—The Board shall fill any vacancy in the membership of the Advisory Council in the same manner as the original appointment. The vacancy shall not affect the power of the remaining members to execute the duties of the Advisory Council.

(2) VACANCY APPOINTMENTS.—Any member appointed to fill a vacancy shall serve for the remainder of the term for which the predecessor of the member was appointed.

(3) REAPPOINTMENT.—The Board may reappoint an appointed member of the Advisory Council for a second term in the same manner as the original appointment.

(d) CHAIRPERSON AND VICE CHAIRPERSON.—The Advisory Council shall select a Chairperson and a Vice Chairperson from among the members of the Advisory Council.

(e) COMPENSATION.—All members of the Advisory Council shall be reimbursed by the Board for travel and per diem in lieu of subsistence expenses during the performance of duties of the Advisory Council in accordance with subchapter I of chapter 57 of title 5, United States Code.

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

(g) DUTIES.—The Advisory Council shall conduct studies and make recommendations to the Board on the overall functioning of the program established under this Act and consumer and provider satisfaction with such program.

SEC. 303. FEDERAL HEALTH PRIORITIES COUNCIL.

(a) IN GENERAL.—There is hereby established a Federal Health Priorities Council.

(b) APPOINTMENT AND TERMS OF MEMBERS.—

(1) APPOINTMENT.—The Priorities Council shall be composed of 15 individuals appointed by the President, with the advice and consent of the Senate, not later than October 1, 1994. Such individuals shall be representatives from the fields of medicine, dentistry, mental health care, nursing, social services, ethics, economics, business, and consumer groups.

(2) TERMS OF MEMBERS.—The individuals appointed shall serve for a term of 5 years, except that the terms of individuals initially appointed shall be (as specified by the President) for such fewer num-

ber of years as will provide for the expiration of terms on a staggered basis.

(c) VACANCIES.—

(1) IN GENERAL.—The President shall fill any vacancy in the membership of the Priorities Council in the same manner as the original appointment. The vacancy shall not affect the power of the remaining members to execute the duties of the Priorities Council.

(2) VACANCY APPOINTMENTS.—Any member appointed to fill a vacancy shall serve for the remainder of the term for which the predecessor of the member was appointed.

(3) REAPPOINTMENT.—The President may reappoint an appointed member of the Priorities Council for a second term in the same manner as the original appointment.

(d) PRESIDENT AND VICE PRESIDENT.—The Priorities Council shall select a President and a Vice President from among the members of the Priorities Council.

(e) COMPENSATION.—Members of the Priorities Council shall be compensated at a level comparable to level II of the Executive Schedule, in accordance with section 5313 of title 5, United States Code.

(f) STAFF.—The Priorities Council shall employ such staff as the Priorities Council may determine necessary.

(g) APPLICABILITY OF CIVIL SERVICE PROVISIONS.—The staff of the Priorities Council may be appointed without regard to the provisions of title 5, United States Code, governing appointments in the competitive service and be compensated without regard to the provisions of chapter 51, and subchapter III of chapter 53 of title 5 relating to classification and General Schedule pay rates, except that no individual may receive pay less than 120 percent of the minimum rate of basic pay payable for GS–15 of the General Schedule or more than the rate of basic pay payable for level IV of the Executive Schedule.

(h) COMMITTEES.—The Priorities Council may establish such committees of its members and other medical, economic, or health services advisers as it determines to be necessary to assist the Priorities Council in the performance of its duties.

(i) FUNCTIONS.—In order to build a consensus on the values to be used to guide health resource decisions, the Priorities Council shall have the following functions:

(1) Conduct public hearings and solicit testimony and information from advocates for children, senior citizens, the disabled, consumers of mental

health services, low-income people, providers of health care, business leaders, and others.

(2) Building on outcomes research and the development of practice guidelines, conduct studies and make recommendations for how health care dollars should be allocated in the context of a publicly funded national health insurance plan.

(j) REPORTS.—The Priorities Council shall report to the Board a list of health services ranked by priority, from the most important to the least important, representing the comparative benefits of each service to the Nation's population. The recommendation shall be accompanied by a report of an independent actuary retained for the Board to determine rates necessary to cover the costs of the included services in order to establish an appropriate annual global budget. The recommendation is to be used in evaluating and modifying the health care services and the long-term care services covered under this Act. The reports from the Priorities Council to the Board are to be submitted by January 31 of 1996 (and of each subsequent year), to be acted on by the Board by the following January 31.

SEC. 304. AUTHORIZATION OF APPROPRIATIONS.

There are authorized to be appropriated such sums as are necessary for the establishment and operation of

the Board, Advisory Council, and Priorities Council to carry out the purposes of this Act.

Subtitle B—State Administration

SEC. 311. STATE PROGRAMS.

(a) SUBMISSION OF PROGRAMS.—

(1) IN GENERAL.—Not later than October 1, 1996, each State shall submit to the Board the State program in the State.

(2) REGIONAL PROGRAMS.—Any State may join with neighboring States to submit to the Board a regional program in lieu of a State program, as described in section 314.

(b) REVIEW AND APPROVAL OF PROGRAMS.—The Board shall review programs submitted under subsection (a) and determine whether such programs meet the requirements for approval, not later than October 1, 1997. The Board shall not approve such a program unless it finds that the program provides, consistent with the provisions of this Act, for—

(1) adequate financing of health care services and long-term care services covered under this Act through a designated fund, including the annual submission of the State program budget to the Board,

(2) adequate administration, including the designation of a single nonprofit State agency responsible for administration of the program, and sufficient provisions to ensure against fraud and abuse,

(3) the establishment of—

(A) an institution reimbursement negotiation board to negotiate global operating, capital, and health training budgets with hospitals and other health care and long-term care institutions,

(B) a practitioner reimbursement negotiation board (with membership including State government representatives, consumers, general practice physicians, specialists, and nonphysician practitioners) to negotiate reimbursement rates for participating providers, and

(C) at the State's option, a State advisory board (with broad representation of health policy experts, institutional providers, practitioners, and consumers) to generally oversee and review the performance of the State program,

(4) assurances that individuals have the freedom to choose practitioners and other health care providers for services covered under this Act, and

(5) an organized grievance procedure available to consumers through which complaints about the organization and administration of the State program may be filed, heard, and resolved.

(c) OPERATIONAL STATUS.—A State program in a State shall not be considered operational unless it is approved and remains approved under subsection (b).

(d) FAILURE TO COMPLY WITH THIS ACT.—Whenever the Board, after reasonable notice and opportunity for hearing to the designated State agency finds that in the administration of the State program there is a failure to comply with any provision of this Act, the Board may—

(1) withhold further payments to the State under section 402 and may limit such withholding to specific portions of such program affected by the failure, or

(2) place the State program, or specific portions of such program, in receivership under the jurisdiction of the Board,

until such failure has been corrected.

(e) JUDICIAL REVIEW.—

(1) IN GENERAL.—If any State is dissatisfied with the Board's action in denying approval of such State's program or finding a failure under subsection (d) with respect to such program, such State

may, within 60 days after notice of such action, file with the United States court of appeals for the circuit in which such State is located a petition for review of that action. A copy of the petition shall be forthwith transmitted by the clerk of the court to the Board. The Board thereupon shall file in the court the record of the proceedings upon which the Board's action was based, as provided in section 2112 of title 28, United States Code.

(2) FINDINGS OF FACT.—The findings of fact by the Board, if supported by substantial evidence, shall be conclusive; but the court, for good cause shown, may remand the case to the Board to take further evidence, and the Board may thereupon make new or modified findings of fact and may modify the Board's previous action, and shall file in the court the record of the further proceedings. Such new or modified findings of fact shall likewise be conclusive if supported by substantial evidence.

(3) JURISDICTION OF COURT.—Upon the filing of such petition, the court shall have jurisdiction to affirm the action of the Board or to set it aside, in whole or in part. The judgment of the court shall be subject to review by the Supreme Court of the Unit-

ed States upon certiorari or certification as provided in section 1254 of title 28, United States Code.

SEC. 312. USE OF FISCAL INTERMEDIARIES.

(a) IN GENERAL.—Each State program may contract with fiscal intermediaries in a process of competitive bidding.

(b) ROLE OF FISCAL INTERMEDIARY.—

(1) IN GENERAL.—Subject to paragraph (2) and under continuous State oversight, the fiscal intermediary shall process claims and reimbursements, distribute the allocation of funds as specified in agreements on global operating budgets, and assume general responsibility for the administration of the State program.

(2) LIMITATION.—The fiscal intermediary may not participate in, nor administer, the negotiating processes used to establish global operating budgets or practitioner reimbursement rates.

(c) TYPE OF ORGANIZATION.—The fiscal intermediary may be any type of entity designated by the State, including nonprofit associations and private companies, as long as the State or regional program provides for public accountability. Such accountability may include review of the operations of the fiscal intermediary by the State advisory board.

SEC. 313. STATE WAIVERS; MANAGED CARE.

(a) STATE WAIVERS.—A State program shall be allowed to obtain waivers from the Board—

(1) to implement alternative and innovative—

(A) methods of reimbursing health care providers,

(B) patient cost-sharing arrangements, and

(C) administrative structures, and

(2) to provide the services covered under this Act through the use of health plans paid through a capitation method in order to allow the freedom of choice of all eligible individuals in the selection of a health plan.

In approving any waiver the Board shall assure itself that the State program otherwise complies with the requirements of this Act that are not inconsistent with the granting of such waiver.

(b) MANAGED CARE OPTION.—No provision of this Act shall be construed to prohibit or discourage any State from developing, or contracting with, managed care networks for the purpose of delivering services covered under this Act of a higher quality and in a more cost-effective manner, as long as such networks otherwise meet the requirements of this Act.

(c) ORGANIZED APPROACHES TO DELIVERY OF SERVICES.—The Board shall sponsor efforts to encourage States and providers of services to develop and expand organized approaches to the delivery of health care services covered under this Act, including health maintenance organizations, hospital-based and community-oriented team health services, and neighborhood-hospital-home health care plans.

SEC. 314. STATE REGIONAL CONSORTIA.

(a) IN GENERAL.—Any group of States may enter into an agreement to establish a regional consortium for the purposes of implementing a program to be approved by the Board under section 311. Such regional consortium shall have jurisdiction over all States that are parties to such agreement and that shall be subject to the provisions of section 311 as if such consortium were established by a single State.

(b) CONSORTIUM AGREEMENT.—Any agreement to establish a State regional consortium shall, in addition to providing for the requirements specified in section 311(b), provide for—

(1) a mechanism to resolve any disputes between or among the States that are parties to the agreement, and

(2) the collection of data and information concerning the operations of the consortium and the submission of such data and information to the Board on an annual basis.

(c) CONGRESSIONAL REVIEW.—Any consortium agreement described in this section which has been approved by the Board, shall be submitted to the Congress and shall be considered in effect, unless within 60 days of the submission of the agreement, the Congress enacts a disapproval resolution under the procedures described in section 501.

SEC. 315. GRANTS TO STATES.

(a) IN GENERAL.—The Board shall make grants (including cooperative agreements) available to States for funding programs and for research designed to prevent or minimize the high costs of health care, to treat illness, disease, or medical conditions created by conditions in the environment or workplace, and to promote health and wellness.

(b) SPECIFIC PROGRAM AREAS.—Grants under this section shall be awarded for initiatives in the areas of—

(1) environmental health, and

(2) health promotion and disease prevention.

(c) REQUESTS FOR PROPOSALS.—The Board shall issue periodic requests each year for proposals for grants under this section.

SEC. 316. TECHNICAL ASSISTANCE TO STATES.

(a) GRANTS.—

(1) IN GENERAL.—Not later than October 1, 1995, the Board shall award a grant to each State or group of States to assist in paying the costs associated with the establishment and initial operation of the State plan or the State regional consortium agreement.

(2) AMOUNTS.—Not less than $500,000 shall be provided to each State or group of States under a grant awarded under paragraph (1), and any State or group of States shall remit to the Trust Fund any unspent amount of such grant at the end of the 2-year period beginning with the date of the awarding of such grant.

(3) PLANNING FUNCTIONS.—Amounts provided under grants awarded under paragraph (1) shall be utilized for planning functions only.

(4) STUDY.—Not later than October 1, 1998, the Board shall prepare and submit to the appropriate committees of Congress, a report that shall contain the results of a study conducted by the

Board concerning the use of the grants awarded under paragraph (1), and whether such use was effective preparing State plans and State regional consortia agreements and simplifying administrative procedures.

(b) TECHNICAL ASSISTANCE.—The Board shall provide technical assistance to States in developing State plans and State regional consortia agreements.

(c) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated such sums as may be necessary to carry out this section.

TITLE IV—FINANCING

Subtitle A—Health Budgets

SEC. 401. NATIONAL HEALTH BUDGET.

(a) IN GENERAL.—

(1) ANNUAL BUDGETS.—Except as provided in paragraph (2), the Board shall establish an annual fiscal year budget of expenditures that estimates the total expenditures to be made in such fiscal year by the Federal Government and States for health care services and long-term care services covered under this Act, including the administrative costs associated with such services.

(2) BIENNIAL BUDGETS.—The Board may establish biennial fiscal year budgets in lieu of annual budgets.

(b) NATIONAL AVERAGE PER CAPITA COSTS.—

(1) IN GENERAL.—At least 6 months before the beginning of the first fiscal year of the program under this Act, the Board shall compute the national average per capita cost for each of the services described in subsection (a) using data the Board deems to be appropriate.

(2) ADJUSTMENTS FOR RISK GROUPS.—

(A) IN GENERAL.—The Board shall develop an adjustment factor to the national average per capita costs computed under paragraph (1) for each risk group (as designated under subparagraph (B)) to reflect the national average per capita costs for that risk group.

(B) RISK GROUPS.—The Board shall designate a series of risk groups, determined by age, sex, and other factors that represent distinct patterns of health care services and long-term care services utilization and costs.

(3) STATE ADJUSTMENTS TO NATIONAL AVERAGE PER CAPITA COSTS.—The Board shall develop

for each State a factor to adjust the national average per capita costs for each risk group to reflect—

(A) average labor and nonlabor costs that are necessary to produce the services described in subsection (a),

(B) any special social, environmental, epidemiological, or other condition affecting health status or the need for health care services and long-term care services,

(C) the geographic distribution of the State's population, particularly the proportion of the population residing in rural or medically underserved areas,

(D) the quality and availability of the State's existing health care resources needed for delivering health care services and long-term care services, and

(E) any other economic, geographic, and sociologic factors.

(c) STATE TOTAL EXPENDITURES.—The Board shall compute for each State total projected expenditures in the next fiscal year for each of the services described in subsection (a), by multiplying—

(1) the national average per capita costs of each risk group designated in subsection (b)(2)(B), by

(2) the product of the State adjustment factors described in subsection (b)(3) and the number of persons in the State estimated by the Bureau of the Census to be resident members of each risk group at the beginning of the next fiscal year.

(d) FEDERAL CONTRIBUTIONS.—

(1) IN GENERAL.—The Board shall determine the appropriate Federal contribution for each State, constituting the Federal percentage share of each State's total projected expenditures for the services described in section (a). The Federal share shall be determined by subtracting the State share from 100 percent of the total projected expenditures for such State (as described under subsection (c)), but in no event shall such Federal contribution be less than 75 percent nor more than 85 percent of such expenditures. The Federal share for all States shall equal 80 percent of the aggregate of such expenditures for all States.

(2) ADJUSTMENTS IN STATE SHARE.—In determining each State share, the Board shall develop a formula that considers a State's—

(A) per capita income,

(B) total taxable resources,

(C) economic performance relative to the national economy as it affects the availability of taxable resources, and

(D) other relevant economic and demographic indicators.

(e) SUBSEQUENT CALCULATIONS.—For each subsequent fiscal year, the Board shall recompute under subsections (a), (b), (c), and (d) at least 6 months before the beginning of such fiscal year. In making such a recomputation, the Board shall take into account—

(1) changes in medical technology, outcomes research evidence concerning the efficacy and safety of health care services and long-term care services, needs for health personnel, professional practice guidelines, and changing health care priorities, after reviewing recommendations of the Advisory Council and the Priorities Council, and

(2) changes in the services described in subsection (a) under regulations promulgated by the Board and accepted by the Congress under section 204.

(f) EFFECT OF BOARD ACTIONS.—Any determination made by the Board under this section with respect to any fiscal year shall be submitted to the Congress at least 6 months before the beginning of such fiscal year,

and shall have the force of law, unless within 60 days of the submission of such determination, the Congress enacts a disapproval resolution under the procedures described in section 501.

SEC. 402. PAYMENTS TO STATES.

(a) IN GENERAL.—For each fiscal year, each State with a State program approved under section 311, is entitled to receive (subject to section 311(d)), from amounts in the Trust Fund, a Federal contribution in an amount equal to the product of—

(1) the Federal share for such State (computed under section 401(d), and

(2) such State's total projected expenditures (computed under section 401(c)).

(b) USE OF DEDICATED FUNDS.—

(1) IN GENERAL.—All revenues, including the Federal contribution and State revenues provided to finance a State program under this Act shall be allocated to a dedicated fund specified by the State. Payments for health care services and long-term care services covered under this Act shall be made from such fund.

(2) SPECIAL ACCOUNTS.—Each State shall establish within its designated fund special accounts, the amount of revenues deposited in each to be de-

termined by the State. The various special accounts shall include the following:

(A) An Institutional Global Operating Budget Account shall be used to fund total expenditures for the operating costs of hospitals and other health care and long-term care institutions, allocated according to the method specified in section 411(b).

(B) An Institutional Capital Account shall be used to fund total expenditures for capital-related items in hospitals and other health care and long-term care institutions, allocated according to the method specified in section 411(c).

(C) A Health Training Account shall be used to fund direct and indirect graduate medical education in hospitals and other health care and long-term care institutions to cover excess operating and capital costs associated with teaching and related research activities, allocated according to the method specified in section 411(d).

(D) A Practitioner Reimbursement Account shall be used to fund the reimbursement of services provided by health care practitioners,

allocated according to the method specified in section 412.

SEC. 403. STATE PROGRAM BUDGETS.

(a) IN GENERAL.—Each State program shall establish an annual fiscal year State program budget which provides for—

(1) the total expenditures to be made under the State program in such fiscal year for health care services and long-term care services covered under this Act (including administrative and associated costs), and

(2) the revenues to meet such expenditures.

(b) COORDINATION.—Each State program budget shall be coordinated, in a manner specified by the Board, with the national health budget established under section 401(a).

(c) STATE SHARE.—

(1) IN GENERAL.—Each State program shall cover the State share of program costs through the use of tax revenues and other financing methods allowed under section 424.

(2) ADDITIONS TO STATE SHARE.—Each State shall raise the revenues necessary to cover at least the State share specified in the national health budget established by the Board (computed under

section 401(d)). Each State is permitted to raise additional revenues and to increase such State's health program expenditures beyond the amount specified in the State share specified for the national health budget—

(A) to cover the costs of benefits for health care services or long-term care services the State program authorizes in addition to the services covered in this Act or as amended by the Board and the Congress,

(B) to provide for increased global operating, capital, or health training budgets for hospitals and other health care and long-term care institutions,

(C) to provide for any unexpected increase in health care costs identified by the State program, and

(D) for other purposes that may be identified by the Board.

(d) BARRIERS TO ACCESS PROHIBITED.—No State, either by intention or as an unstated consequence of budget allocations, may restrict or cause to be restricted timely access to the medically necessary and appropriate health care services and long-term care services covered under

this Act, or permit queues for services to form that have the potential of being life threatening.

(e) ANNUAL PUBLICATION.—The State program shall provide for the publication annually of the most recent State program budget established under this section.

Subtitle B—Payments to Providers

SEC. 411. PAYMENTS TO HOSPITALS AND OTHER HEALTH CARE AND LONG-TERM CARE INSTITUTIONS.

(a) IN GENERAL.—Each State program shall be responsible for—

(1) allocating from the State program budget the aggregate amount of money to be directed to hospitals and other health care and long-term care institutions for the global operating, capital, and health training budgets of such institutions, and

(2) devising mechanisms for the allocation from such budget of capital expenditures in non-institutional settings.

(b) GLOBAL BUDGETS FOR OPERATING EXPENSES FOR HOSPITALS AND OTHER HEALTH CARE AND LONG-TERM CARE INSTITUTIONS.—The following principles shall guide a State institution reimbursement negotiation board in negotiating institutional global operating budgets:

(1) Each State program budget shall include a separate account for global operating expenses to provide for total State expenditures for the operating expenses of hospitals and other health care and long-term care institutions.

(2) Payment shall be based on an annual prospective global budget for operating expenses submitted by an institution, in a manner specified by the State program, to the agency designated by the State program.

(3) The budgets shall take into account amounts that are reasonable and necessary in the efficient provision of necessary hospital and other institutional services covered under this Act.

(4) The operating budgets shall not include capital-related and health training expenses.

(5) Adjustments may later be made in the budget to reflect significant changes in the volume or types of services assumed in the approval of the budget.

(6) A State should encourage innovation by permitting any institution to include in its budget for the immediate year any programs designed to increase efficiency in later years, if those improve-

ments can be demonstrated to the satisfaction of the designated State agency.

(c) CAPITAL BUDGETS FOR HOSPITALS AND OTHER HEALTH CARE AND LONG-TERM CARE INSTITUTIONS.—The following principles shall guide a State institution reimbursement negotiation board in negotiating institutional capital budgets:

(1) Each State program budget shall include a separate account for capital expenses to provide for total State expenditures for the capital-related items in hospitals and other health care and long-term care institutions.

(2) Each State program budget shall specify the general manner in which such expenditures for capital-related items are to be distributed among different types of institutions and the different areas of the State to take into account the need for capital expenditures throughout the State.

(3) Capital expenditures are those authorized by the State for the provision of insured health services, regardless of whether the source of funds for the capital expenditure is derived from accumulated depreciation charges, operating surpluses or retained earnings, expenditure of accumulated fund balances, issuance of bonds, notes, debentures or other evi-

dence of indebtedness, borrowed funds, or any other source including equity capitalization.

(4) Unless otherwise provided in this Act regarding underserved areas, or waived by the designated State agency if necessary to provide equitable resource allocation and access to quality care, hospitals and other health care and long-term care institutions shall furnish a 15 percent match for funds allocated from the Institutional Capital Account of the budget.

(d) HEALTH TRAINING FOR HOSPITALS AND OTHER HEALTH CARE AND LONG-TERM CARE INSTITUTIONS.—The following principles shall guide a State institution reimbursement negotiation board in negotiating institutional health training budgets:

(1) Each State program budget shall include a separate account for direct and indirect graduate medical education-related expenses in hospitals and other health care and long-term care institutions.

(2) Each state program budget shall specify the general manner in which such expenditures for direct and indirect graduate medical education are to be distributed among different types of institutions and the different areas of the State.

(3) The distribution of funds to hospitals and other health care and long-term care institutions from the Health Training Account must conform to the following principles:

(A) At least 50 percent of the funding from the Health Training Account is to be directed to primary care training programs.

(B) For each 5-year period beginning after the date which is 5 years after the date of the enactment of this Act, the Advisory Board will evaluate the required minimum percentage of funds that States must direct to primary care and recommend whether the percentage should be changed to ensure consistency with the goal of encouraging primary care residency training programs.

(C) The State is to develop a methodology for funding nonhospital-based residency programs and to establish opportunities for residencies in community-based health care facilities.

(D) The distribution of funds from the Health Training Account must take into account the potentially higher costs of placing medical students in rural residency programs.

(E) The distribution of funds from the Health Training Account must accommodate the education and training needs of nonphysician practitioners.

SEC. 412. PAYMENTS FOR PRACTITIONERS SERVICES.

The State practitioner reimbursement negotiation board shall negotiate with the State organizations representing each of the practitioner disciplines in order to derive a relative value scale fee schedule that fulfills each of the following principles:

(1) Appropriate levels of payment are provided primary care services, including general, family, and preventive procedures.

(2) The same compensation is given for the same procedures even when performed by different types of practitioners licensed to offer those procedures.

(3) Reimbursement rates for different procedures performed by practitioners in different disciplines reflect the relative value of those procedures.

(4) Urban and rural practitioners receive the same reimbursement rates for the same services, unless the State determines that a differential rate is required to increase the access to health care practitioners in underserved areas.

(5) A process is established that keeps overall reimbursements in line with the amount of funding budgeted for practitioner reimbursements.

SEC. 413. SPECIAL NONPHYSICIAN PRACTITIONER PROVISIONS.

The following principles shall guide the State practitioner reimbursement negotiation board in negotiating reimbursement rates for nonphysician practitioners:

(1) When the same services covered under this Act are provided by practitioners licensed by the State, reimbursement rates for those same services shall be the same regardless of the type of practitioner providing such services.

(2) For procedures covered under this Act, services provided by all practitioners licensed in the State for those services are to be included in the reimbursement fee schedule.

SEC. 414. MANDATORY ASSIGNMENT.

(a) IN GENERAL.—Except with respect to patient cost-sharing provisions under section 203 of this Act, no individual shall be liable for payment of any amount for health care services or long-term care services covered under this Act, and payment by a State program shall constitute payment in full for such services.

(b) ENFORCEMENT.—The State program shall apply appropriate sanctions against the entity if such entity knowingly and willfully charges for an item or service or accepts payment in violation of subsection (a).

Subtitle C—Revenues

SEC. 421. FEDERAL SOURCES OF REVENUES.

(a) AMERICAN HEALTH SECURITY PLAN PREMIUMS.—The Board, in consultation with the Secretary of the Treasury, shall develop a mechanism for determining and collecting a premium from individuals and employers for health care services and long-term care services covered under this Act, to be known as the American Health Security Plan premium.

(b) DETERMINATION OF PREMIUM AMOUNT.—The Board shall determine the American Health Security Plan premium for each taxable year beginning after December 31, 1996, by estimating the total amount necessary to equal the excess of—

(1) expenditures described in section 423(c) for the fiscal year beginning in such taxable year, over

(2) receipts described in section 423(b) (other than paragraph (1)) for such fiscal year.

(c) COLLECTION OF PREMIUM.—

(1) INDIVIDUALS.—The Board shall collect the American Health Security Plan premium from indi-

viduals using a mechanism with the following characteristics:

(A) Income-based (including earned and unearned income).

(B) Progressive.

(C) Payable in increments during the course of the year.

(D) Payable by individuals or by employers on behalf of employees (at the option of the employer), as described in paragraph (2)(C).

(E) Subject to the provisions of subtitle F of the Internal Revenue Code of 1986.

(2) EMPLOYERS.—The Board shall collect the American Health Security Plan premium from employers using a mechanism with the following characteristics:

(A) Aggregate employer contributions would equal an amount necessary to prevent an increase in the percentage of 1993 aggregate household health care expenditures.

(B) Contribution rate based on each employer's ability to pay as indicated by factors such as the size of the employer's workforce and profitability.

(C) Any employer would have the option of paying all or part of the American Health Security Plan premium otherwise payable by such employer's employees.

(D) Subject to the provisions of subtitle F of the Internal Revenue Code of 1986.

(d) EFFECT OF BOARD ACTIONS.—Any premium determination made by the Board under this subsection with respect to any taxable year shall be submitted to the Congress at least 6 months before the beginning of such taxable year, and shall have the force of law, unless within 60 days of the submission of such determination, the Congress enacts a disapproval resolution under the procedures described in section 501.

(e) EFFECTIVE DATE.—The provisions of this section shall apply with respect to remuneration paid after December 31, 1996, and with respect to earnings from self-employment attributable to taxable years beginning after such date.

SEC. 422. TAX TREATMENT OF AMERICAN HEALTH SECURITY PLAN AND PRIVATE HEALTH AND LONG-TERM CARE INSURANCE.

(a) TAX EXCLUSIONS FOR AMOUNTS RECEIVED FROM, AND EMPLOYER CONTRIBUTIONS TO, THE PLAN.—

(1) AMOUNTS RECEIVED.—Subsection (e) of section 105 of the Internal Revenue Code of 1986 (relating to amounts received under accident and health plans) is amended to read as follows:

''(e) ACCIDENT OR HEALTH INSURANCE.—For purposes of this section, section 104, and section 106, the term 'accident or health insurance' means an approved State program under section 311 of the American Health Security Plan Act of 1993.''.

(2) EMPLOYER CONTRIBUTIONS.—Section 106 of such Code (relating to contributions by employer to accident and health plans) is amended by striking ''an accident or health plan'' and inserting ''accident or health insurance''.

(3) CONFORMING AMENDMENT.—Section 105 of such Code is amended by striking subsection (h).

(b) BUSINESS EXPENSE DEDUCTION FOR HEALTH INSURANCE.—Section 162 of the Internal Revenue Code of 1986 (relating to trade or business expenses) is amended by redesignating subsection (m) as subsection (n) and by inserting after subsection (l) the following new subsection:

''(m) GROUP HEALTH PLANS.—The expenses paid or incurred by an employer for a group health plan shall not be allowed as a deduction under this section unless the

plan is an approved State program under section 311 of the American Health Security Plan Act of 1993.''.

(c) RULES RELATING TO DEDUCTIONS FOR INDIVIDUALS.—

(1) SAME TREATMENT FOR SELF-EMPLOYED INDIVIDUALS AND BUSINESSES.—Section 162(l) of the Internal Revenue Code of 1986 (relating to special rules for health insurance costs of self-employed individuals) is amended—

(A) by striking ''25 percent of'' in paragraph (1), and

(B) by striking paragraph (6).

(2) SIMILAR TREATMENT FOR OTHER INDIVIDUALS.—Subsection (d) of section 213 of such Code (relating to medical, dental, etc., expenses) is amended—

(A) by striking paragraph (1) and inserting the following new paragraph:

''(1) MEDICAL CARE.—The term 'medical care' means American Health Security Plan premiums and cost-sharing amounts paid for coverage under an approved State program under section 311 of the American Health Security Plan Act of 1993.'',

(B) by striking paragraphs (2), (6), (7), and (9), and by redesignating paragraphs (3),

(4), (5), and (8) as paragraphs (2), (3), (4), and (5), respectively.

(d) TERMINATION OF CHILD HEALTH INSURANCE CREDIT.—Clause (i) of section 32(b)(2)(A) of such Code is amended by inserting ''(0 percent for taxable years beginning after December 31, 1999)'' after ''6 percent''.

(e) EFFECTIVE DATE.—The amendments made by this section shall apply with respect to any taxable year beginning after December 31, 1999.

SEC. 423. FEDERAL HEALTH TRUST FUND.

(a) TRUST FUND ESTABLISHED.—There is hereby created on the books of the Treasury of the United States a trust fund to be known as the ''Federal Health Care Trust Fund''. The Trust Fund shall consist of such gifts and bequests as may be made and such amounts as may be deposited in, or appropriated to, such Trust Fund as provided in this Act.

(b) RECEIPTS.—

(1) TRANSFER OF AMOUNTS EQUIVALENT TO CERTAIN TAXES.—

(A) IN GENERAL.—There are hereby appropriated to the Trust Fund amounts equivalent to 100 percent of the American Health Security Plan premiums received in the Treasury

as the result of the mechanism described in section 421 of this Act.

(B) ADDITIONAL REVENUES.—There are appropriated to the Trust Fund amounts equivalent to the additional revenues received in the Treasury as the result of the amendments made by section 422 of this Act.

(C) TRANSFERS BASED ON ESTIMATES.—The amounts appropriated by subparagraphs (A) and (B) shall be transferred from time to time (not less frequently than monthly) from the general fund in the Treasury to the Trust Fund, such amounts to be determined on the basis of estimates by the Secretary of the Treasury of the taxes and premiums, specified in such subparagraphs, paid to or deposited into the Treasury; and proper adjustments shall be made in amounts subsequently transferred to the extent prior estimates were in excess of or were less than the taxes and premiums specified in such subparagraphs.

(2) TRANSFER OF FUNDS.—All amounts, not otherwise obligated, that remain in the Federal Hospital Insurance Trust Fund and the Federal Supplemental Medical Insurance Trust Fund on the first

day of the fiscal year 2000 shall be transferred to the Trust Fund.

(3) APPROPRIATION OF ADDITIONAL SUMS.—For fiscal years beginning after September 30, 1999, there are hereby authorized to be appropriated, and are appropriated, to the Trust Fund such additional sums as equal the amounts appropriated with respect to title XIX of the Social Security Act, section 1079 of title 10, United States Code (CHAMPUS), and chapter 89 of title 5, United States Code, as in effect for fiscal year 1999. Such amount shall be adjusted each fiscal year by the increase in the Consumer Price Index (as determined by the Department of Labor) for the previous fiscal year.

(4) APPROPRIATION OF SUMS FOR ADMINISTRATIVE COSTS.—For fiscal years 1995, 1996, and 1997, there are hereby authorized to be appropriated, and are appropriated, to the Trust Fund such additional sums as may be required to make expenditures referred to in subsection (c)(2).

(5) RETURNED GRANT FUNDS.—Any returned grant funds as described in section 316(a)(2) of this Act shall be transferred to the Trust Fund.

(c) EXPENDITURES.—

(1) TO STATES.—Payments in each fiscal year to each State from the Trust Fund as determined under section 402 are hereby authorized and appropriated.

(2) ADMINISTRATIVE EXPENSES AND GRANTS.—There are hereby authorized and appropriated such sums as are necessary for the administrative expenses and grants described in sections 212(g), 304, 315, 316(c) and 803 of this Act for each fiscal year.

(3) CONTINGENCY ACCOUNT.—There are hereby authorized and appropriated such sums as determined necessary by the Board to cover unanticipated events that affect the health care needs of individuals described in section 101(a), to be available without fiscal year limitation.

(d) INCORPORATION OF TRUST FUND PROVISIONS.—The provisions of subsections (b) through (e) of section 1841 of the Social Security Act (42 U.S.C. 1395t), as in effect on the day before the date of the enactment of this Act, shall apply to the Trust Fund in the same manner as such provisions apply to the Federal Supplemental Medical Insurance Trust Fund, except that any reference to the Secretary of Health and Human Services or the

Administrator of the Health Care Financing Administration shall be deemed a reference to the Board.

(e) TRUST FUND OFF-BUDGET.—The receipts and disbursements of the Trust Fund and the taxes described in subsection (b)(1) shall not be included in the totals of the budget of the United States Government as submitted by the President or of the congressional budget and shall be exempt from any general budget limitation imposed by statute on expenditures and net lending (budget outlays) of the United States Government.

SEC. 424. STATE SOURCES OF REVENUES.

(a) IN GENERAL.—Each State shall be responsible for establishing a financing program for the implementation of the State program in the State. Such financing program may include—

(1) funds used to finance the State share of medicaid under title XIX of the Social Security Act as in effect on the day before the date described in section 902(f) of this Act,

(2) State and local funding for public hospitals and other indigent care programs, and

(3) State funding from general revenues, earmarked taxes, payroll taxes, sales taxes, and such other measures consistent with this Act as the State may provide.

(b) ON-GOING ENTITLEMENT.—Each State with a State program approved by the Commission is entitled to funding from the Commission in the amounts provided under section 402.

TITLE V—CONGRESSIONAL CONSIDERATION

SEC. 501. RULES GOVERNING CONGRESSIONAL CONSIDERATION.

(a) RULES OF HOUSE OF REPRESENTATIVES AND SENATE.—This section is enacted by the Congress—

(1) as an exercise of the rulemaking power of the House of Representatives and the Senate, respectively, and as such is deemed a part of the rules of each House, respectively, but applicable only with respect to the procedure to be followed in that House in the case of disapproval resolutions described in subsection (b), and supersedes other rules only to the extent that such rules are inconsistent therewith; and

(2) with full recognition of the constitutional right of either House to change the rules (so far as relating to the procedure of that House) at any time, in the same manner and to the same extent as in the case of any other rule of that House.

(b) TERMS OF THE RESOLUTION.—For purposes of this Act, the term ''disapproval resolution'' means only a joint resolution of the two Houses of the Congress, providing in—

(1) the matter after the resolving clause of which is as follows: ''That the Congress disapproves the action of the Federal Health Board as submitted by the Board on _____'', the blank space being filled in with the appropriate date; and

(2) the title of which is as follows: ''Joint Resolution disapproving the action of the Federal Health Board''.

(c) INTRODUCTION AND REFERRAL.—On the day on which the action of the Board is transmitted to the House of Representatives and the Senate, a disapproval resolution with respect to such action shall be introduced (by request) in the House of Representatives by the Majority Leader of the House, for himself and the Minority Leader of the House, or by Members of the House designated by the Majority Leader of the House, for himself and the Minority Leader of the House, or by Members of the House designated by the Majority Leader and Minority Leader of the House; and shall be introduced (by request) in the Senate by the Majority Leader of the Senate, for himself

and the Minority Leader of the Senate, or by Members of the Senate designated by the Majority Leader and Minority Leader of the Senate. If either House is not in session on the day on which such an action is transmitted, the disapproval resolution with respect to such action shall be introduced in the House, as provided in the preceding sentence, on the first day thereafter on which the House is in session. The disapproval resolution introduced in the House of Representatives and the Senate shall be referred to the appropriate committees of each House.

(d) AMENDMENTS PROHIBITED.—No amendment to a disapproval resolution shall be in order in either the House of Representatives or the Senate; and no motion to suspend the application of this subsection shall be in order in either House, nor shall it be in order in either House for the Presiding Officer to entertain a request to suspend the application of this subsection by unanimous consent.

(e) PERIOD FOR COMMITTEE AND FLOOR CONSIDERATION.—

(1) IN GENERAL.—Except as provided in paragraph (2), if the committee or committees of either House to which a disapproval resolution has been referred have not reported it at the close of the 45th day after its introduction, such committee or com-

mittees shall be automatically discharged from further consideration of the disapproval resolution and it shall be placed on the appropriation calendar. A vote on final passage of the disapproval resolution shall be taken in each House on or before the close of the 45th day after the disapproval resolution is reported by the committees or committee of that House to which it was referred, or after such committee or committees have been discharged from further consideration of the disapproval resolution. If prior to the passage by one House of a disapproval resolution of that House, that House receives the same disapproval resolution from the other House then—

(A) the procedure in that House shall be the same as if no disapproval resolution had been received from the other House; but

(B) the vote on final passage shall be on the disapproval resolution of the other House.

(2) COMPUTATION OF DAYS.—For purposes of paragraph (1), in computing a number of days in either House, there shall be excluded any day on which the House is not in session.

(f) FLOOR CONSIDERATION IN THE HOUSE OF REPRESENTATIVES.—

(1) MOTION TO PROCEED.—A motion in the House of Representatives to proceed to the consideration of a disapproval resolution shall be highly privileged and not debatable. An amendment to the motion shall not be in order, nor shall it be in order to move to reconsider the vote by which the motion is agreed to or disagreed to.

(2) DEBATE.—Debate in the House of Representatives on a disapproval resolution shall be limited to not more than 20 hours, which shall be divided equally between those favoring and those opposing the disapproval resolution. A motion further to limit debate shall not be debatable. It shall not be in order to move to recommit a disapproval resolution or to move to reconsider the vote by which a disapproval resolution is agreed to or disagreed to.

(3) MOTION TO POSTPONE.—Motions to postpone, made in the House of Representatives with respect to the consideration of a disapproval resolution, and motions to proceed to the consideration of other business, shall be decided without debate.

(4) APPEALS.—All appeals from the decisions of the Chair relating to the application of the Rules of the House of Representatives to the procedure re-

lating to a disapproval resolution shall be decided without debate.

(5) GENERAL RULES APPLY.—Except to the extent specifically provided in the preceding provisions of this subsection, consideration of a disapproval resolution shall be governed by the Rules of the House of Representatives applicable to other bills and resolutions in similar circumstances.

(g) FLOOR CONSIDERATION IN THE SENATE.—

(1) MOTION TO PROCEED.—A motion in the Senate to proceed to the consideration of a disapproval resolution shall be privileged and not debatable. An amendment to the motion shall not be in order, nor shall it be in order to move to reconsider the vote by which the motion is agreed to or disagreed to.

(2) GENERAL DEBATE.—Debate in the Senate on a disapproval resolution, and all debatable motions and appeals in connection therewith, shall be limited to not more than 20 hours. The time shall be equally divided between, and controlled by, the Majority Leader and the Minority Leader or their designees.

(3) DEBATE OF MOTIONS AND APPEALS.—Debate in the Senate on any debatable motion or ap-

peal in connection with a disapproval resolution shall be limited to not more than 1 hour, to be equally divided between, and controlled by, the mover and the manager of the disapproval resolution, except that in the event the manager of the disapproval resolution is in favor of any such motion or appeal, the time in opposition thereto, shall be controlled by the Minority Leader or his designee. Such leaders, or either of them, may, from time under their control on the passage of a disapproval resolution, allot additional time to any Senator during the consideration of any debatable motion or appeal.

(4) OTHER MOTIONS.—A motion in the Senate to further limit debate is not debatable. A motion to recommit a disapproval resolution is not in order.

(h) POINT OF ORDER REQUIRING SUPERMAJORITY FOR MODIFICATIONS TO ACTIONS ONCE APPROVED.—

(1) IN GENERAL.—It shall not be in order in the House of Representatives or the Senate to consider any amendment to the actions of the Federal Health Board except as provided in paragraph (2).

(2) WAIVER.—The point of order described in paragraph (1) may be waived or suspended in the House of Representatives or the Senate only, by the

affirmative vote of three-fifths of the Members duly chosen and sworn.

TITLE VI—PRIVATE OPTIONS

SEC. 601. PRIVATE SUPPLEMENTAL INSURANCE.

Except as provided in section 603, nothing in this Act shall be construed to prohibit the purchase of private insurance that provides coverage of health care and long-term care services supplementing the services covered under this Act.

SEC. 602. OPTION TO PURCHASE DUPLICATIVE PRIVATE INSURANCE.

Except as provided in section 603, nothing in this Act shall be construed to prohibit the purchase of private insurance that provides coverage of health care and long-term care services covered under this Act.

SEC. 603. LIMITS ON PRIVATE INSURANCE.

(a) IN GENERAL.—No insurer may issue a private insurance policy if such policy provides coverage for the cost-sharing requirements for health care services and other non-long-term care services covered under this Act.

(b) CERTIFICATION OF NOTIFICATION.—At the time of sale, the issuer of any private insurance policy shall secure in writing a certification by the purchaser that the purchaser has been informed of any duplication in coverage of the services covered under this Act.

(c) REVIEW OF PRACTICES.—No later than 2 years after the full implementation of the provisions of this Act, the Comptroller General of the United States shall review the practices of the private insurance industry and make such recommendations as necessary to the Congress in order to prevent fraud and abuse in the sale of duplicative or supplemental private health insurance and to protect the integrity of the American Health Security Plan.

(d) OBLIGATION TO PAY PREMIUM REMAINS.—The purchase of any type of private health insurance policy shall not relieve the purchaser of the payment of the American Health Security Plan premium imposed under section 421.

TITLE VII—EXPANSION OF OUTCOMES RESEARCH AND DELIVERY OF SERVICES IN UNDERSERVED AREAS

SEC. 701. EXPANSION OF OUTCOMES RESEARCH.

Paragraph (1) of section 1142(i) of the Social Security Act (42 U.S.C. 1320b–12(i)) is amended by striking ''and'' at the end of subparagraph (D) and by striking (E) and inserting the following:

''(E) $225,000,000 for fiscal year 1994;

''(F) $275,000,000 for fiscal year 1995; and

''(G) $325,000,000 for fiscal year 1996.''.

SEC. 702. NATIONAL HEALTH SERVICE CORPS.

(a) INCREASE IN AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated to carry out subpart II of part D of title III of the Public Health Services Act (42 U.S.C. 254d et seq.) for fiscal year 1994, an amount equal to—

(1) the amount appropriated under such subpart for fiscal year 1993; and

(2) an additional amount equal to 40 percent of the amount described in paragraph (1).

When making loans under such subpart, priority should be given to students from schools that have primary care programs and that stress underserved practices.

(b) COMMUNITY FINANCING PROGRAM.—Subpart II of part D of title III of the Public Health Service Act (42 U.S.C. 254d et seq.) is amended by inserting after section 336A, the following new section:

''SEC. 336B. COMMUNITY FINANCING PROGRAMS.

''(a) ESTABLISHMENT.—The Secretary may award grants under this section to local communities to enable such communities to establish programs to finance the health-related education of residents of such communities.

''(b) APPLICATION.—To be eligible to receive a grant under subsection (a), a community shall prepare and sub-

mit to the Secretary an application, at such time, in such manner and containing such information as the Secretary may require.

''(c) USE.—A community that receives a grant under subsection (a), shall use amounts received under such grant to provide assistance to local residents with respect to the health-related educational expenses of such residents. Such community shall not provide assistance under a grant under this section to a local resident unless such resident agrees to practice in a health-related field in such community for not less than 4 years after graduation. In providing assistance to such residents, the community should give priority to residents attending schools that have primary care programs and that stress underserved practices.

''(d) AMOUNTS.—The amount of a grant awarded to a community under this section shall not exceed 75 percent of the cost to such community in administering and implementing a community financing program under this section.

''(e) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to carry out this section, $10,000,000 for each of the fiscal year 1994 through 1996.''.

SEC. 703. COMMUNITY AND MIGRANT HEALTH CENTERS.

Subpart I of part D of title III of the Public Health Service Act (42 U.S.C. 254d et seq.) is amended by inserting after section 330, the following new section:

"SEC. 330A. NEW COMMUNITY AND MIGRANT HEALTH CENTERS.

''(a) NEW COMMUNITY AND MIGRANT HEALTH CENTERS.—

''(1) IN GENERAL.—The Secretary shall award grants to eligible entities to expand the availability of comprehensive primary health services (as defined in section 330(b)(1)) in medically underserved areas.

''(2) ELIGIBILITY.—To be eligible to receive a grant under this section an entity shall—

''(A) be an entity that—

''(i) meets the requirements of section 329(a) or 330(a) for being a migrant or community health center, though not a recipient of a grant under either section;

''(ii) does not meet the requirements of section 329(a) or 330(a) for being a migrant or community health center, but that provides assurances satisfactory to the Secretary, including subsequent demonstrable evidence, that such entity will meet the requirements of either section not later than

2 years after receiving a grant under this section;

''(iii) is eligible for a planning grant under sections 329(c) or 330(c); or

''(iv) is able to provide a subset of the required services, be able to prove that it cannot meet the requirements of section 329(a) or 330(a), and demonstrate that it is the most qualified entity in the service area; and

''(B) prepare and submit to the Secretary an application at such time, in such manner and containing such information as the Secretary may require.

''(b) EXPANSION OF CURRENT COMMUNITY AND MIGRANT HEALTH CENTERS.—

''(1) IN GENERAL.— Community and migrant health centers in existence on the date of enactment of this section may utilize any increase in revenue experienced as a result of the increase in the number of insured patients treated for the expansion of the amounts and types of services furnished, to serve additional patients or areas, or to promote the recruitment, training or retention of personnel.

''(2) RECOMMENDATIONS.—Not later than 3 years after the date of enactment of this section, the Secretary shall prepare and submit to the appropriate committees of Congress recommendations concerning the provision of paragraph (1).

''(c) REPORT.—Not later than 3 years after the date of enactment of this section, the Secretary shall prepare and submit to the appropriate committees of Congress a report concerning the need for further migrant and community health center primary care service capacity development and recommendations concerning the appropriate level of support needed for activities to address such capacity development.

''(d) AUTHORIZATIONS OF APPROPRIATIONS.—

''(1) IN GENERAL.—There are authorized to be appropriated to carry out this section, $300,000,000 for fiscal years 1994 through 1996.

''(2) ADDITIONAL AMOUNTS.—Amounts provided under this section shall be in addition to any amounts appropriated under sections 329 and 330.''.

TITLE VIII—MALPRACTICE REFORM

SEC. 801. GRANTS TO STATES.

(a) IN GENERAL.—The Board shall make grants to States for the development and implementation of medical

malpractice reforms, as described in section 802. A State shall use a grant made under this section to develop, implement, and evaluate the effectiveness of such reforms.

(b) COMPLIANCE WITH FEDERAL STANDARDS.—Beginning 2 years after the implementation of the reforms, each State shall annually submit a report to the Board containing such information as the Board may require to determine whether the State is in compliance with the terms of the grant made under this section.

SEC. 802. CRITERIA FOR STATE MALPRACTICE REFORMS.

(a) IN GENERAL.—Each State must demonstrate to the Board that the reforms to the State medical malpractice system that the State develops or has already adopted or intends to adopt meet the criteria described in subsection (b).

(b) CRITERIA.—The criteria for medical malpractice reforms are as follows:

(1) COSTS.—Decrease administrative costs and reduce incentives for filing non-meritorious claims.

(2) EFFICIENCY.—Reduce the time between the filing of medical malpractice claims and case resolutions using procedures which may include the establishment of voluntary alternative dispute resolution mechanisms, such as mediation, arbitration,

minitrials, and summary judgments, to facilitate earlier case resolutions.

(3) ACCESS.—Develop mechanisms to ensure that victims of malpractice or medically injured patients have the meaningful ability to seek compensation, including voluntary alternative dispute resolution mechanisms designed for small claims.

(4) QUALITY.—Improve the quality of health care by strengthening mechanisms that reduce the occurrence of medical injury, and detect and sanction health care professionals who commit health care malpractice.

(5) EQUITY.—Enhance the fairness of compensation provided to injured individuals for both medically and non-medically-related damages, and increase incentives for experience rating of insurance premiums.

(c) BOARD STUDY OF CRITERIA.—

(1) STUDY.—The Board shall collect data from the States awarded grants under section 801 on the effects of the reforms established to meet the criteria described in subsection (b) on the medical malpractice systems of such States. The data shall be used to evaluate the effectiveness and appropriateness of the criteria described in subsection (b) in ad-

dressing the problems of the medical malpractice systems of such States. The Board may modify such criteria based on such study.

(2) REPORT.—The Board shall report the results of the study described in paragraph (1) to the Congress on a periodic basis.

SEC. 803. AUTHORIZATION OF APPROPRIATIONS.

There are authorized to be appropriated for grants under this title such sums as may be necessary for fiscal years 1994 through 1997.

TITLE IX—EFFECTIVE DATES; TERMINATIONS; TRANSITION; RELATION TO ERISA.

SEC. 901. EFFECTIVE DATES.

(a) FEDERAL ADMINISTRATION.—Not later than October 1, 1995, the Board shall promulgate regulations regarding the health care and long-term care services covered under this Act and the related patient cost-sharing schedules under title II, develop the means for computing the National Health Budget and Federal contributions to the States under subtitle A of title IV, and establish the procedures for reviewing and approving State plans under section 311.

(b) PROVISION OF SERVICES.—

(1) PREVENTIVE AND PRIMARY CARE SERVICES.—The provision of preventive and primary care services under approved State plans, as established under section 201, shall take effect with respect to services furnished on or after October 1, 1997.

(2) ACUTE CARE SERVICES.—The provision of acute care services under approved State plans, as established under section 201, shall take effect with respect to services furnished on or after October 1, 1998.

(3) LONG-TERM CARE SERVICES.—The provision of long-term care services under approved State plans, as established under section 202, shall take effect with respect to services furnished on or after October 1, 1999.

(c) MODIFICATION OF TRANSITION PERIOD.—

(1) IN GENERAL.—Notwithstanding any other provision of this Act and to the extent the Board determines it is appropriate and fiscally responsible, the Board may promulgate regulations to reduce the period between the date of the enactment of this Act and the effective dates otherwise provided in this Act.

(2) EFFECT OF BOARD ACTIONS.—Any determination made by the Board under this subsection

to change an effective date under this Act shall be submitted to the Congress at least 6 months before the new effective date, and shall have the force of law, unless within 60 days of the submission of such determination, the Congress enacts a disapproval resolution under the procedures described in section 501.

SEC. 902. TERMINATION OF OTHER PROGRAMS.

(a) MEDICARE AND MEDICAID.—

(1) IN GENERAL.—Titles XVIII and XIX of the Social Security Act are repealed.

(2) REPEAL OF HOSPITAL INSURANCE TAXES UPON FULL IMPLEMENTATION OF PLAN.—Sections 1401(b), 1402(k)(2), 3101(b), 3111(b), 3121(x)(2), 3231(e)(2)(B)(i)(II), and 6413(c)(3) of the Internal Revenue Code of 1986 are repealed.

(b) REPEAL OF CHAMPUS PROVISIONS.—

(1) AMENDMENTS TO CHAPTER 55 OF TITLE 10.—Sections 1079 through 1083, 1086, and 1097 through 1100 of title 10, United States Code, are repealed.

(2) TABLE OF SECTIONS.—The table of sections at the beginning of chapter 55 of title 10, United States Code, is amended by striking out the items relating to the sections referred to in paragraph (1).

(3) CONFORMING AMENDMENTS.—Chapter 55 of title 10, United States Code, is amended as follows:

(A) DEFINITION.—Section 1072 is amended by striking out paragraph (4).

(B) REIMBURSEMENT OF THE DEPARTMENT OF VETERANS AFFAIRS.—Section 1104(b) is amended—

(i) in the subsection heading, by striking out ''FROM CHAMPUS FUNDS''; and

(ii) by striking out ''from funds'' and all that follows and inserting in lieu thereof ''for medical care provided by the Department of Veterans Affairs pursuant to such agreement.''.

(c) REPEAL OF FEDERAL EMPLOYEES HEALTH BENEFITS PROGRAM.—Chapter 89 of title 5, United States Code, is repealed.

(d) EFFECTIVE DATE.—The repeals and amendments made by this section shall take effect on October 1, 1999.

SEC. 903. TRANSITION.

(a) IN GENERAL.—The Board shall issue such regulations as are necessary to provide for a transition to the

American Health Security Plan established under this Act from the programs repealed under section 902.

(b) RELATION TO OTHER PROGRAMS.—The Board shall recommend to the Congress appropriate legislative proposals for the amendment or repeal of any other Federal program inconsistent with, or duplicative of, the principles of the American Health Security Plan established under this Act.

SEC. 904. RELATION TO ERISA.

The provisions of the Employee Retirement Income Security Act are superseded to the extent inconsistent with the requirements of this Act.

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