I

113TH CONGRESS
1ST SESSION

H. R. 1200

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

IN THE HOUSE OF REPRESENTATIVES

MARCH 14, 2013

Mr. MCDERMOTT introduced the following bill; which was referred to the Committee on Energy and Commerce, and in addition to the Committees on Ways and Means, Oversight and Government Reform, Armed Services, and Education and the Workforce, for a period to be subsequently determined by the Speaker, in each case for consideration of such provisions as fall within the jurisdiction of the committee concerned

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A BILL

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

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

SECTION 1. SHORT TITLE.

This Act may be cited as the ''American Health Security Act of 2013''.

SEC. 2. SENSE OF THE HOUSE OF REPRESENTATIVES CONCERNING THE STATUS OF HEALTH CARE.

It is the sense of the House of Representatives that the 113th Congress should recognize and proclaim that health care is a human right.

SEC. 3. TABLE OF CONTENTS.

The table of contents of this Act is as follows:

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

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

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

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

(c) STATE DEFINED.—

(1) IN GENERAL.—In this Act, subject to paragraph (2), the term ''State'' means each of the 50 States and the District of Columbia.

(2) ELECTION.—If the Governor of Puerto Rico, the Virgin Islands, Guam, American Samoa, or the Northern Mariana Islands certifies to the President that the legislature of the Commonwealth or

territory has enacted legislation desiring that the Commonwealth or territory be included as a State under the provisions of this Act, such Commonwealth or territory shall be included as a ''State'' under this Act beginning January 1 of the first year beginning 90 days after the President receives the notification.

SEC. 102. UNIVERSAL 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 benefits for health care services under this Act under the appropriate State health security program. In this section, the term ''appropriate State health security program'' means, with respect to an individual, the State health security program for the State in which the individual maintains a primary residence.

(b) TREATMENT OF CERTAIN NONIMMIGRANTS.—

(1) IN GENERAL.—The American Health Security Standards Board (in this Act referred to as the ''Board'') may make eligible for benefits for health care services under the appropriate State health security program 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 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.—

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

(A) to preserve the public health of communities;

(B) to compensate States for the additional health care financing burdens created by such individuals; and

(C) to prevent adverse financial and medical consequences of uncompensated care,

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

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

(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 234A of the Immigration and Nationality Act (8 U.S.C. 1160, 1161, or 1255a).

SEC. 103. ENROLLMENT.

(a) IN GENERAL.—Each State health security program shall provide a mechanism for the enrollment of individuals entitled or eligible for benefits under this Act. The mechanism shall—

(1) include a process for the automatic enrollment of individuals at the time of birth in the United States and at the time of immigration into the United States or other acquisition of lawful resident status in the United States;

(2) provide for the enrollment, as of January 1, 2015, of all individuals who are eligible to be enrolled as of such date; and

(3) include a process for the enrollment of individuals made eligible for health care services under subsections (b) and (c) of section 102.

(b) AVAILABILITY OF APPLICATIONS.—Each State health security program shall make applications for enrollment under the program available—

(1) at employment and payroll offices of employers located in the State;

(2) at local offices of the Social Security Administration;

(3) at social services locations;

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

(5) at other locations (including post offices and schools) accessible to a broad cross-section of individuals eligible to enroll.

(c) ISSUANCE OF HEALTH SECURITY CARDS.—In conjunction with an individual's enrollment for benefits under this Act, the State health security program shall provide for the issuance of a health security card (to be referred to as a ''smart card'') that shall be used for purposes of identification and processing of claims for benefits under the program. The State health security program may provide for issuance of such cards by employers for

purposes of carrying out enrollment pursuant to subsection (a)(2).

SEC. 104. PORTABILITY OF BENEFITS.

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

(1) 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, or eligible for, such benefits under the program;

(2) shall provide continuation of payment for covered health care 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, or eligibility for, such services; and

(3) 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 health security 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) 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 health security program for similar services rendered in the State, with due regard, in the case of hospital services, to the size of the hospital, standards of service, and other relevant factors.

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

SEC. 105. EFFECTIVE DATE OF BENEFITS.

Benefits shall first be available under this Act for items and services furnished on or after January 1, 2015.

SEC. 106. RELATIONSHIP TO EXISTING FEDERAL HEALTH PROGRAMS.

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

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

(A) no benefits shall be available under title XVIII of the Social Security Act for any item or service furnished after December 31, 2014;

(B) no individual is entitled to medical assistance under a State plan approved under title XIX of such Act for any item or service furnished after such date;

(C) no individual is entitled to medical assistance under an SCHIP plan under title XXI of such Act for any item or service furnished after such date; and

(D) no payment shall be made to a State under section 1903(a) or 2105(a) of such Act with respect to medical assistance or child health assistance for any item or service furnished after such date.

(2) TRANSITION.—In the case of inpatient hospital services and extended care services during a continuous period of stay which began before January 1, 2015, and which had not ended as of such date, for which benefits are provided under title XVIII, under a State plan under title XIX, or a State child health plan under title XXI, of the Social Security Act, the Secretary of Health and Human

Services and each State plan, respectively, shall provide for continuation of benefits under such title or plan until the end of the period of stay.

(b) FEDERAL EMPLOYEES HEALTH BENEFITS PROGRAM.—No benefits shall be made available under chapter 89 of title 5, United States Code, for any part of a coverage period occurring after December 31, 2014.

(c) TRICARE.—No benefits shall be made available under sections 1079 and 1086 of title 10, United States Code, for items or services furnished after December 31, 2014.

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

(e) TREATMENT OF PREMIUM CREDITS, COST-SHARING REDUCTIONS, AND SMALL EMPLOYER CREDITS.—

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

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

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

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

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

(2) DETERMINATION.—The amounts determined under paragraph (1) shall be estimated by the Secretary of the Treasury in consultation with the Secretary of Health and Human Services.

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

SEC. 201. COMPREHENSIVE BENEFITS.

(a) IN GENERAL.—Subject to the succeeding provisions of this title, individuals enrolled for benefits under this Act are entitled to have payment made under a State health security program for the following items and services if medically necessary or appropriate for the maintenance of health or for the diagnosis, treatment, or rehabilitation of a health condition:

(1) HOSPITAL SERVICES.—Inpatient and outpatient hospital care, including 24-hour-a-day emergency services.

(2) PROFESSIONAL SERVICES.—Professional services of health care practitioners authorized to provide health care services under State law, including patient education and training in self-management techniques.

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

(4) PREVENTIVE SERVICES.—Preventive services (as defined in section 202(b)).

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

(A) Nursing facility services.

(B) Home health services.

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

(D) Hospice care.

(E) Services in intermediate care facilities for individuals with an intellectual disability.

(6) PRESCRIPTION DRUGS, BIOLOGICALS, INSULIN, MEDICAL FOODS.—

(A) Outpatient prescription drugs and biologics, as specified by the Board consistent with section 615.

(B) Insulin.

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

(7) DENTAL SERVICES.—Dental services (as defined in section 202(h)).

(8) MENTAL HEALTH AND SUBSTANCE ABUSE TREATMENT SERVICES.—Mental health and substance abuse treatment services (as defined in section 202(f)).

(9) DIAGNOSTIC TESTS.—Diagnostic tests.

(10) OTHER ITEMS AND SERVICES.—

(A) OUTPATIENT THERAPY.—Outpatient physical therapy services, outpatient speech pathology services, and outpatient occupational therapy services in all settings.

(B) DURABLE MEDICAL EQUIPMENT.—Durable medical equipment.

(C) HOME DIALYSIS.—Home dialysis supplies and equipment.

(D) AMBULANCE.—Emergency ambulance service.

(E) PROSTHETIC DEVICES.—Prosthetic devices, including replacements of such devices.

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

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

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

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

(e) EMPLOYERS MAY PROVIDE ADDITIONAL BENEFITS.—Nothing in this Act shall be construed as limiting the additional benefits that an employer may provide to employees or their dependents, or to former employees or their dependents.

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

SEC. 202. DEFINITIONS RELATING TO SERVICES.

(a) COMMUNITY-BASED PRIMARY HEALTH SERVICES.—In this title, the term ''community-based primary health services'' means ambulatory health services furnished—

(1) by a rural health clinic;

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

(3) in a school-based setting;

(4) by public educational agencies and other providers of services to children entitled to assistance under the Individuals with Disabilities Education Act for services furnished pursuant to a written Individualized Family Services Plan or Individual Education Plan under such Act; and

(5) public and private nonprofit entities receiving Federal assistance under the Public Health Service Act.

(b) PREVENTIVE SERVICES.—

(1) IN GENERAL.—In this title, the term ''preventive services'' means items and services—

(A) which—

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

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

(B) which are provided consistent with the periodicity schedule established under paragraph (3).

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

(A) Immunizations recommended by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention.

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

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

(D) Periodic screening mammography, Pap smears, and colorectal examinations and examinations for prostate cancer.

(E) Physical examinations.

(F) Family planning services.

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

(H) Hearing aids, but only upon a determination of a certified audiologist or physician that a hearing problem exists and is caused by a condition that can be corrected by use of a hearing aid.

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

(J) With respect to women, such additional preventive care and screenings not described in subparagraph (I) that are included in the comprehensive guidelines of the Health Resources and Services Administration.

(3) SCHEDULE.—The Board shall establish, in consultation with experts in preventive medicine and public health and taking into consideration those preventive services recommended by the Preventive Services Task Force and published as the Guide to Clinical Preventive Services, a periodicity schedule for the coverage of preventive services under paragraph (1). Such schedule shall take into consideration the cost-effectiveness of appropriate preventive

care and shall be revised not less frequently than once every 5 years, in consultation with experts in preventive medicine and public health.

(c) HOME AND COMMUNITY-BASED LONG-TERM CARE SERVICES.—In this title, the term ''home and community-based long-term care services'' means the following services provided to an individual to enable the individual to remain in such individual's place of residence within the community:

(1) Home health aide services.

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

(3) Medical social work services.

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

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

(6) Personal assistance services, and homemaker services (including meals) incidental to the provision of personal assistance services.

(d) HOME HEALTH SERVICES.—

(1) IN GENERAL.—The term ''home health services'' means items and services described in section 1861(m) of the Social Security Act and includes home infusion services.

(2) HOME INFUSION SERVICES.—The term ''home infusion services'' includes the nursing, pharmacy, and related services that are necessary to conduct the home infusion of a drug regimen safely and effectively under a plan established and periodically reviewed by a physician and that are provided in compliance with quality assurance requirements established by the Secretary.

(e) MEDICAL FOODS.—In this title, the term ''medical foods'' means foods which are formulated to be consumed or administered enterally under the supervision of a physician and which are intended for the specific dietary management of a disease or condition for which distinctive nutritional requirements, based on recognized scientific principles, are established by medical evaluation.

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

(1) SERVICES DESCRIBED.—In this title, the term ''mental health and substance abuse treatment services'' means the following services related to the prevention, diagnosis, treatment, and rehabilitation of mental illness and promotion of mental health:

(A) INPATIENT HOSPITAL SERVICES.—Inpatient hospital services furnished primarily for the diagnosis or treatment of mental illness or

substance abuse for up to 60 days during a year, reduced by a number of days determined by the Secretary so that the actuarial value of providing such number of days of services under this paragraph to the individual is equal to the actuarial value of the days of inpatient residential services furnished to the individual under subparagraph (B) during the year after such services have been furnished to the individual for 120 days during the year (rounded to the nearest day), but only if (with respect to services furnished to an individual described in section 204(b)(1)) such services are furnished in conformity with the plan of an organized system of care for mental health and substance abuse services in accordance with section 204(b)(2).

(B) INTENSIVE RESIDENTIAL SERVICES.—Intensive residential services (as defined in paragraph (2)) furnished to an individual for up to 120 days during any calendar year, except that—

(i) such services may be furnished to the individual for additional days during the year if necessary for the individual to

complete a course of treatment to the extent that the number of days of inpatient hospital services described in subparagraph (A) that may be furnished to the individual during the year (as reduced under such subparagraph) is not less than 15; and

(ii) reduced by a number of days determined by the Secretary so that the actuarial value of providing such number of days of services under this paragraph to the individual is equal to the actuarial value of the days of intensive community-based services furnished to the individual under subparagraph (D) during the year after such services have been furnished to the individual for 90 days (or, in the case of services described in subparagraph (D)(ii), for 180 days) during the year (rounded to the nearest day).

(C) OUTPATIENT SERVICES.—Outpatient treatment services of mental illness or substance abuse (other than intensive community-based services under subparagraph (D)) for an unlimited number of days during any calendar year furnished in accordance with standards es-

tablished by the Secretary for the management of such services, and, in the case of services furnished to an individual described in section 204(b)(1) who is not an inpatient of a hospital, in conformity with the plan of an organized system of care for mental health and substance abuse services in accordance with section 204(b)(2).

(D) INTENSIVE COMMUNITY-BASED SERVICES.—Intensive community-based services (as described in paragraph (3))—

(i) for an unlimited number of days during any calendar year, in the case of services described in section 1861(ff)(2)(E) of the Social Security Act (42 U.S.C. 1395x(ff)(2)(E)) that are furnished to an individual who is a seriously mentally ill adult, a seriously emotionally disturbed child, or an adult or child with serious substance abuse disorder (as determined in accordance with criteria established by the Secretary);

(ii) in the case of services described in section 1861(ff)(2)(C) of the Social Security Act (42 U.S.C. 1395x(ff)(2)(C)), for

up to 180 days during any calendar year, except that such services may be furnished to the individual for a number of additional days during the year equal to the difference between the total number of days of intensive residential services which the individual may receive during the year under part A (as determined under subparagraph (B)) and the number of days of such services which the individual has received during the year; or

(iii) in the case of any other such services, for up to 90 days during any calendar year, except that such services may be furnished to the individual for the number of additional days during the year described in clause (ii).

(2) INTENSIVE RESIDENTIAL SERVICES DEFINED.—

(A) IN GENERAL.—Subject to subparagraphs (B) and (C), the term ''intensive residential services'' means inpatient services provided in any of the following facilities:

(i) Residential detoxification centers.

(ii) Crisis residential programs or mental illness residential treatment programs.

(iii) Therapeutic family or group treatment homes.

(iv) Residential centers for substance abuse treatment.

(B) REQUIREMENTS FOR FACILITIES.—No service may be treated as an intensive residential service under subparagraph (A) unless the facility at which the service is provided—

(i) is legally authorized to provide such service under the law of the State (or under a State regulatory mechanism provided by State law) in which the facility is located or is certified to provide such service by an appropriate accreditation entity approved by the State in consultation with the Secretary; and

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

(C) SERVICES FURNISHED TO AT-RISK CHILDREN.—In the case of services furnished

to an individual described in section 204(b)(1), no service may be treated as an intensive residential service under this subsection unless the service is furnished in conformity with the plan of an organized system of care for mental health and substance abuse services in accordance with section 204(b)(2).

(D) MANAGEMENT STANDARDS.—No service may be treated as an intensive residential service under subparagraph (A) unless the service is furnished in accordance with standards established by the Secretary for the management of such services.

(3) INTENSIVE COMMUNITY-BASED SERVICES DEFINED.—

(A) IN GENERAL.—The term ''intensive community-based services'' means the items and services described in subparagraph (B) prescribed by a physician (or, in the case of services furnished to an individual described in section 204(b)(1), by an organized system of care for mental health and substance abuse services in accordance with such section) and provided under a program described in subparagraph (D) under the supervision of a physician (or, to

the extent permitted under the law of the State in which the services are furnished, a non-physician mental health professional) pursuant to an individualized, written plan of treatment established and periodically reviewed by a physician (in consultation with appropriate staff participating in such program) which sets forth the physician's diagnosis, the type, amount, frequency, and duration of the items and services provided under the plan, and the goals for treatment under the plan, but does not include any item or service that is not furnished in accordance with standards established by the Secretary for the management of such services.

(B) ITEMS AND SERVICES DESCRIBED.—The items and services described in this subparagraph are—

(i) partial hospitalization services consisting of the items and services described in subparagraph (C);

(ii) psychiatric rehabilitation services;

(iii) day treatment services for individuals under 19 years of age;

(iv) in-home services;

(v) case management services, including collateral services designated as such case management services by the Secretary;

(vi) ambulatory detoxification services; and

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

that are reasonable and necessary for the diagnosis or active treatment of the individual's condition, reasonably expected to improve or maintain the individual's condition and functional level and to prevent relapse or hospitalization, and furnished pursuant to such guidelines relating to frequency and duration of services as the Secretary shall by regulation establish (taking into account accepted norms of medical practice and the reasonable expectation of patient improvement).

(C) ITEMS AND SERVICES INCLUDED AS PARTIAL HOSPITALIZATION SERVICES.—For purposes of subparagraph (B)(i), partial hospitalization services consist of the following:

(i) Individual and group therapy with physicians or psychologists (or other mental health professionals to the extent authorized under State law).

(ii) Occupational therapy requiring the skills of a qualified occupational therapist.

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

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

(v) Individualized activity therapies that are not primarily recreational or diversionary.

(vi) Family counseling (the primary purpose of which is treatment of the individual's condition).

(vii) Patient training and education (to the extent that training and educational activities are closely and clearly

related to the individual's care and treatment).

(viii) Diagnostic services.

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

(i) legally authorized to furnish such a program under State law (or the State regulatory mechanism provided by State law) or certified to furnish such a program by an appropriate accreditation entity approved by the State in consultation with the Secretary; and

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

(g) CARE COORDINATION SERVICES.—

(1) IN GENERAL.—In this title, the term ''care coordination services'' means services provided by care coordinators (as defined in paragraph (2)) to individuals described in paragraph (3) for the coordination and monitoring of home and community-based long-term care services to ensure appropriate,

cost-effective utilization of such services in a comprehensive and continuous manner, and includes—

(A) transition management between inpatient facilities and community-based services, including assisting patients in identifying and gaining access to appropriate ancillary services; and

(B) evaluating and recommending appropriate treatment services, in cooperation with patients and other providers and in conjunction with any quality review program or plan of care under section 205.

(2) CARE COORDINATOR.—

(A) IN GENERAL.—In this title, the term ''care coordinator'' means an individual or nonprofit or public agency or organization which the State health security program determines—

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

(ii) demonstrates capability in establishing and periodically reviewing and revising plans of care, and in arranging for

and monitoring the provision and quality of services under any plan.

(B) INDEPENDENCE.—State health security programs shall establish safeguards to ensure that care coordinators have no financial interest in treatment decisions or placements. Care coordination may not be provided through any structure or mechanism through which quality review is performed.

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

(h) DENTAL SERVICES.—

(1) IN GENERAL.—In this title, subject to subsection (b), the term ''dental services'' means the following:

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

(B) Prevention and diagnosis of dental disease, including examinations of the hard and soft tissues of the oral cavity and related structures, radiographs, dental sealants, fluorides, and dental prophylaxis.

(C) Treatment of dental disease, including non-cast fillings, periodontal maintenance services, and endodontic services.

(D) Space maintenance procedures to prevent orthodontic complications.

(E) Orthodontic treatment to prevent severe malocclusions.

(F) Full dentures.

(G) Medically necessary oral health care.

(H) Any items and services for special needs patients that are not described in subparagraphs (A) through (G) and that—

(i) are required to provide such patients the items and services described in subparagraphs (A) through (G);

(ii) are required to establish oral function (including general anesthesia for individuals with physical or emotional limitations that prevent the provision of dental care without such anesthesia);

(iii) consist of orthodontic care for severe dentofacial abnormalities; or

(iv) consist of prosthetic dental devices for genetic or birth defects or fitting for such devices.

(I) Any dental care for individuals with a seizure disorder that is not described in subparagraphs (A) through (H) and that is required because of an illness, injury, disorder, or other health condition that results from such seizure disorder.

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

(A) PREVENTION AND DIAGNOSIS.—

(i) EXAMINATIONS AND PROPHYLAXIS.—The examinations and prophylaxis described in paragraph (1)(B) are covered only consistent with a periodicity schedule established by the Board, which schedule may provide for special treatment of individuals less than 18 years of age and of special needs patients.

(ii) DENTAL SEALANTS.—The dental sealants described in such paragraph are not covered for individuals 18 years of age or older. Such sealants are covered for individuals less than 10 years of age for protection of the 1st permanent molars. Such sealants are covered for individuals 10

years of age or older for protection of the 2d permanent molars.

(B) TREATMENT OF DENTAL DISEASE.—Prior to January 1, 2020, the items and services described in paragraph (1)(C) are covered only for individuals less than 18 years of age and special needs patients. On or after such date, such items and services are covered for all individuals enrolled for benefits under this Act, except that endodontic services are not covered for individuals 18 years of age or older.

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

(i) are limited to posterior teeth;

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

(iii) do not include a space maintainer that is placed within 6 months of the expected eruption of the permanent posterior tooth concerned.

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

(A) MEDICALLY NECESSARY ORAL HEALTH CARE.—The term ''medically necessary oral health care'' means oral health care that is required as a direct result of, or would have a direct impact on, an underlying medical condition. Such term includes oral health care directed toward control or elimination of pain, infection, or reestablishment of oral function.

(B) SPECIAL NEEDS PATIENT.—The term ''special needs patient'' includes an individual with a genetic or birth defect, a developmental disability, or an acquired medical disability.

(i) NURSING FACILITY; NURSING FACILITY SERVICES.—Except as may be provided by the Board, the terms ''nursing facility'' and ''nursing facility services'' have the meanings given such terms in sections 1919(a) and 1905(f), respectively, of the Social Security Act.

(j) SERVICES IN INTERMEDIATE CARE FACILITIES FOR INDIVIDUALS WITH AN INTELLECTUAL DISABILITY.—Except as may be provided by the Board—

(1) the term ''intermediate care facility for individuals with an intellectual disability'' has the meaning given the term ''intermediate care facility for individuals with mental retardation'' in section

1905(d) of the Social Security Act (as in effect before the enactment of this Act); and

(2) the term ''services in intermediate care facilities for individuals with an intellectual disability'' means services described in section 1905(a)(15) of such Act (as so in effect) in an intermediate care facility for individuals with an intellectual disability to an individual determined to require such services in accordance with standards specified by the Board and comparable to the standards described in section 1902(a)(31)(A) of such Act (as so in effect).

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

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

(a) QUALIFYING INDIVIDUALS.—For purposes of section 201(a)(5)(C), individuals described in this subsection are the following individuals:

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

(A) to be unable to perform, without the assistance of an individual, at least 2 of the following 5 activities of daily living (or who has a

similar level of disability due to cognitive impairment)—

(i) bathing;

(ii) eating;

(iii) dressing;

(iv) toileting; and

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

(B) due to cognitive or mental impairments, to require supervision because the individual behaves in a manner that poses health or safety hazards to himself or herself or others; or

(C) due to cognitive or mental impairments, to require queuing to perform activities of daily living.

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

(b) LIMIT ON SERVICES.—

(1) IN GENERAL.—The aggregate expenditures by a State health security program with respect to

home and community-based long-term care services in a period (specified by the Board) may not exceed 65 percent (or such alternative ratio as the Board establishes under paragraph (2)) of the average of the amount of payment that would have been made under the program during the period if all the home-based long-term care beneficiaries had been residents of nursing facilities in the same area in which the services were provided.

(2) ALTERNATIVE RATIO.—The Board may establish for purposes of paragraph (1) an alternative ratio (of payments for home and community-based long-term care services to payments for nursing facility services) as the Board determines to be more consistent with the goal of providing cost-effective long-term care in the most appropriate and least restrictive setting.

SEC. 204. EXCLUSIONS AND LIMITATIONS.

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

(b) SPECIAL DELIVERY REQUIREMENTS FOR MENTAL HEALTH AND SUBSTANCE ABUSE TREATMENT SERVICES PROVIDED TO AT-RISK CHILDREN.—

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

(A) the services are provided to an individual less than 22 years of age;

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

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

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

(A) The system has established linkages with existing mental health services and substance abuse treatment service delivery programs in the plan service area (or is in the

process of developing or operating a system with appropriate public agencies in the area to coordinate the delivery of such services to individuals in the area).

(B) The system provides for the participation and coordination of multiple agencies and providers that serve the needs of children in the area, including agencies and providers involved with child welfare, education, juvenile justice, criminal justice, health care, mental health, and substance abuse prevention and treatment.

(C) The system provides for the involvement of the families of children to whom mental health services and substance abuse treatment services are provided in the planning of treatment and the delivery of services.

(D) The system provides for the development and implementation of individualized treatment plans by multidisciplinary and multiagency teams, which are recognized and followed by the applicable agencies and providers in the area.

(E) The system ensures the delivery and coordination of the range of mental health services and substance abuse treatment services re-

quired by individuals under 22 years of age who have a serious emotional disturbance or a substance abuse disorder.

(F) The system provides for the management of the individualized treatment plans described in subparagraph (D) and for a flexible response to changes in treatment needs over time.

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

(d) APPLICATION OF PRACTICE GUIDELINES.—In the case of services for which the American Health Security Quality Council (established under section 501) has recognized a national practice guideline, the services are considered to meet the standards specified in section 201(a) if they have been provided in accordance with such guideline or in accordance with such guidelines as are provided by the State health security program consistent with title V. For purposes of this subsection, a service shall be considered to have been provided in accordance with

a practice guideline if the health care provider providing the service exercised appropriate professional discretion to deviate from the guideline in a manner authorized or anticipated by the guideline.

(e) SPECIFIC LIMITATIONS.—

(1) LIMITATIONS ON EYEGLASSES, CONTACT LENSES, HEARING AIDS, AND DURABLE MEDICAL EQUIPMENT.—Subject to section 201(e), the Board may impose such limits relating to the costs and frequency of replacement of eyeglasses, contact lenses, hearing aids, and durable medical equipment to which individuals enrolled for benefits under this Act are entitled to have payment made under a State health security program as the Board deems appropriate.

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

(3) MISCELLANEOUS EXCLUSIONS FROM COVERED SERVICES.—Covered services under this Act do not include the following:

(A) Surgery and other procedures (such as orthodontia) performed solely for cosmetic purposes (as defined in regulations) and hospital or other services incident thereto, unless—

(i) required to correct a congenital anomaly;

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

(iii) otherwise determined to be medically necessary and appropriate under section 201(a).

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

(C) The services of a professional practitioner if they are furnished in a hospital or other facility which is not a participating provider.

(f) NURSING FACILITY SERVICES AND HOME HEALTH SERVICES.—Nursing facility services and home health services (other than post-hospital services, as defined by the Board) furnished to an individual who is not

described in section 203(a) are not covered services unless the services are determined to meet the standards specified in section 201(a) and, with respect to nursing facility services, to be provided in the least restrictive and most appropriate setting.

SEC. 205. CERTIFICATION; QUALITY REVIEW; PLANS OF CARE.

(a) CERTIFICATIONS.—State health security programs may require, as a condition of payment for institutional health care services and other services of the type described in such sections 1814(a) and 1835(a) of the Social Security Act, periodic professional certifications of the kind described in such sections.

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

(c) PLAN OF CARE REQUIREMENTS.—A State health security program may require, consistent with standards established by the Board, that payment for services exceeding specified levels or duration be provided only as consistent with a plan of care or treatment formulated by one or more providers of the services or other qualified professionals. Such a plan may include, consistent with

subsection (b), case management at specified intervals as a further condition of payment for services.

TITLE III—PROVIDER PARTICIPATION

SEC. 301. PROVIDER PARTICIPATION AND STANDARDS.

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

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

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

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

(b) REQUIREMENTS IN PARTICIPATION AGREEMENT.—

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

(A) Services to eligible persons will be furnished by the provider without discrimination

on the ground of race, national origin, income, religion, age, sex or sexual orientation, disability, handicapping condition, or (subject to the professional qualifications of the provider) illness. Nothing in this subparagraph shall be construed as requiring the provision of a type or class of services which services are outside the scope of the provider's normal practice.

(B) No charge will be made for any covered services other than for payment authorized by this Act.

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

(i) quality review by designated entities;

(ii) the making of payments under this Act (including the examination of records as may be necessary for the verification of information on which payments are based);

(iii) statistical or other studies required for the implementation of this Act; and

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

(D) The provider agrees not to bill the program for any services for which benefits are not available because of section 204(d).

(E) In the case of a provider that is not an individual, the provider agrees not to employ or use for the provision of health services any individual or other provider who or which has had a participation agreement under this subsection terminated for cause.

(F) In the case of a provider paid under a fee-for-service basis under section 612, the provider agrees to submit bills and any required supporting documentation relating to the provision of covered services within 30 days (or such shorter period as a State health security program may require) after the date of providing such services.

(2) TERMINATION OF PARTICIPATION AGREEMENTS.—

(A) IN GENERAL.—Participation agreements may be terminated, with appropriate notice—

(i) by the Board or a State health security program for failure to meet the requirements of this title; or

(ii) by a provider.

(B) TERMINATION PROCESS.—Providers shall be provided notice and a reasonable opportunity to correct deficiencies before the Board or a State health security program terminates an agreement unless a more immediate termination is required for public safety or similar reasons.

SEC. 302. QUALIFICATIONS FOR PROVIDERS.

(a) IN GENERAL.—A health care provider is considered to be qualified to provide covered services if the provider is licensed or certified and meets—

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

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

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

(b) MINIMUM PROVIDER STANDARDS.—

(1) IN GENERAL.—The Board shall establish, evaluate, and update national minimum standards to ensure the quality of services provided under this Act and to monitor efforts by State health security programs to ensure the quality of such services. A State health security program may also establish additional minimum standards which providers shall meet.

(2) NATIONAL MINIMUM STANDARDS.—The national minimum standards under paragraph (1) shall be established for institutional providers of services, individual health care practitioners, and comprehensive health service organizations. Except as the Board may specify in order to carry out this title, a hospital, nursing facility, or other institutional provider of services shall meet standards for such a facility under the medicare program under title XVIII of the Social Security Act (42 U.S.C. 1395 et seq.). Such standards also may include, where appropriate, elements relating to—

(A) adequacy and quality of facilities;

(B) training and competence of personnel (including continuing education requirements);

(C) comprehensiveness of service;

(D) continuity of service;

(E) patient satisfaction (including waiting time and access to services); and

(F) performance standards (including organization, facilities, structure of services, efficiency of operation, and outcome in palliation, improvement of health, stabilization, cure, or rehabilitation).

(3) TRANSITION IN APPLICATION.—If the Board provides for additional requirements for providers under this subsection, any such additional requirement shall be implemented in a manner that provides for a reasonable period during which a previously qualified provider is permitted to meet such an additional requirement.

(4) EXCHANGE OF INFORMATION.—The Board shall provide for an exchange, at least annually, among State health security programs of information with respect to quality assurance and cost containment.

SEC. 303. QUALIFICATIONS FOR COMPREHENSIVE HEALTH SERVICE ORGANIZATIONS.

(a) IN GENERAL.—For purposes of this Act, a comprehensive health service organization (in this section referred to as a ''CHSO'') is a public or private organization which, in return for a capitated payment amount, under-

takes to furnish, arrange for the provision of, or provide payment with respect to—

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

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

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

(b) ENROLLMENT.—

(1) IN GENERAL.—All eligible persons living in or near the specified service area of a CHSO are eligible to enroll in the organization; except that the number of enrollees may be limited to avoid overtaxing the resources of the organization.

(2) MINIMUM ENROLLMENT PERIOD.—Subject to paragraph (3), the minimum period of enrollment with a CHSO shall be 1 year, unless the enrolled individual becomes ineligible to enroll with the organization.

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

(c) REQUIREMENTS FOR CHSOS.—

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

(2) CONTINUITY OF CARE.—Each CHSO shall furnish services in such manner as to provide continuity of care and (when services are furnished by different providers) shall provide ready referral of patients to such services and at such times as may be medically appropriate.

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

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

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

(4) PATIENT GRIEVANCE PROGRAM.—Each CHSO shall have in effect a patient grievance program and shall conduct regularly surveys of the sat-

isfaction of members with services provided by or through the organization.

(5) MEDICAL STANDARDS.—Each CHSO shall provide that a committee or committees of health care practitioners associated with the organization will promulgate medical standards, oversee the professional aspects of the delivery of care, perform the functions of a pharmacy and drug therapeutics committee, and monitor and review the quality of all health services (including drugs, education, and preventive services).

(6) QUALITY AND OTHER REPORTING REQUIREMENTS.—

(A) IN GENERAL.—The Board shall determine appropriate measures to assess the quality of care furnished by the CHSO, such as measures of—

(i) clinical processes and outcomes;

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

(iii) utilization (such as rates of hospital admissions for ambulatory care sensitive conditions).

(B) OTHER DUTIES.—The CHSO shall—

(i) define processes to promote evidence-based medicine and patient engagement, report on quality and cost measures, and coordinate care, such as through the use of telehealth, remote patient monitoring, and other such enabling technologies; and

(ii) demonstrate to the Board that the CHSO meets patient-centeredness criteria specified by the Board, such as the use of patient and caregiver assessments or the use of individualized care plans.

(C) REPORTING REQUIREMENTS.—A CHSO shall submit data in a form and manner specified by the Board on measures the Board determines necessary in order to evaluate the quality of care furnished by the CHSO. Such data may include care transitions across health care settings, including hospital discharge planning and post-hospital discharge follow-up by CHSO professionals, as the Board determines appropriate.

(D) QUALITY PERFORMANCE STANDARDS.—The Board shall establish quality performance standards to assess the quality of care

furnished by CHSOs and shall seek to improve the quality of care furnished by CHSOs over time by specifying higher standards, new measures, or both for purposes of assessing such quality of care.

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

(8) UTILIZATION AND BONUS INFORMATION.—Each CHSO shall—

(A) comply with the requirements of section 1876(i)(8) of the Social Security Act (relating to prohibiting physician incentive plans that provide specific inducements to reduce or limit medically necessary services); and

(B) make available to its membership utilization information and data regarding financial performance, including bonus or incentive payment arrangements to practitioners.

(9) PROVISION OF SERVICES TO ENROLLEES AT INSTITUTIONS OPERATING UNDER GLOBAL BUDGETS.—The organization shall arrange to reimburse for hospital services and other facility-based services (as identified by the Board) for services provided to members of the organization in accordance with the

global operating budget of the hospital or facility approved under section 611.

(10) BROAD MARKETING.—Each CHSO shall provide for the marketing of its services (including dissemination of marketing materials) to potential enrollees in a manner that is designed to enroll individuals representative of the different population groups and geographic areas included within its service area and meets such requirements as the Board or a State health security program may specify.

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

(A) such requirements relating to minimum enrollment;

(B) such requirements relating to financial solvency;

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

(D) such other requirements,

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

(d) PROVISION OF EMERGENCY SERVICES TO NONENROLLEES.—A CHSO may furnish emergency services to persons who are not enrolled in the organization. Pay-

ment for such services, if they are covered services to eligible persons, shall be made to the organization unless the organization requests that it be made to the individual provider who furnished the services.

SEC. 304. LIMITATION ON CERTAIN PHYSICIAN REFERRALS.

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

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

''(M) Ambulance services.

''(N) Home infusion therapy services.''.

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

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

(2) in subsection (a)(1)(B), by striking ''under this title'';

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

''(1) DENIAL OF PAYMENT.—No payment may be made under a State health security program for a designated health service for which a claim is presented in violation of subsection (a)(1)(B). No individual, third-party payor, or other entity is liable for payment for designated health services for which a claim is presented in violation of such subsection.''; and

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

TITLE IV—ADMINISTRATION

Subtitle A—General Administrative Provisions

SEC. 401. AMERICAN HEALTH SECURITY STANDARDS BOARD.

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

(b) APPOINTMENT AND TERMS OF MEMBERS.—

(1) IN GENERAL.—The Board shall be composed of—

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

(B) 6 other individuals (described in paragraph (2)) appointed by the President with the advice and consent of the Senate.

The President shall first nominate individuals under subparagraph (B) on a timely basis so as to provide for the operation of the Board by not later than January 1, 2014.

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

(A) The members shall be chosen on the basis of backgrounds in health policy, health economics, the healing professions, and the administration of health care institutions.

(B) The members shall provide a balanced point of view with respect to the various health care interests and at least 2 of them shall represent the interests of individual consumers.

(C) At least 1 member shall have a nursing background.

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

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

(3) TERMS OF APPOINTED MEMBERS.—Individuals appointed under paragraph (1)(B) shall serve for a term of 6 years, except that the terms of 5 of the individuals initially appointed shall be, as designated by the President at the time of their appointment, for 1, 2, 3, 4, and 5 years. During a term of membership on the Board, no member shall engage in any other business, vocation or employment.

(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 re-

mainder 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. A member who has served for 2 consecutive 6-year terms shall not be eligible for reappointment until 2 years after the member has ceased to serve.

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

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

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

(f) GENERAL DUTIES OF THE BOARD.—

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

(A) eligibility;

(B) enrollment;

(C) benefits;

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

(E) national and State funding levels;

(F) methods for determining amounts of payments to providers of covered services, consistent with subtitle B of title VI;

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

(H) assisting State health security programs with planning for capital expenditures and service delivery;

(I) planning for health professional education funding (as specified in title VI);

(J) allocating funds provided under title VII; and

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

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

(g) UNIFORM REPORTING STANDARDS; ANNUAL REPORT; STUDIES.—

(1) UNIFORM REPORTING STANDARDS.—

(A) IN GENERAL.—The Board shall establish uniform reporting requirements and standards to ensure an adequate national data base regarding health services practitioners, services and finances of State health security programs, approved plans, providers, and the costs of facilities and practitioners providing services. Such standards shall include, to the maximum extent feasible, health outcome measures.

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

(2) ANNUAL REPORT.—Beginning January 1, of the second year beginning after the date of the enactment of this Act, the Board shall annually report to Congress on the following:

(A) The status of implementation of the Act.

(B) Enrollment under this Act.

(C) Benefits under this Act.

(D) Expenditures and financing under this Act.

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

(F) Quality assurance.

(G) Health care utilization patterns, including any changes attributable to the program.

(H) Long-range plans and goals for the delivery of health services.

(I) Differences in the health status of the populations of the different States, including income and racial characteristics.

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

(K) Plans for improving service to medically underserved populations.

(L) Transition problems as a result of implementation of this Act.

(M) Opportunities for improvements under this Act.

(3) STATISTICAL ANALYSES AND OTHER STUDIES.—The Board may, either directly or by contract—

(A) make statistical and other studies, on a nationwide, regional, State, or local basis, of any aspect of the operation of this Act, including studies of the effect of the Act upon the health of the people of the United States and the effect of comprehensive health services upon the health of persons receiving such services;

(B) develop and test methods of providing through payment for services or otherwise, additional incentives for adherence by providers to standards of adequacy, access, and quality; methods of consumer and peer review and peer control of the utilization of drugs, of laboratory services, and of other services; and methods of consumer and peer review of the quality of services;

(C) develop and test, for use by the Board, records and information retrieval systems and budget systems for health services administration, and develop and test model systems for use by providers of services;

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

(E) develop, in collaboration with the pharmaceutical profession, and test, improved administrative practices or improved methods for the reimbursement of independent pharmacies for the cost of furnishing drugs as a covered service; and

(F) make such other studies as it may consider necessary or promising for the evaluation, or for the improvement, of the operation of this Act.

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

(h) EXECUTIVE DIRECTOR.—

(1) APPOINTMENT.—There is hereby established the position of Executive Director of the Board. The Director shall be appointed by the Board and shall serve as secretary to the Board and perform such duties in the administration of this title as the Board may assign.

(2) DELEGATION.—The Board is authorized to delegate to the Director or to any other officer or

employee of the Board or, with the approval of the Secretary of Health and Human Services (and subject to reimbursement of identifiable costs), to any other officer or employee of the Department of Health and Human Services, any of its functions or duties under this Act other than—

(A) the issuance of regulations; or

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

(3) COMPENSATION.—The Executive Director of the Board shall be entitled to compensation at a level equivalent to level III of the Executive Schedule, in accordance with section 5314 of title 5, United States Code.

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

(1) in section 12(1), by inserting after ''Corporation;'' the first place it appears the following: ''the Chair of the American Health Security Standards Board;'';

(2) in section 12(2), by inserting after ''Resolution Trust Corporation,'' the following: ''the American Health Security Standards Board,''; and

(3) by inserting before section 9 the following:

''SPECIAL PROVISIONS CONCERNING AMERICAN HEALTH SECURITY STANDARDS BOARD

''SEC. 8M. The Inspector General of the American Health Security Standards Board, in addition to the other authorities vested by this Act, shall have the same authority, with respect to the Board and the American Health Security Program under this Act, as the Inspector General for the Department of Health and Human Services has with respect to the Secretary of Health and Human Services and the medicare and medicaid programs, respectively.''.

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

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

SEC. 402. AMERICAN HEALTH SECURITY ADVISORY COUNCIL.

(a) IN GENERAL.—The Board shall provide for an American Health Security Advisory Council (in this section referred to as the ''Council'') to advise the Board on its activities.

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

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

(2) 20 members, not otherwise in the employ of the United States, appointed by the Board without regard to the provisions of title 5, United States Code, governing appointments in the competitive service.

The appointed members shall include, in accordance with subsection (e), individuals who are representative of State health security programs, public health professionals, providers of health services, and of individuals (who shall constitute a majority of the Council) who are representative of consumers of such services, including a balanced representation of employers, unions, consumer organizations, and population groups with special health care needs. To the greatest extent feasible, the membership of the Council shall represent the various geographic regions of the United States and shall reflect the racial, ethnic, and gender composition of the population of the United States.

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

(1) any member appointed to fill a vacancy occurring during the term for which the member's

predecessor was appointed shall be appointed for the remainder of that term; and

(2) the terms of the members first taking office shall expire, as designated by the Board at the time of appointment, at the end of the first year with respect to 5 members, at the end of the second year with respect to 5 members, at the end of the third year with respect to 5 members, and at the end of the fourth year with respect to 5 members after the date of enactment of this Act.

(d) VACANCIES.—

(1) IN GENERAL.—The Board shall fill any vacancy in the membership of the 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 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 Council for a second term in the same manner as the original appointment.

(e) QUALIFICATIONS.—

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

(2) PROVIDERS.—Members of the Council who are representative of providers of health care shall be individuals who are outstanding in fields related to medical, hospital, or other health activities, or who are representative of organizations or associations of professional health practitioners.

(3) CONSUMERS.—Members who are representative of consumers of such care shall be individuals, not engaged in and having no financial interest in the furnishing of health services, who are familiar with the needs of various segments of the population for personal health services and are experienced in dealing with problems associated with the consumption of such services.

(f) DUTIES.—

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

(A) to advise the Board on matters of general policy in the administration of this Act, in

the formulation of regulations, and in the performance of the Board's duties under section 401; and

(B) to study the operation of this Act and the utilization of health services under it, with a view to recommending any changes in the administration of the Act or in its provisions which may appear desirable.

(2) REPORT.—The Council shall make an annual report to the Board on the performance of its functions, including any recommendations it may have with respect thereto, and the Board shall promptly transmit the report to the Congress, together with a report by the Board on any recommendations of the Council that have not been followed.

(g) STAFF.—The Council, its members, and any committees of the Council shall be provided with such secretarial, clerical, or other assistance as may be authorized by the Board for carrying out their respective functions.

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

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

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

SEC. 403. CONSULTATION WITH PRIVATE ENTITIES.

The Secretary and the Board shall consult with private entities, such as professional societies, national associations, nationally recognized associations of experts, medical schools and academic health centers, consumer groups, and labor and business organizations in the formulation of guidelines, regulations, policy initiatives, and information gathering to ensure the broadest and most informed input in the administration of this Act. Nothing in this Act shall prevent the Secretary from adopting guidelines developed by such a private entity if, in the Secretary's and Board's judgment, such guidelines are generally accepted as reasonable and prudent and consistent with this Act.

SEC. 404. STATE HEALTH SECURITY PROGRAMS.

(a) SUBMISSION OF PLANS.—

(1) IN GENERAL.—Each State shall submit to the Board a plan for a State health security program for providing for health care services to the residents of the State in accordance with this Act.

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

(3) REGIONAL PLANNING MECHANISMS.—The Board shall provide incentives for States to develop regional planning mechanisms to promote the rational distribution of, adequate access to, and efficient use of, tertiary care facilities, equipment, and services.

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

(b) REVIEW AND APPROVAL OF PLANS.—

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

less it finds that the plan (or State law) provides, consistent with the provisions of this Act, for the following:

(A) Payment for required health services for eligible individuals in the State in accordance with this Act.

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

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

(D) Establishment of payment methodologies (consistent with subtitle B of title VII).

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

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

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

(ii) gives priority to the most acute shortages and maldistributions of health personnel and facilities and the most serious deficiencies in the delivery of covered services and to the means for the speedy alleviation of these shortcomings.

(G) The licensure and regulation of all health providers and facilities to ensure compliance with Federal and State laws and to promote quality of care.

(H) Establishment of a quality review system in accordance with section 503.

(I) Establishment of an independent ombudsman for consumers to register complaints about the organization and administration of the State health security program and to help resolve complaints and disputes between consumers and providers.

(J) Publication of an annual report on the operation of the State health security program, which report shall include information on cost, progress towards achieving full enrollment, public access to health services, quality review, health outcomes, health professional training,

and the needs of medically underserved populations.

(K) Provision of a fraud and abuse prevention and control unit that the Inspector General determines meets the requirements of section 412(a).

(L) Prohibit payment in cases of prohibited physician referrals under section 304.

(2) CONSEQUENCES OF FAILURE TO COMPLY.—If the Board finds that a State plan submitted under paragraph (1) does not meet the requirements for approval under this section or that a State health security program or specific portion of such program, the plan for which was previously approved, no longer meets such requirements, the Board shall provide notice to the State of such failure and that unless corrective action is taken within a period specified by the Board, the Board shall place the State health security program (or specific portions of such program) in receivership under the jurisdiction of the Board.

(c) STATE HEALTH SECURITY ADVISORY COUNCILS.—

(1) IN GENERAL.—For each State, the Governor shall provide for appointment of a State

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

(2) MEMBERSHIP.—Each State Health Security Advisory Council shall be composed of at least 11 individuals. The appointed members shall include individuals who are representative of the State health security program, public health professionals, providers of health services, and of individuals (who shall constitute a majority) who are representative of consumers of such services, including a balanced representation of employers, unions and consumer organizations. To the greatest extent feasible, the membership of each State Health Security Advisory Council shall represent the various geographic regions of the State and shall reflect the racial, ethnic, and gender composition of the population of the State.

(3) DUTIES.—

(A) IN GENERAL.—Each State Health Security Advisory Council shall review, and submit comments to the Governor concerning the implementation of the State health security program in the State.

(B) ASSISTANCE.—Each State Health Security Advisory Council shall provide assistance and technical support to community organizations and public and private non-profit agencies submitting applications for funding under appropriate State and Federal public health programs, with particular emphasis placed on assisting those applicants with broad consumer representation.

(d) STATE USE OF FISCAL AGENTS.—

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

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

SEC. 405. COMPLEMENTARY CONDUCT OF RELATED HEALTH PROGRAMS.

In performing functions with respect to health personnel education and training, health research, environ-

mental health, disability insurance, vocational rehabilitation, the regulation of food and drugs, and all other matters pertaining to health, the Secretary of Health and Human Services shall direct all activities of the Department of Health and Human Services toward contributions to the health of the people complementary to this Act.

Subtitle B—Control Over Fraud and Abuse

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

The following sections of the Social Security Act shall apply to State health security programs in the same manner as they apply to State medical assistance plans under title XIX of such Act (except that in applying such provisions any reference to the Secretary is deemed a reference to the Board):

(1) Section 1128 (relating to exclusion of individuals and entities).

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

(3) Section 1128B (criminal penalties).

(4) Section 1124 (relating to disclosure of ownership and related information).

(5) Section 1126 (relating to disclosure of certain owners).

SEC. 412. REQUIREMENTS FOR OPERATION OF STATE HEALTH CARE FRAUD AND ABUSE CONTROL UNITS.

(a) REQUIREMENT.—In order to meet the requirement of section 404(b)(1)(K), each State health security program shall establish and maintain a health care fraud and abuse control unit (in this section referred to as a ''fraud unit'') that meets requirements of this section and other requirements of the Board. Such a unit may be a State medicaid fraud control unit (described in section 1903(q) of the Social Security Act).

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

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

(2) be separate and distinct from the State agency with principal responsibility for the administration of the State health security program; and

(3) meet one of the following requirements:

(A) It shall be a unit of the office of the State Attorney General or of another department of State government which possesses statewide authority to prosecute individuals for criminal violations.

(B) If it is in a State the constitution of which does not provide for the criminal prosecution of individuals by a statewide authority and

has formal procedures, approved by the Board, that—

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

(ii) assure its assistance of, and coordination with, such authority or authorities in such prosecutions.

(C) It shall have a formal working relationship with the office of the State Attorney General and have formal procedures (including procedures for its referral of suspected criminal violations to such office) which are approved by the Board and which provide effective coordination of activities between the fraud unit and such office with respect to the detection, investigation, and prosecution of suspected criminal violations relating to the State health insurance plan.

(c) FUNCTIONS.—The fraud unit shall—

(1) have the function of conducting a statewide program for the investigation and prosecution of violations of all applicable State laws regarding any

and all aspects of fraud in connection with any aspect of the provision of health care services and activities of providers of such services under the State health security program;

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

(3) provide for the collection, or referral for collection to a single State agency, of overpayments that are made under the State health security program to providers and that are discovered by the fraud unit in carrying out its activities.

(d) RESOURCES.—The fraud unit shall—

(1) employ such auditors, attorneys, investigators, and other necessary personnel;

(2) be organized in such a manner; and

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

as is necessary to promote the effective and efficient conduct of the unit's activities.

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

(1) similar fraud units in other States;

(2) the Inspector General; and

(3) the Attorney General of the United States.

(f) REPORTS.—The fraud unit shall submit to the Inspector General an application and annual reports containing such information as the Inspector General determines to be necessary to determine whether the unit meets the previous requirements of this section.

TITLE V—QUALITY ASSESSMENT

SEC. 501. AMERICAN HEALTH SECURITY QUALITY COUNCIL.

(a) ESTABLISHMENT.—There is hereby established an American Health Security Quality Council (in this title referred to as the ''Council'').

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

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

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

(2) STANDARDS OF QUALITY, PERFORMANCE MEASURES, AND MEDICAL REVIEW CRITERIA.—The Council shall review and evaluate each standard of quality, performance measure, and medical review criterion developed under part B of title IX of the Public Health Service Act. The Council shall determine whether the standard, measure, or criterion is appropriate for use in assessing or reviewing the quality of services provided by State health security programs, health care institutions, or health care professionals.

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

such entities to ensure national consistency in quality standards.

(4) REPORTING.—The Council shall report to the Board annually on the conduct of activities under such title and shall report to the Board annually specifically on findings from outcomes research and development of practice guidelines that may affect the Board's determination of coverage of services under section 401(f)(1)(G).

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

(c) APPOINTMENT AND TERMS OF MEMBERS.—

(1) IN GENERAL.—The Council shall be composed of 10 members appointed by the President. The President shall first appoint individuals on a timely basis so as to provide for the operation of the Council by not later than January 1, 2014.

(2) SELECTION OF MEMBERS.—Each member of the Council shall be a member of a health profession. Five members of the Council shall be physicians. Individuals shall be appointed to the Council on the basis of national reputations for clinical and academic excellence. To the greatest extent feasible, the membership of the Council shall represent the

various geographic regions of the United States and shall reflect the racial, ethnic, and gender composition of the population of the United States.

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

(d) VACANCIES.—

(1) IN GENERAL.—The President shall fill any vacancy in the membership of the 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 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 a member of the Council for a second term in the same manner as the original appointment. A member who has served for 2 consecutive 5-year terms shall not be eligible for reappointment until 2 years after the member has ceased to serve.

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

(f) COMPENSATION.—Members of the Council who are not employees of the Federal Government shall be entitled to compensation at a level equivalent to level II of the Executive Schedule, in accordance with section 5313 of title 5, United States Code.

SEC. 502. DEVELOPMENT OF CERTAIN METHODOLOGIES, GUIDELINES, AND STANDARDS.

(a) PROFILING OF PATTERNS OF PRACTICE; IDENTIFICATION OF OUTLIERS.—The Council shall adopt methodologies for profiling the patterns of practice of health care professionals and for identifying outliers (as defined in subsection (e)).

(b) CENTERS OF EXCELLENCE.—The Council shall develop guidelines for certain medical procedures designated by the Board to be performed only at tertiary care centers which can meet standards for frequency of procedure performance and intensity of support mechanisms that are consistent with the high probability of desired patient outcome. Reimbursement under this Act for such a designated procedure may only be provided if the procedure was performed at a center that meets such standards.

(c) REMEDIAL ACTIONS.—The Council shall develop standards for education and sanctions with respect to outliers so as to ensure the quality of health care services provided under this Act. The Council shall develop criteria for referral of providers to the State licensing board if education proves ineffective in correcting provider practice behavior.

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

(1) the methodologies adopted under subsection (a);

(2) the guidelines developed under subsection (b); and

(3) the standards developed under subsection (c);

for use by the States under section 503.

(e) OUTLIER DEFINED.—In this title, the term ''outlier'' means a health care provider whose pattern of practice, relative to applicable practice guidelines, suggests deficiencies in the quality of health care services being provided.

SEC. 503. STATE QUALITY REVIEW PROGRAMS.

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

duct quality reviews of persons providing covered services under the program, in accordance with standards established under subsection (b)(1) (except as provided in subsection (b)(2)) and subsection (d).

(b) FEDERAL STANDARDS.—

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

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

(B) the identification of outliers (consistent with methodologies adopted under section 502(a));

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

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

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

established under paragraph (1). Positive improvements in quality shall be documented by reductions in the variations of clinical care process and improvement in patient outcomes.

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

(d) INTERNAL QUALITY REVIEW.—Nothing in this section shall preclude an institutional provider from establishing its own internal quality review and enhancement programs.

SEC. 504. ELIMINATION OF UTILIZATION REVIEW PROGRAMS; TRANSITION.

(a) INTENT.—It is the intention of this title to replace by January 1, 2017, random utilization controls with a systematic review of patterns of practice that compromise the quality of care.

(b) SUPERSEDING CASE REVIEWS.—

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

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

(2) TRANSITION.—Before January 1, 2017, the Board and the States may employ existing utilization review standards and mechanisms as may be necessary to effect the transition to pattern of practice-based reviews.

(3) CONSTRUCTION.—Nothing in this subsection shall be construed—

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

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

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

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

TITLE VI—HEALTH SECURITY BUDGET; PAYMENTS; COST CONTAINMENT MEASURES

Subtitle A—Budgeting and Payments to States

SEC. 601. NATIONAL HEALTH SECURITY BUDGET.

(a) NATIONAL HEALTH SECURITY BUDGET.—

(1) IN GENERAL.—By not later than September 1 before the beginning of each year (beginning with 2014), the Board shall establish a national health security budget, which—

(A) specifies the total expenditures (including expenditures for administrative costs) to be made by the Federal Government and the States for covered health care services under this Act; and

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

Pursuant to subsection (b), such budget for a year shall not exceed the budget for the preceding year increased by the percentage increase in gross domestic product.

(2) DIVISION OF BUDGET INTO COMPONENTS.—The national health security budget shall consist of at least 4 components:

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

(B) A component for health professional education expenditures.

(C) A component for administrative costs.

(D) A component for operating and other expenditures not described in subparagraphs (A) through (C) (in this title referred to as the ''operating component''), consisting of amounts not included in the other components. A State may provide for the allocation of this component between capital expenditures and other expenditures.

(3) ALLOCATION AMONG COMPONENTS.—Taking into account the State health security budgets established and submitted under section 603, the Board shall allocate the national health security budget among the components in a manner that—

(A) assures a fair allocation for quality assessment activities (consistent with the national health security spending growth limit); and

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

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

(b) BASIS FOR TOTAL EXPENDITURES.—

(1) IN GENERAL.—The total expenditures specified in such budget shall be the sum of the capitation amounts computed under section 602(a) and the amount of Federal administrative expenditures needed to carry out this Act.

(2) NATIONAL HEALTH SECURITY SPENDING GROWTH LIMIT.—For purposes of this subtitle, the national health security spending growth limit described in this paragraph for a year is (A) zero, or, if greater, (B) the average annual percentage increase in the gross domestic product (in current dollars) during the 3-year period beginning with the first quarter of the fourth previous year to the first quarter of the previous year minus the percentage increase (if any) in the number of eligible individuals residing in any State the United States from the first quarter of the second previous year to the first quarter of the previous year.

(c) DEFINITIONS.—In this title:

(1) CAPITAL EXPENDITURES.—The term ''capital expenditures'' means expenses for the purchase,

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

(2) HEALTH PROFESSIONAL EDUCATION EXPENDITURES.—The term ''health professional education expenditures'' means expenditures in hospitals and other health care facilities to cover costs associated with teaching and related research activities.

SEC. 602. COMPUTATION OF INDIVIDUAL AND STATE CAPITATION AMOUNTS.

(a) CAPITATION AMOUNTS.—

(1) INDIVIDUAL CAPITATION AMOUNTS.—In establishing the national health security budget under section 601(a) and in computing the national average per capita cost under subsection (b) for each year, the Board shall establish a method for computing the capitation amount for each eligible individual residing in each State. The capitation amount for an eligible individual in a State classified within a risk group (established under subsection (d)(2)) is the product of—

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

(B) the State adjustment factor (established under subsection (c)) for the State; and

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

(2) STATE CAPITATION AMOUNT.—

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

(B) USE OF STATISTICAL MODEL.—The Board may provide for the computation of State capitation amounts based on statistical models that fairly reflect the elements that comprise the State capitation amount described in subparagraph (A).

(C) POPULATION INFORMATION.—The Bureau of the Census shall assist the Board in determining the number, place of residence, and risk group classification of eligible individuals.

(b) COMPUTATION OF NATIONAL AVERAGE PER CAPITA COST.—

(1) FOR 2014.—For 2014, the national average per capita cost under this paragraph is equal to—

(A) the average per capita health care expenditures in the United States in 2012 (as estimated by the Board);

(B) increased to 2013 by the Board's estimate of the actual amount of such per capita expenditures during 2013; and

(C) updated to 2014 by the national health security spending growth limit specified in section 601(b)(2) for 2014.

(2) FOR SUCCEEDING YEARS.—For each succeeding year, the national average per capita cost under this subsection is equal to the national average per capita cost computed under this subsection for the previous year increased by the national health security spending growth limit (specified in section 601(b)(2)) for the year involved.

(c) STATE ADJUSTMENT FACTORS.—

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

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

(B) any social, environmental, or geographic condition affecting health status or the need for health care services, to the extent such a condition is not taken into account in the establishment of risk groups under subsection (d);

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

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

(2) MODIFICATION OF HEALTH PROFESSIONAL EDUCATION COMPONENT.—With respect to the portion of the national health security budget allocated to expenditures for health professional education, the Board shall modify the State adjustment factors so as to take into account—

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

(B) differences among States in their relative need for expenditures for health professional education, taking into account the health professional education expenditures proposed in State health security budgets under section 603(a).

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

(4) PHASE-IN.—In applying State adjustment factors under this subsection during the 5-year period beginning with 2014, the Board shall phase-in, over such period, the use of factors described in paragraph (1) in a manner so that the adjustment factor for a State is based on a blend of such factors and a factor that reflects the relative actual average per capita costs of health services of the different States as of the time of enactment of this Act.

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

priate adjustments in the State adjustment factors under this subsection.

(d) ADJUSTMENTS FOR RISK GROUP CLASSIFICATION.—

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

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

(3) PERIODIC ADJUSTMENT.—In establishing the national health security budget before the beginning of each year, the Board shall provide for appropriate adjustments in the risk adjustment factors under this subsection.

SEC. 603. STATE HEALTH SECURITY BUDGETS.

(a) ESTABLISHMENT AND SUBMISSION OF BUDGETS.—

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

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

(i) By the 4 components (described in section 601(a)(2)), consistent with subsection (b).

(ii) Within the operating component—

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

(II) expenditures for payment to comprehensive health service organizations;

(III) expenditures for payment of services provided by health care practitioners; and

(IV) expenditures for other covered items and services.

Amounts included in the operating component include amounts that may be used by providers for capital expenditures.

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

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

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

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

(B) take into account the amounts established under the national health security budget under section 601 for the year.

(4) ADJUSTMENT IN ALLOCATIONS PERMITTED.—

(A) IN GENERAL.—Subject to subparagraphs (B) and (C), in the case of a final budget, a State may change the allocation of amounts among components.

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

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

(b) EXPENDITURE LIMITS.—

(1) IN GENERAL.—The total expenditures specified in each State health security budget under subsection (a)(1) shall take into account Federal contributions made under section 604.

(2) LIMIT ON CLAIMS PROCESSING AND BILLING EXPENDITURES.—Each State health security budget shall provide that State administrative expenditures, including expenditures for claims processing and billing, shall not exceed 3 percent of the total expenditures under the State health security program, unless the Board determines, on a case-by-case basis, that additional administrative expenditures would improve health care quality and cost effectiveness.

(3) WORKER ASSISTANCE.—A State health security program may provide that, for budgets for years before 2017, up to 1 percent of the budget may be used for purposes of programs providing assistance to workers who are currently performing functions in the administration of the health insurance system and who may experience economic dis-

location as a result of the implementation of the program.

(c) APPROVAL PROCESS FOR CAPITAL EXPENDITURES PERMITTED.—Nothing in this title shall be construed as preventing a State health security program from providing for a process for the approval of capital expenditures based on information derived from regional planning agencies.

SEC. 604. FEDERAL PAYMENTS TO STATES.

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

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

(2) the Federal contribution percentage (established under subsection (b)).

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

priate. In addition, during the 5-year period beginning with 2014, the Board may provide for a transition adjustment to the formula in order to take into account current expenditures by the State (and local governments thereof) for health services covered under the State health security program. The weighted-average Federal contribution percentage for all States shall equal 86 percent and in no event shall such percentage be less than 81 percent nor more than 91 percent.

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

(d) EFFECT OF SPENDING EXCESS OR SURPLUS.—

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

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

SEC. 605. ACCOUNT FOR HEALTH PROFESSIONAL EDUCATION EXPENDITURES.

(a) SEPARATE ACCOUNT.—Each State health security program shall—

(1) include a separate account for health professional education expenditures; and

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

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

(1) The disbursement of funds shall be consistent with achievement of the national and program goals (specified in section 701(b)) within the State health security program and the distribution of funds from the account shall be conditioned upon the receipt of such reports as the Board may require in order to monitor compliance with such goals.

(2) The distribution of funds from the account shall take into account the potentially higher costs of placing health professional students in clinical education programs in health professional shortage areas.

Subtitle B—Payments by States to Providers

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

(a) DIRECT PAYMENT UNDER GLOBAL BUDGET.—Payment for operating expenses for institutional and facility-based care, including hospital services and nursing facility services, under State health security programs shall be made directly to each institution or facility by each State health security program under an annual prospective global budget approved under the program. Such a budget shall include payment for outpatient care and non-facility-based care that is furnished by or through the facility. In the case of a hospital that is wholly owned (or controlled) by a comprehensive health service organization that is paid under section 614 on the basis of a global budget, the global budget of the organization shall include the budget for the hospital.

(b) ANNUAL NEGOTIATIONS; BUDGET APPROVAL.—

(1) IN GENERAL.—The prospective global budget for an institution or facility shall—

(A) be developed through annual negotiations between—

(i) a panel of individuals who are appointed by the Governor of the State and who represent consumers, labor, business, and the State government; and

(ii) the institution or facility; and

(B) be based on a nationally uniform system of cost accounting established under standards of the Board.

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

(A) With respect to inpatient hospital services, the number, and classification by diagnosis-related group, of discharges.

(B) An institution's or facility's past expenditures.

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

(D) The extent to which capital expenditures are financed directly or indirectly through reductions in direct care to patients, including reductions in registered nursing staffing patterns or changes in emergency room or primary care services or availability.

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

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

(G) The compensation level of the institution's or facility's work force.

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

(I) The institution's or facility's previous financial and clinical performance, based on utilization and outcomes data provided under this Act.

(J) The type of institution or facility, including whether the institution or facility is part of a clinical education program or serves a health professional education, research or other training purpose.

(K) Technological advances or changes.

(L) Costs of the institution or facility associated with meeting Federal and State regulations.

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

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

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

(P) With respect to facilities that provide mental health services and substance abuse treatment services, any additional costs involved in the treatment of dually diagnosed individuals.

The portion of such a budget that relates to expenditures for health professional education shall be consistent with the State health security budget for such expenditures.

(3) PROVISION OF REQUIRED INFORMATION; DIAGNOSIS-RELATED GROUP.—No budget for an institution or facility for a year may be approved unless the institution or facility has submitted on a timely basis to the State health security program such information as the program or the Board shall specify,

including in the case of hospitals information on discharges classified by diagnosis-related group.

(c) ADJUSTMENTS IN APPROVED BUDGETS.—

(1) ADJUSTMENTS TO GLOBAL BUDGETS THAT CONTRACT WITH COMPREHENSIVE HEALTH SERVICE ORGANIZATIONS.—Each State health security program shall develop an administrative mechanism for reducing operating funds to institutions or facilities in proportion to payments made to such institutions or facilities for services contracted for by a comprehensive health service organization.

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

(d) DONATIONS PERMISSIBLE.—The States health security programs may permit institutions and facilities to raise funds from private sources to pay for newly constructed facilities, major renovations, and equipment. The expenditure of such funds, whether for operating or capital expenditures, does not obligate the State health security program to provide for continued support for such expenditures unless included in an approved global budget.

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

(a) FEE FOR SERVICE.—

(1) IN GENERAL.—Every independent health care practitioner is entitled to be paid, for the provision of covered health services under the State health security program, a fee for each billable covered service.

(2) GLOBAL FEE PAYMENT METHODOLOGIES.—The Board shall establish models and encourage State health security programs to implement alternative payment methodologies that incorporate global fees for related services (such as all outpatient procedures for treatment of a condition) or for a basic group of services (such as primary care services) furnished to an individual over a period of time, in order to encourage continuity and efficiency in the provision of services. Such methodologies shall be designed to ensure a high quality of care.

(3) BILLING DEADLINES; ELECTRONIC BILLING.—A State health security program may deny payment for any service of an independent health care practitioner for which it did not receive a bill and appropriate supporting documentation (which had been previously specified) within 30 days after the date the service was provided. Such a program

may require that bills for services for which payment may be made under this section, or for any class of such services, be submitted electronically.

(b) PAYMENT RATES BASED ON NEGOTIATED PROSPECTIVE FEE SCHEDULES.—With respect to any payment method for a class of services of practitioners, the State health security program shall establish, on a prospective basis, a payment schedule. The State health security program may establish such a schedule after negotiations with organizations representing the practitioners involved. Such fee schedules shall be designed to provide incentives for practitioners to choose primary care medicine, including general internal medicine, family medicine, gynecology, and pediatrics, over medical specialization. Nothing in this section shall be construed as preventing a State from adjusting the payment schedule amounts on a quarterly or other periodic basis depending on whether expenditures under the schedule will exceed the budgeted amount with respect to such expenditures.

(c) BILLABLE COVERED SERVICE DEFINED.—In this section, the term ''billable covered service'' means a service covered under section 201 for which a practitioner is entitled to compensation by payment of a fee determined under this section.

SEC. 613. PAYMENTS TO COMPREHENSIVE HEALTH SERVICE ORGANIZATIONS.

(a) IN GENERAL.—Payment under a State health security program to a comprehensive health service organization to its enrollees shall be determined by the State—

(1) based on a global budget described in section 611; or

(2) based on the basic capitation amount described in subsection (b) for each of its enrollees.

(b) BASIC CAPITATION AMOUNT.—

(1) IN GENERAL.—The basic capitation amount described in this subsection for an enrollee shall be determined by the State health security program on the basis of the average amount of expenditures that is estimated would be made under the State health security program for covered health care services for an enrollee, based on actuarial characteristics (as defined by the State health security program).

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

(3) ADJUSTMENT FOR SERVICES NOT PROVIDED.—The State health security program shall ad-

just such average amounts to take into account the cost of covered health care services that are not provided by the comprehensive health service organization under section 303(a).

SEC. 614. PAYMENTS FOR COMMUNITY-BASED PRIMARY HEALTH SERVICES.

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

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

(2) be based on the basic primary care capitation amount described in subsection (c) for each individual enrolled with the provider of such services; or

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

(b) PAYMENT ADJUSTMENT.—Payments under subsection (a) may include, consistent with the budgets developed under this title—

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

disease, and for whom the cost of such care is otherwise uncompensated;

(2) an additional amount, as set by the State health security program, to cover the reasonable costs incurred by a provider that furnishes case management services (as defined in section 1915(g)(2) of the Social Security Act), transportation services, and translation services; and

(3) an additional amount, as set by the State health security program, to cover the costs incurred by a provider in conducting health professional education programs in connection with the provision of such services.

(c) BASIC PRIMARY CARE CAPITATION AMOUNT.—

(1) IN GENERAL.—The basic primary care capitation amount described in this subsection for an enrollee with a provider of community-based primary health services shall be determined by the State health security program on the basis of the average amount of expenditures that is estimated would be made under the State health security program for such an enrollee, based on actuarial characteristics (as defined by the State health security program).

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

adjust such average amounts to take into account the special health needs, including a disproportionate number of medically underserved individuals, of populations served by the provider.

(3) ADJUSTMENT FOR SERVICES NOT PROVIDED.—The State health security program shall adjust such average amounts to take into account the cost of community-based primary health services that are not provided by the provider.

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

SEC. 615. PAYMENTS FOR PRESCRIPTION DRUGS.

(a) ESTABLISHMENT OF LIST.—

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

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

(b) PRICES.—For each such listed prescription drug or biological covered under this Act, for insulin, and for medical foods, the Board shall from time to time determine a product price or prices which shall constitute the maximum to be recognized under this Act as the cost of a drug to a provider thereof. The Board may conduct negotiations, on behalf of State health security programs, with product manufacturers and distributors in determining the applicable product price or prices.

(c) CHARGES BY INDEPENDENT PHARMACIES.—Each State health security program shall provide for payment for a prescription drug or biological or insulin furnished by an independent pharmacy based on the drug's cost to the pharmacy (not in excess of the applicable product price established under subsection (b)) plus a dispensing fee. In accordance with standards established by the Board, each State health security program, after consultation with representatives of the pharmaceutical profession, shall establish schedules of dispensing fees, designed to afford reasonable compensation to independent pharmacies after taking into account variations in their cost of operation resulting from regional differences, differences in the volume of prescription drugs dispensed, differences in services provided, the need to maintain expend-

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

SEC. 616. PAYMENTS FOR APPROVED DEVICES AND EQUIPMENT.

(a) ESTABLISHMENT OF LIST.—The Board shall establish a list of approved durable medical equipment and therapeutic devices and equipment (including eyeglasses, hearing aids, and prosthetic appliances), that the Board determines are necessary for the maintenance or restoration of health or of employability or self-management and eligible for coverage under this Act.

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

(c) PRICES.—For each such listed item covered under this Act, the Board shall from time to time determine a product price or prices which shall constitute the maximum to be recognized under this Act as the cost of the item to a provider thereof. The Board may conduct negotiations, on behalf of State health security programs, with

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

(d) EXCLUSIONS.—The Board may exclude from coverage under this Act ineffective, unsafe, or overpriced products where better alternatives are determined to be available.

SEC. 617. PAYMENTS FOR OTHER ITEMS AND SERVICES.

In the case of payment for other covered health services, the amount of payment under a State health security program shall be established by the program—

(1) in accordance with payment methodologies which are specified by the Board, after consultation with the American Health Security Advisory Council, or methodologies established by the State under section 620; and

(2) consistent with the State health security budget.

SEC. 618. PAYMENT INCENTIVES FOR MEDICALLY UNDERSERVED AREAS.

(a) MODEL PAYMENT METHODOLOGIES.—In addition to the payment amounts otherwise provided in this title, the Board shall establish model payment methodologies and other incentives that promote the provision of covered health care services in medically underserved

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

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

SEC. 619. AUTHORITY FOR ALTERNATIVE PAYMENT METHODOLOGIES.

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

(1) such payment methodology does not affect the entitlement of individuals to coverage, the weighting of fee schedules to encourage an increase in the number of primary care providers, the ability of individuals to choose among qualified providers, the benefits covered under the program, or the compliance of the program with the State health security budget under subtitle A; and

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

evaluate the appropriateness of applying the alternative methodology to other States.

Subtitle C—Mandatory Assignment and Administrative Provisions

SEC. 631. MANDATORY ASSIGNMENT.

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

(b) ENFORCEMENT.—If an entity knowingly and willfully bills for an item or service or accepts payment in violation of subsection (a), the Board may apply sanctions against the entity in the same manner as sanctions could have been imposed under section 1842(j)(2) of the Social Security Act for a violation of section 1842(j)(1) of such Act. Such sanctions are in addition to any sanctions that a State may impose under its State health security program.

SEC. 632. PROCEDURES FOR REIMBURSEMENT; APPEALS.

(a) PROCEDURES FOR REIMBURSEMENT.—In accordance with standards issued by the Board, a State health security program shall establish a timely and administratively simple procedure to ensure payment within 60 days of the date of submission of clean claims by providers under this Act.

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

TITLE VII—PROMOTION OF PRIMARY HEALTH CARE; DEVELOPMENT OF HEALTH SERVICE CAPACITY; PROGRAMS TO ASSIST THE MEDICALLY UNDERSERVED

Subtitle A—Promotion and Expansion of Primary Care Professional Training

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

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

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

to as the ''Secretary''), to achieve the national goals specified in subsection (b);

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

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

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

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

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

(2) MIDLEVEL PRIMARY CARE PRACTITIONERS.—To ensure an adequate supply of primary care practitioners, there shall be a number, specified by the Board, of midlevel primary care practitioners

(as defined in subsection (e)(2)) employed in the health care system as of January 1, 2017.

(3) DENTISTRY.—To ensure an adequate supply of dental care practitioners, there shall be a number, specified by the Board, of dentists (as defined in subsection (e)(1)) employed in the health care system as of January 1, 2017.

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

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

(2) CONSIDERATION.—The program goals under paragraph (1) shall be based on the distribution of medical schools and other teaching facilities within each State health security program, and the number of positions for graduate medical education.

(3) MEDICAL RESIDENCY EDUCATION CONSORTIUM.—In this subsection, the term ''medical residency education consortium'' means a consortium of medical residency education programs in a contig-

uous geographic area (which may be an interstate area) if the consortium—

(A) includes at least 1 medical school with a teaching hospital and related teaching settings; and

(B) has an affiliation with qualified community-based primary health service providers described in section 202(a) and with at least 1 comprehensive health service organization established under section 303.

(4) ENFORCEMENT THROUGH STATE HEALTH SECURITY BUDGETS.—The Board shall develop a formula for reducing payments to State health security programs (that provide for payments to a medical residency education program) that failed to meet the goal for the program established under this subsection.

(d) METHOD FOR ATTAINMENT OF NATIONAL GOAL FOR MIDLEVEL PRIMARY CARE PRACTITIONERS.—To assist in attaining the national goal identified in subsection (b)(2), the Board shall—

(1) advise the Public Health Service on allocations of funding under titles VII and VIII of the Public Health Service Act, the National Health Service Corps, and other programs in order to in-

crease the supply of midlevel primary care practitioners; and

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

(e) DEFINITIONS.—In this title:

(1) DENTIST.—The term ''dentist'' means a practitioner who performs the evaluation, diagnosis, prevention or treatment (nonsurgical, surgical, or related procedures) of diseases, disorders or conditions of the oral cavity, maxillofacial area or the adjacent and associated structures and their impact on the human body, within the scope of his or her education, training and experience, in accordance with the ethics of the profession and applicable law.

(2) MEDICAL RESIDENCY EDUCATION PROGRAM.—The term ''medical residency education program'' means a program that provides education and training to graduates of medical schools in order to meet requirements for licensing and certification as a physician, and includes the medical school supervising the program and includes the hospital or other facility in which the program is operated.

(3) MIDLEVEL PRIMARY CARE PRACTITIONER.—The term ''midlevel primary care practitioner'' means a clinical nurse practitioner, certified nurse midwife, physician assistance, or other nonphysician practitioner, specified by the Board, as authorized to practice under State law.

(4) PRIMARY CARE RESIDENT.—The term ''primary care resident'' means (in accordance with criteria established by the Board) a resident being trained in a distinct program of family practice medicine, general practice, general internal medicine, or general pediatrics.

SEC. 702. ESTABLISHMENT OF ADVISORY COMMITTEE ON HEALTH PROFESSIONAL EDUCATION.

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

(b) MEMBERSHIP.—The Committee shall be composed of—

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

(2) 12 members, not otherwise in the employ of the United States, appointed by the Board without regard to the provisions of title 5, United States

Code, governing appointments in the competitive service.

The appointed members shall provide a balanced point of view with respect to health professional education, primary care disciplines, and health care policy and shall include individuals who are representative of medical schools, other health professional schools, residency programs, primary care practitioners, teaching hospitals, professional associations, public health organizations, State health security programs, and consumers.

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

(1) any member appointed to fill a vacancy occurring during the term for which the member's predecessor was appointed shall be appointed for the remainder of that term; and

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

(d) VACANCIES.—

(1) IN GENERAL.—The Board shall fill any vacancy in the membership of the Committee 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 Committee.

(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 Committee for a second term in the same manner as the original appointment.

(e) DUTIES.—It shall be the duty of the Committee to advise the Board concerning graduate medical education policies under this title.

(f) STAFF.—The Committee, its members, and any committees of the Committee shall be provided with such secretarial, clerical, or other assistance as may be authorized by the Board for carrying out their respective functions.

(g) MEETINGS.—The Committee shall meet as frequently as the Board deems necessary, but not less than 4 times each year. Upon request by 4 or more members it shall be the duty of the Chair to call a meeting of the Committee.

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

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

SEC. 703. GRANTS FOR HEALTH PROFESSIONS EDUCATION, NURSE EDUCATION, AND THE NATIONAL HEALTH SERVICE CORPS.

(a) TRANSFERS TO PUBLIC HEALTH SERVICE.—

(1) IN GENERAL.—The Board shall make transfers from the American Health Security Trust Fund to the Public Health Service under subpart II of part D of title III, title VII, and title VIII of the Public Health Service Act for the support of the National Health Service Corps, health professions education, and nursing education, including education of clinical nurse practitioners, certified registered nurse anesthetists, certified nurse midwives, and physician assistants.

(2) FISCAL YEAR 2018 AND SUBSEQUENT YEARS.—The amount transferred for the support of the National Health Service Corps for fiscal year

2018 and each subsequent fiscal year shall be equal to the amount transferred for the preceding fiscal year adjusted by the product of—

(A) one plus the average percentage increase in the costs of health professions education during the prior fiscal year; and

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

(b) RANGE OF FUNDS.—The amount of transfers under subsection (a) for any fiscal year for title VII and VIII shall be an amount (specified by the Board each year) not less than 3/100 percent and not to exceed 4/100 percent of the amounts the Board estimates will be expended from the Trust Fund in the fiscal year.

(c) FUNDS SUPPLEMENTAL TO OTHER FUNDS.—The funds provided under this section with respect to provision of services are in addition to, and not in replacement of, funds made available under the provisions referred to in subsection (a) and shall be administered in accordance with the terms of such provisions. The Board shall make no transfer of funds under this section for any fiscal year

for which the total appropriations for the programs authorized by such provisions are less than the total amount appropriated for such programs in fiscal year 2012.

Subtitle B—Direct Health Care Delivery

SEC. 711. SET-ASIDE FOR PUBLIC HEALTH.

(a) TRANSFERS TO PUBLIC HEALTH SERVICE.—From the amounts provided under subsection (c), the Board shall make transfers from the American Health Security Trust Fund to the Public Health Service for the following purposes (other than payment for services covered under title II):

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

(2) For prevention and treatment of tuberculosis under section 317 of the Public Health Service Act (42 U.S.C. 247b).

(3) For the prevention and treatment of sexually transmitted diseases under section 318 of the Public Health Service Act (42 U.S.C. 247c).

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

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

(6) Grants to States for prevention and treatment of substance abuse under subpart II of part B of title XIX of the Public Health Service Act (42 U.S.C. 300x–21 et seq.).

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

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

(b) RANGE OF FUNDS.—The amount of transfers under subsection (a) for any fiscal year shall be an amount (specified by the Board each year) not less than 1/10 percent and not to exceed 14/100 percent of the amounts the Board estimates will be expended from the Trust Fund in the fiscal year.

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

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

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

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

(3) Measurable outcomes and process objectives for improving health status, and a report on outcomes from the previous year.

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

(5) A description of the core public health functions to be carried out at the local level.

(6) A description of the relationship between the State's public health system, community-based

health promotion and disease prevention providers, and the State health security program.

(e) LIMITATION ON FUND TRANSFERS.—The Board shall make no transfer of funds under this section for any fiscal year for which the total appropriations for such programs are less than the total amount appropriated for such programs in fiscal year 2012.

(f) PUBLIC HEALTH FORMULA GRANTS.—The Secretary shall provide stable funds to States through formula grants for the purpose of carrying out core public health functions to monitor and protect the health of communities from communicable diseases and exposure to toxic environmental pollutants, occupational hazards, harmful products, and poor health outcomes. Such functions include the following:

(1) Data collection, analysis, and assessment of public health data, vital statistics, and personal health data to assess community health status and outcomes reporting. This function includes the acquisition and installation of hardware and software, and personnel training and technical assistance to operate and support automated and integrated information systems.

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

(3) Investigation and control of adverse health conditions, and threats to the health status of individuals and the community. This function includes the identification and control of outbreaks of infectious disease, patterns of chronic disease and injury, and cooperative activities to reduce the levels of violence.

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

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

(A) screening tests for metabolic diseases in newborns;

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

(C) tuberculosis and other diseases requiring partner notification; and

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

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

(7) Research on effective and cost-effective public health practices. This function includes the development, testing, evaluation, and publication of results of new prevention and public health control interventions.

(8) Integration and coordination of the prevention programs and services of community-based providers, local and State health departments, and other sectors of State and local government that affect health.

SEC. 712. SET-ASIDE FOR PRIMARY HEALTH CARE DELIVERY.

(a) TRANSFERS TO SECTION 330 PROGRAM OF THE PUBLIC HEALTH SERVICE ACT.—

(1) IN GENERAL.—The Board shall make transfers from the American Health Security Trust Fund to the Public Health Service for the program authorized under section 330 of the Public Health Service Act (42 U.S.C. 254b).

(2) FISCAL YEAR 2018 AND SUBSEQUENT YEARS.—The amount transferred for fiscal year 2018 and each subsequent fiscal year shall be equal

to the amount transferred for the preceding fiscal year adjusted by the product of—

(A) one plus the average percentage increase in costs incurred per patient served by entities receiving funding under such section; and

(B) one plus the average percentage increase in the total number of patients served by entities receiving funding under such section.

(b) TRANSFERS TO PUBLIC HEALTH SERVICE.—From the amounts provided under subsection (d), the Board shall make transfers from the American Health Security Trust Fund to the Public Health Service for the program of primary care service expansion grants under subpart V of part D of title III of the Public Health Service Act (as added by section 713 of this Act).

(c) RANGE OF FUNDS.—The amount of transfers under subsection (b) for any fiscal year shall be an amount (specified by the Board each year) not less than 6/100 percent and not to exceed 1/10 percent of the amounts the Board estimates will be expended from the Trust Fund in the fiscal year.

(d) FUNDS SUPPLEMENTAL TO OTHER FUNDS.—The funds provided under this section with respect to provision of services are in addition to, and not in replace-

ment of, funds made available under the sections 340A, 1001, and 2655 of the Public Health Service Act. The Board shall make no transfer of funds under this section for any fiscal year for which the total appropriations for such sections are less than the total amount appropriated under such sections in fiscal year 2012.

SEC. 713. PRIMARY CARE SERVICE EXPANSION GRANTS.

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

"Subpart XIII—Primary Care Expansion

"SEC. 340J. EXPANDING PRIMARY CARE DELIVERY CAPACITY IN URBAN AND RURAL AREAS.

''(a) GRANTS FOR PRIMARY CARE CENTERS.—From the amounts described in subsection (c), the American Health Security Standards Board shall make grants to public and nonprofit private entities for projects to plan and develop primary care centers which will serve medically underserved populations (as defined in section 330(b)(3)) in urban and rural areas and to deliver primary care services to such populations in such areas. The funds provided under such a grant may be used for the same purposes for which a grant may be made under subsection (c), (e), (f), (g), (h), or (i) of section 330.

''(b) PROCESS OF AWARDING GRANTS.—The provisions of subsection (k)(1) of section 330 shall apply to a grant under this section in the same manner as they apply to a grant under the corresponding subsection of such section. The provisions of subsection (r)(2)(A) of such section shall apply to grants for projects to plan and develop primary care centers under this section in the same manner as they apply to grants under such section.

''(c) FUNDING AS SET-ASIDE FROM TRUST FUND.—Funds in the American Health Security Trust Fund (established under section 801 of the act) shall be available to carry out this section.

''(d) PRIMARY CARE CENTER DEFINED.—In this section, the term 'primary care center' means—

''(1) a health center (as defined in section 330(a)(1));

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

''(3) a Federally-qualified health center (as defined in section 1905(l)(2)(B) of the Social Security Act).''.

(b) TECHNICAL AMENDMENTS.—Part D of title III of the Public Health Service Act (42 U.S.C. 254b et seq.) is amended—

(1) by redesignating subpart XI, as added by section 10333 of the Patient Protection and Affordable Care Act (Public Law 111–148), as subpart XII; and

(2) by redesignating section 340H of the Public Health Service Act (42 U.S.C. 256i), as added by section 10333 of the Patient Protection and Affordable Care Act (Public Law 111–148), as section 340I.

Subtitle C—Primary Care and Outcomes Research

SEC. 721. SET-ASIDE FOR OUTCOMES RESEARCH.

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

(b) RANGE OF FUNDS.—The amount of transfers under subsection (a) for any fiscal year shall be an amount (specified by the Board each year) not less than 1/100 percent and not to exceed 2/100 percent of the amounts the

Board estimates will be expended from the Trust Fund in the fiscal year.

(c) FUNDS SUPPLEMENTAL TO OTHER FUNDS.—The funds provided under this section with respect to provision of services are in addition to, and not in replacement of, funds made available to the Agency for Healthcare Research and Quality under section 947 of the Public Health Service Act (42 U.S.C. 299c–6). The Board shall make no transfer of funds under this section for any fiscal year for which the total appropriations under such section are less than the total amount appropriated under such section and title in fiscal year 2012.

(d) CONFORMING AMENDMENT.—Section 947(b) of the Public Health Service Act (42 U.S.C. 299c–6(b)) is amended by inserting after ''of the fiscal years 2001 through 2005'' the following: ''and of fiscal year 2014 and each subsequent year''.

SEC. 722. OFFICE OF PRIMARY CARE AND PREVENTION RESEARCH.

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

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

(2) by inserting after part F (42 U.S.C. 287d et seq.) the following new part:

"PART G—RESEARCH ON PRIMARY CARE AND PREVENTION

"SEC. 486E. OFFICE OF PRIMARY CARE AND PREVENTION RESEARCH.

''(a) ESTABLISHMENT.—There is established within the Office of the Director of NIH an office to be known as the Office of Primary Care and Prevention Research (in this part referred to as the 'Office'). The Office shall be headed by a director, who shall be appointed by the Director of NIH.

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

''(1) identify projects of research on primary care and prevention, for children as well as adults, that should be conducted or supported by the national research institutes, with particular emphasis on—

''(A) clinical patient care, with special emphasis on pediatric clinical care and diagnosis;

''(B) diagnostic effectiveness;

''(C) primary care education;

''(D) health and family planning services;

''(E) medical effectiveness outcomes of primary care procedures and interventions; and

''(F) the use of multidisciplinary teams of health care practitioners;

''(2) identify multidisciplinary research related to primary care and prevention that should be so conducted;

''(3) promote coordination and collaboration among entities conducting research identified under any of paragraphs (1) and (2);

''(4) encourage the conduct of such research by entities receiving funds from the national research institutes;

''(5) recommend an agenda for conducting and supporting such research;

''(6) promote the sufficient allocation of the resources of the national research institutes for conducting and supporting such research; and

''(7) prepare the report required under section 486G.

''(c) PRIMARY CARE AND PREVENTION RESEARCH DEFINED.—For purposes of this part, the term 'primary care and prevention research' means research on improvement of the practice of family medicine, general internal medicine, and general pediatrics, and includes research relating to—

''(1) obstetrics and gynecology, dentistry, or mental health or substance abuse treatment when

provided by a primary care physician or other primary care practitioner; and

''(2) primary care provided by multidisciplinary teams.

''SEC. 486F. NATIONAL DATA SYSTEM AND CLEARINGHOUSE ON PRIMARY CARE AND PREVENTION RESEARCH.

''(a) DATA SYSTEM.—The Director of NIH, in consultation with the Director of the Office, shall establish a data system for the collection, storage, analysis, retrieval, and dissemination of information regarding primary care and prevention research that is conducted or supported by the national research institutes. Information from the data system shall be available through information systems available to health care professionals and providers, researchers, and members of the public.

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

"SEC. 486G. BIENNIAL REPORT.

''(a) IN GENERAL.—With respect to primary care and prevention research, the Director of the Office shall, not later than 1 year after the date of the enactment of this part, and biennially thereafter, prepare a report—

''(1) describing and evaluating the progress made during the preceding 2 fiscal years in research and treatment conducted or supported by the National Institutes of Health;

''(2) summarizing and analyzing expenditures made by the agencies of such Institutes (and by such Office) during the preceding 2 fiscal years; and

''(3) making such recommendations for legislative and administrative initiatives as the Director of the Office determines to be appropriate.

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

"SEC. 486H. AUTHORIZATION OF APPROPRIATIONS.

''For the Office of Primary Care and Prevention Research, there are authorized to be appropriated $150,000,000 for fiscal year 2014, $180,000,000 for fiscal year 2015, and $216,000,000 for fiscal year 2016.''.

(b) REQUIREMENT OF SUFFICIENT ALLOCATION OF RESOURCES OF INSTITUTES.—Section 402(b) of the Public Health Service Act (42 U.S.C. 282(b)) is amended—

(1) in paragraph (23), by striking ''and'' after the semicolon at the end;

(2) in paragraph (24), by striking the period at the end and inserting ''; and''; and

(3) by inserting after paragraph (24) the following new paragraph:

''(25) after consultation with the Director of the Office of Primary Care and Prevention Research, shall ensure that resources of the National Institutes of Health are sufficiently allocated for projects on primary care and prevention research that are identified under section 486E(b).''.

Subtitle D—School-Related Health Services

SEC. 731. AUTHORIZATIONS OF APPROPRIATIONS.

(a) FUNDING FOR SCHOOL-RELATED HEALTH SERVICES.—For the purpose of carrying out this subtitle, there are authorized to be appropriated $100,000,000 for fiscal year 2016, $275,000,000 for fiscal year 2017, $350,000,000 for fiscal year 2018, and $400,000,000 for each of the fiscal years 2019 and 2020.

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

SEC. 732. ELIGIBILITY FOR DEVELOPMENT AND OPERATION GRANTS.

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

(1) State health agencies that apply on behalf of local community partnerships and other communities in need of health services for school-aged children within the State.

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

(b) LOCAL COMMUNITY PARTNERSHIPS.—

(1) IN GENERAL.—A local community partnership under subsection (a)(2) is an entity that, at a minimum, includes—

(A) a local health care provider with experience in delivering services to school-aged children;

(B) one or more local public schools; and

(C) at least one community-based organization located in the community to be served

that has a history of providing services to school-aged children in the community who are at-risk.

(2) PARTICIPATION.—A partnership described in paragraph (1) shall, to the maximum extent feasible, involve broad based community participation from parents and adolescent children to be served, health and social service providers, teachers and other public school and school board personnel, development and service organizations for adolescent children, and interested business leaders. Such participation may be evidenced through an expanded partnership, or an advisory board to such partnership.

(c) DEFINITIONS REGARDING CHILDREN.—For purposes of this subtitle:

(1) The term ''adolescent children'' means school-aged children who are adolescents.

(2) The term ''school-aged children'' means individuals who are between the ages of 4 and 19 (inclusive).

SEC. 733. PREFERENCES.

(a) IN GENERAL.—In making grants under sections 734 and 735, the Secretary shall give preference to applicants whose communities to be served show the most sub-

stantial level of need for such services among school-aged children, as measured by indicators of community health including the following:

(1) High levels of poverty.

(2) The presence of a medically underserved population.

(3) The presence of a health professional shortage area.

(4) High rates of indicators of health risk among school-aged children, including a high proportion of such children receiving services through the Individuals with Disabilities Education Act, adolescent pregnancy, sexually transmitted disease (including infection with the human immunodeficiency virus), preventable disease, communicable disease, intentional and unintentional injuries, community and gang violence, unemployment among adolescent children, juvenile justice involvement, and high rates of drug and alcohol exposure.

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

SEC. 734. GRANTS FOR DEVELOPMENT OF PROJECTS.

(a) IN GENERAL.—The Secretary may make grants to State health agencies or to local community partnerships to develop school health service sites.

(b) USE OF FUNDS.—A project for which a grant may be made under subsection (a) may include the cost of the following:

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

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

(3) The development of agreements, and the acquisition and development of equipment and information services, necessary to support information exchange between school health service sites and health plans, health providers, and other entities authorized to collect information under this Act.

(4) Other activities necessary to assume operational status.

(c) APPLICATION FOR GRANT.—

(1) IN GENERAL.—Applicants shall submit applications in a form and manner prescribed by the Secretary.

(2) APPLICATIONS BY STATE HEALTH AGENCIES.—

(A) In the case of applicants that are State health agencies, the application shall contain assurances that the State health agency is applying for funds—

(i) on behalf of at least one local community partnership; and

(ii) on behalf of at least one other community identified by the State as in need of the services funded under this subtitle but without a local community partnership.

(B) In the case of the communities identified in applications submitted by State health agencies that do not yet have local community partnerships (including the community identified under subparagraph (A)(ii)), the State shall describe the steps that will be taken to aid the communities in developing a local community partnership.

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

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

(1) An assessment of the need for school health services in the communities to be served, using the latest available health data and health goals and objectives established by the Secretary.

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

(3) An explanation of how the applicant will integrate its services with those of other health and social service programs within the community.

(4) A description of a quality assurance program which complies with standards that the Secretary may prescribe.

(e) NUMBER OF GRANTS.—Not more than one planning grant may be made to a single applicant. A planning grant may not exceed 2 years in duration.

SEC. 735. GRANTS FOR OPERATION OF PROJECTS.

(a) IN GENERAL.—The Secretary may make grants to State health agencies or to local community partnerships for the cost of operating school health service sites.

(b) USE OF GRANT.—The costs for which a grant may be made under this section include the following:

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

(2) The cost of furnishing services whose purpose is to increase the capacity of individuals to utilize available health services, including transportation, community and patient outreach, patient education, translation services, and such other services as the Secretary determines to be appropriate in carrying out such purpose.

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

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

(5) Linkage of individuals to health plans, community health services and social services.

(6) Other activities deemed necessary by the Secretary.

(c) APPLICATION FOR GRANT.—Applicants shall submit applications in a form and manner prescribed by the Secretary. In order to receive a grant under this section, an applicant shall include in the application the following information:

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

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

(3) Such other information as the Secretary determines to be appropriate.

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

(1) The applicant furnishes the following services:

(A) Diagnosis and treatment of simple illnesses and minor injuries.

(B) Preventive health services, including health screenings.

(C) Services provided for the purpose described in subsection (b)(2).

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

(E) Health and social services, counseling services, and necessary referrals, including referrals regarding mental health and substance abuse.

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

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

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

(4) The applicant has reviewed and will periodically review the needs of the population served by the applicant in order to ensure that its services are accessible to the maximum number of school-aged children in the area, and that, to the maximum extent possible, barriers to access to services of the applicant are removed (including barriers resulting from the area's physical characteristics, its economic, social and cultural grouping, the health care utilization patterns of such children, and available transportation).

(5) In the case of an applicant which serves a population that includes a substantial proportion of individuals of limited English speaking ability, the applicant has developed a plan to meet the needs of

such population to the extent practicable in the language and cultural context most appropriate to such individuals.

(6) The applicant will provide non-Federal contributions toward the cost of the project in an amount determined by the Secretary.

(7) The applicant will operate a quality assurance program consistent with section 734(d).

(e) DURATION OF GRANT.—A grant under this section shall be for a period determined by the Secretary.

(f) REPORTS.—A recipient of funding under this section shall provide such reports and information as are required in regulations of the Secretary.

SEC. 736. FEDERAL ADMINISTRATIVE COSTS.

Of the amounts made available under section 731, the Secretary may reserve not more than 5 percent for administrative expenses regarding this subtitle.

SEC. 737. DEFINITIONS.

For purposes of this subtitle:

(1) The term ''adolescent children'' has the meaning given such term in section 732(c).

(2) The term ''at risk'' means at-risk with respect to health.

(3) The term ''community health center'' has the meaning given such term in section 330 of the Public Health Service Act.

(4) The term ''health professional shortage area'' means a health professional shortage area designated under section 332 of the Public Health Service Act.

(5) The term ''medically underserved population'' has the meaning given such term in section 330 of the Public Health Service Act.

(6) The term ''school-aged children'' has the meaning given such term in section 732(c).

TITLE VIII—FINANCING PROVISIONS; AMERICAN HEALTH SECURITY TRUST FUND

SEC. 800. AMENDMENT OF 1986 CODE; SECTION 15 NOT TO APPLY.

(a) AMENDMENT OF 1986 CODE.—Except as otherwise expressly provided, whenever in this title an amendment or repeal is expressed in terms of an amendment to, or repeal of, a section or other provision, the reference shall be considered to be made to a section or other provision of the Internal Revenue Code of 1986.

(b) SECTION 15 NOT TO APPLY.—The amendments made by subtitle B shall not be treated as a change in

a rate of tax for purposes of section 15 of the Internal Revenue Code of 1986.

Subtitle A—American Health Security Trust Fund

SEC. 801. AMERICAN HEALTH SECURITY TRUST FUND.

(a) IN GENERAL.—There is hereby created on the books of the Treasury of the United States a trust fund to be known as the American Health Security Trust Fund (in this section referred to as the ''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) APPROPRIATIONS INTO TRUST FUND.—

(1) TAXES.—There are hereby appropriated to the Trust Fund for each fiscal year (beginning with fiscal year 2015), out of any moneys in the Treasury not otherwise appropriated, amounts equivalent to 100 percent of the aggregate increase in tax liabilities under the Internal Revenue Code of 1986 which is attributable to the application of the amendments made by this title. The amounts appropriated by the preceding sentence shall be transferred from time to time (but 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 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 amounts that should have been so transferred.

(2) CURRENT PROGRAM RECEIPTS.—Notwithstanding any other provision of law, there are hereby appropriated to the Trust Fund for each fiscal year (beginning with fiscal year 2015) the amounts that would otherwise have been appropriated to carry out the following programs:

(A) The Medicare program, under parts A, B, and D of title XVIII of the Social Security Act (other than amounts attributable to any premiums under such parts).

(B) The Medicaid program, under State plans approved under title XIX of such Act.

(C) The Federal employees health benefit program, under chapter 89 of title 5, United States Code.

(D) The TRICARE program (formerly known as the CHAMPUS program), under chapter 55 of title 10, United States Code.

(E) The maternal and child health program (under title V of the Social Security Act), vocational rehabilitation programs, programs for drug abuse and mental health services under the Public Health Service Act, programs providing general hospital or medical assistance, and any other Federal program identified by the Board, in consultation with the Secretary of the Treasury, to the extent the programs provide for payment for health services the payment of which may be made under this Act.

(c) INCORPORATION OF PROVISIONS.—The provisions of subsections (b) through (i) of section 1817 of the Social Security Act shall apply to the Trust Fund under this Act in the same manner as they applied to the Federal Hospital Insurance Trust Fund under part A of title XVIII of such Act, except that the American Health Security Standards Board shall constitute the Board of Trustees of the Trust Fund.

(d) TRANSFER OF FUNDS.—Any amounts remaining in the Federal Hospital Insurance Trust Fund or the Federal Supplementary Medical Insurance Trust Fund after the settlement of claims for payments under title XVIII have been completed, shall be transferred into the American Health Security Trust Fund.

Subtitle B—Taxes Based on Income and Wages

SEC. 811. PAYROLL TAX ON EMPLOYERS.

(a) IN GENERAL.—Section 3111 (relating to tax on employers) is amended by redesignating subsections (c) and (d) as subsection (d) and (e), respectively, and by inserting after subsection (b) the following new subsection:

''(c) HEALTH CARE.—In addition to other taxes, there is hereby imposed on every employer an excise tax, with respect to having individuals in his employ, equal to 6.7 percent of the wages (as defined in section 3121(a)) paid by him with respect to employment (as defined in section 3121(b)).''.

(b) SELF-EMPLOYMENT INCOME.—Section 1401 (relating to rate of tax on self-employment income) is amended by redesignating subsection (c) as subsection (d) and inserting after subsection (b) the following new subsection:

''(c) HEALTH CARE.—In addition to other taxes, there shall be imposed for each taxable year, on the self-employment income of every individual, a tax equal to 6.7 percent of the amount of the self-employment income for such taxable year.''.

(c) COMPARABLE TAXES FOR RAILROAD SERVICES.—

(1) TAX ON EMPLOYERS.—Section 3221 is amended by redesignating subsections (c) and (d) as subsections (d) and (e), respectively, and by inserting after subsection (b) the following new subsection:

''(c) HEALTH CARE.—In addition to other taxes, there is hereby imposed on every employer an excise tax, with respect to having individuals in his employ, equal to 6.7 percent of the compensation paid by such employer for services rendered to such employer.''.

(2) TAX ON EMPLOYEE REPRESENTATIVES.—Section 3211 (relating to tax on employee representatives) is amended by redesignating subsection (c) as subsection (d) and inserting after subsection (b) the following new paragraph:

''(c) HEALTH CARE.—In addition to other taxes, there is hereby imposed on the income of each employee representative a tax equal to 6.7 percent of the compensation received during the calendar year by such employee representative for services rendered by such employee representative.''.

(3) NO APPLICABLE BASE.—Subparagraph (A) of section 3231(e)(2) is amended by adding at the end thereof the following new clause:

"(iv) HEALTH CARE TAXES.—Clause (i) shall not apply to the taxes imposed by sections 3221(c) and 3211(c).".

(4) TECHNICAL AMENDMENT.—

(A) Subsection (d) of section 3211, as redesignated by paragraph (2), is amended by striking "and (b)" and inserting ", (b), and (c)".

(B) Subsection (d) of section 3221, as redesignated by paragraph (1), is amended by striking "and (b)" and inserting ", (b), and (c)".

(d) EFFECTIVE DATE.—The amendments made by this section shall apply to remuneration paid after December 31, 2014.

SEC. 812. HEALTH CARE INCOME TAX.

(a) GENERAL RULE.—Subchapter A of chapter 1 (relating to determination of tax liability) is amended by adding at the end thereof the following new part:

"PART VIII—HEALTH CARE RELATED TAXES

"SUBPART A.—HEALTH CARE INCOME TAX ON INDIVIDUALS

"Subpart A—Health Care Income Tax on Individuals

"Sec. 59B. Health care income tax.

"SEC. 59B. HEALTH CARE INCOME TAX.

"(a) IMPOSITION OF TAX.—In the case of an individual, there is hereby imposed on the taxable income of the taxpayer for the taxable year a tax (in addition to any other tax imposed by this subtitle) determined in accordance with the following tables:

"(1) MARRIED INDIVIDUALS FILING JOINT RETURNS AND SURVIVING SPOUSES.—In the case of any taxpayer making a joint return under section 6013 or a surviving spouse (as defined in section 2(a)), the following table shall apply:

"If taxable income is:	**The tax is:**
Not over $250,000	2.2% of taxable income.
Over $250,000 but not over $400,000.	$5,500, plus 3.2% of the excess over $250,000.
Over $400,000 but not over $600,000.	$10,300, plus 4.2% of the excess over $400,000.
Over $600,000	$18,700, plus 5.2% of the excess over $600,000.

"(2) OTHER TAXPAYERS.—In the case of any taxpayer not described in paragraph (1), the following table shall apply:

"If taxable income is:	**The tax is:**
Not over $200,000	2.2% of taxable income.
Over $200,000 but not over $400,000.	$4,400, plus 3.2% of the excess over $200,000.
Over $400,000 but not over $600,000.	$10,800, plus 4.2% of the excess over $400,000.
Over $600,000	$19,200, plus 5.2% of the excess over $600,000.

"(b) INFLATION ADJUSTMENT.—

"(1) IN GENERAL.—In the case of any taxable year beginning after 2015, each of the dollar

amounts set forth in the tables in subsection (a) shall be increased by an amount equal to—

"(A) such dollar amount, multiplied by

"(B) the cost-of-living adjustment determined under section 1(f)(3) for such calendar year by substituting 'calendar year 2014' for 'calendar year 1992' in subparagraph (B) thereof.

"(2) ROUNDING.—If the amount as adjusted under paragraph (1) is not a multiple of $1,000, such amount shall be rounded to the next lowest multiple of $1,000.

"(c) NO CREDITS AGAINST TAX; NO EFFECT ON MINIMUM TAX.—The tax imposed by this section shall not be treated as a tax imposed by this chapter for purposes of determining—

"(1) the amount of any credit allowable under this chapter, or

"(2) the amount of the minimum tax imposed by section 55.

"(d) SPECIAL RULES.—

"(1) TAX TO BE WITHHELD, ETC.—For purposes of this title, the tax imposed by this section shall be treated as imposed by section 1.

''(2) REIMBURSEMENT OF TAX BY EMPLOYER NOT INCLUDIBLE IN GROSS INCOME.—The gross income of an employee shall not include any payment by his employer to reimburse the employee for the tax paid by the employee under this section.

''(3) OTHER RULES.—The rules of section 59A(d) shall apply to the tax imposed by this section.''.

(b) CLERICAL AMENDMENT.—The table of parts for subchapter A of chapter 1 is amended by adding at the end the following new item:

''PART VIII—HEALTH CARE RELATED TAXES''.

(c) EFFECTIVE DATE.—The amendments made by this section shall apply to taxable years beginning after December 31, 2014.

SEC. 813. SURCHARGE ON HIGH INCOME INDIVIDUALS.

(a) IN GENERAL.—Part VIII of subchapter A of chapter 1, as added by this title, is amended by adding at the end the following new subpart:

''Subpart B—Surcharge on High Income Individuals

''Sec. 59C. Surcharge on high income individuals.

''SEC. 59C. SURCHARGE ON HIGH INCOME INDIVIDUALS.

''(a) GENERAL RULE.—In the case of a taxpayer other than a corporation, there is hereby imposed (in addition to any other tax imposed by this subtitle) a tax equal

to 5.4 percent of so much of the modified adjusted gross income of the taxpayer as exceeds $1,000,000.

''(b) TAXPAYERS NOT MAKING A JOINT RETURN.—In the case of any taxpayer other than a taxpayer making a joint return under section 6013 or a surviving spouse (as defined in section 2(a)), subsection (a) shall be applied by substituting '$500,000' for '$1,000,000'.

''(c) MODIFIED ADJUSTED GROSS INCOME.—For purposes of this section, the term 'modified adjusted gross income' means adjusted gross income reduced by any deduction (not taken into account in determining adjusted gross income) allowed for investment interest (as defined in section 163(d)). In the case of an estate or trust, adjusted gross income shall be determined as provided in section 67(e).

''(d) SPECIAL RULES.—

''(1) NONRESIDENT ALIEN.—In the case of a nonresident alien individual, only amounts taken into account in connection with the tax imposed under section 871(b) shall be taken into account under this section.

''(2) CITIZENS AND RESIDENTS LIVING ABROAD.—The dollar amount in effect under subsection (a) (after the application of subsection (b)) shall be decreased by the excess of—

"(A) the amounts excluded from the taxpayer's gross income under section 911, over

"(B) the amounts of any deductions or exclusions disallowed under section 911(d)(6) with respect to the amounts described in subparagraph (A).

"(3) CHARITABLE TRUSTS.—Subsection (a) shall not apply to a trust all the unexpired interests in which are devoted to one or more of the purposes described in section 170(c)(2)(B).

"(4) NOT TREATED AS TAX IMPOSED BY THIS CHAPTER FOR CERTAIN PURPOSES.—The tax imposed under this section shall not be treated as tax imposed by this chapter for purposes of determining the amount of any credit under this chapter or for purposes of section 55.".

(b) CLERICAL AMENDMENT.—The table of subparts for part VIII of subchapter A of chapter 1, as added by this title, is amended by inserting after the item relating to subpart A the following new item:

"SUBPART B. SURCHARGE ON HIGH INCOME INDIVIDUALS".

(c) SECTION 15 NOT TO APPLY.—The amendment made by subsection (a) shall not be treated as a change in a rate of tax for purposes of section 15 of the Internal Revenue Code of 1986.

(d) EFFECTIVE DATE.—The amendments made by this section shall apply to taxable years beginning after December 31, 2014.

Subtitle C—Other Financing Provisions

SEC. 821. TAX ON SECURITIES TRANSACTIONS.

(a) IN GENERAL.—Chapter 36 is amended by inserting after subchapter B the following new subchapter:

"Subchapter C—Tax on Securities Transactions

"Sec. 4475. Tax on securities transactions.

"SEC. 4475. TAX ON SECURITIES TRANSACTIONS.

"(a) IMPOSITION OF TAX.—

"(1) STOCKS.—There is hereby imposed a tax on each covered transaction in a stock contract of 0.25 percent of the value of the instruments involved in such transaction.

"(2) FUTURES.—There is hereby imposed a tax on each covered transaction in a futures contract of 0.02 percent of the value of the instruments involved in such transaction.

"(3) SWAPS.—There is hereby imposed a tax on each covered transaction in a swaps contract of 0.02 percent of the value of the instruments involved in such transaction.

''(4) CREDIT DEFAULT SWAPS.—There is hereby imposed a tax on each covered transaction in a credit default swaps contract of 0.02 percent of the value of the instruments involved in such transaction.

''(5) OPTIONS.—There is hereby imposed a tax on each covered transaction in an options contract with respect to a transaction described in paragraph (1), (2), (3), or (4) of—

''(A) the rate imposed with respect to such underlying transaction under paragraph (1), (2), (3), or (4) (as the case may be), multiplied by

''(B) the premium paid on such option.

''(b) EXCEPTION FOR RETIREMENT ACCOUNTS, ETC.—No tax shall be imposed under subsection (a) with respect to any stock contract, futures contract, swaps contract, credit default swap, or options contract which is held in any plan, account, or arrangement described in section 220, 223, 401(a), 403(a), 403(b), 408, 408A, 529, or 530.

''(c) EXCEPTION FOR INTERESTS IN MUTUAL FUNDS.—No tax shall be imposed under subsection (a) with respect to the purchase or sale of any interest in a

regulated investment company (as defined in section 851) or of any derivative of such an interest.

''(d) BY WHOM PAID.—

''(1) IN GENERAL.—The tax imposed by this section shall be paid by—

''(A) in the case of a transaction which occurs on a trading facility located in the United States, such trading facility, or

''(B) in any other case, the purchaser with respect to the transaction.

''(2) WITHHOLDING IF BUYER IS NOT A UNITED STATES PERSON.—See section 1447 for withholding by seller if buyer is a foreign person.

''(e) COVERED TRANSACTION.—The term 'covered transaction' means any purchase or sale if—

''(1) such purchase or sale occurs on a trading facility located in the United States, or

''(2) the purchaser or seller is a United States person.

''(f) ADMINISTRATION.—The Secretary shall carry out this section in consultation with the Securities and Exchange Commission and the Commodity Futures Trading Commission.''.

(b) CREDIT FOR FIRST $100,000 OF STOCK TRANSACTIONS PER YEAR.—Subpart C of part IV of subchapter

A of chapter 1 is amended by inserting after section 36A the following new section:

"SEC. 36B. CREDIT FOR SECURITIES TRANSACTION TAXES.

"(a) ALLOWANCE OF CREDIT.—In the case of any purchaser with respect to a covered transaction, there shall be allowed as a credit against the tax imposed by this subtitle for the taxable year an amount equal to the lesser of—

"(1) the aggregate amount of tax imposed under section 4475 on covered transactions during the taxable year with respect to which the taxpayer is the purchaser, or

"(2) $250 ($500 in the case of a joint return).

"(b) AGGREGATION RULE.—For purposes of this section, all persons treated as a single employer under subsection (a) or (b) of section 52, or subsection (m) or (o) of section 414, shall be treated as one taxpayer.

"(c) DEFINITIONS.—For purposes of this section, any term used in this section which is also used in section 4475 shall have the same meaning as when used in section 4475.".

(c) WITHHOLDING.—Subchapter A of chapter 3 is amended by adding at the end the following new section:

"SEC. 1447. WITHHOLDING ON SECURITIES TRANSACTIONS.

"(a) IN GENERAL.—In the case of any outbound securities transaction, the transferor shall deduct and withhold a tax equal to the tax imposed under section 4475 with respect to such transaction.

"(b) OUTBOUND SECURITIES TRANSACTION.—For purposes of this section, the term 'outbound securities transaction' means any covered transaction to which section 4475(a) applies if—

"(1) such transaction does not occur on a trading facility located in the United States, and

"(2) the purchaser with respect to such transaction is not a United States person.".

(d) CONFORMING AMENDMENTS.—

(1) Section 6211(b)(4)(A) is amended by inserting "36B," after "36A,".

(2) Section 1324(b)(2) of title 31, United States Code, is amended by inserting "36B," after "36A,".

(3) The table of subchapters for chapter 36 is amended by inserting after the item relating to subchapter B the following new item:

"Subchapter C. Tax on securities transactions".

(4) The table of sections for subchapter A of chapter 3 is amended by adding at the end the following new item:

''Sec. 1447. Withholding on securities transactions.''.

(5) The table of sections for subpart C of part IV of subchapter A of chapter 1 is amended by inserting after the item relating to section 36A the following new item:

''Sec. 36B. Credit for securities transaction taxes.''.

(e) EFFECTIVE DATE.—The amendments made by this section shall apply to transactions occurring more than 180 days after the date of the enactment of this Act.

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

SEC. 901. ERISA INAPPLICABLE TO HEALTH COVERAGE ARRANGEMENTS UNDER STATE HEALTH SECURITY PROGRAMS.

Section 4 of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1003) is amended—

(1) in subsection (a), by striking ''(b) or (c)'' and inserting ''(b), (c), or (d)''; and

(2) by adding at the end the following new subsection:

''(d) The provisions of this title shall not apply to any arrangement forming a part of a State health security program established pursuant to section 101(b) of the American Health Security Act of 2013.''.

SEC. 902. EXEMPTION OF STATE HEALTH SECURITY PROGRAMS FROM ERISA PREEMPTION.

Section 514(b) of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1144(b)) (as amended by sections 904(b)(3)(B) and 1002(b) of this Act) is amended by adding at the end the following new paragraph:

''(10) Subsection (a) of this section shall not apply to State health security programs established pursuant to section 101(b) of the American Health Security Act of 2013.''.

SEC. 903. PROHIBITION OF EMPLOYEE BENEFITS DUPLICATIVE OF BENEFITS UNDER STATE HEALTH SECURITY PROGRAMS; COORDINATION IN CASE OF WORKERS' COMPENSATION.

(a) IN GENERAL.—Part 5 of subtitle B of title I of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1131 et seq.) is amended by adding at the end the following new section:

''PROHIBITION OF EMPLOYEE BENEFITS DUPLICATIVE OF STATE HEALTH SECURITY PROGRAM BENEFITS; COORDINATION IN CASE OF WORKERS' COMPENSATION

''SEC. 522. (a) Subject to subsection (b), no employee benefit plan may provide benefits which duplicate payment for any items or services for which payment may be made under a State health security program established pursuant to section 101(b) of the American Health Security Act of 2013.

''(b)(1) Each workers compensation carrier that is liable for payment for workers compensation services furnished in a State shall reimburse the State health security plan for the State in which the services are furnished for the cost of such services.

''(2) In this subsection:

''(A) The term 'workers compensation carrier' means an insurance company that underwrites workers compensation medical benefits with respect to one or more employers and includes an employer or fund that is financially at risk for the provision of workers compensation medical benefits.

''(B) The term 'workers compensation medical benefits' means, with respect to an enrollee who is an employee subject to the workers compensation laws of a State, the comprehensive medical benefits

for work-related injuries and illnesses provided for under such laws with respect to such an employee.

''(C) The term 'workers compensation services' means items and services included in workers compensation medical benefits and includes items and services (including rehabilitation services and long-term-care services) commonly used for treatment of work-related injuries and illnesses.''.

(b) CONFORMING AMENDMENT.—Section 4(b) of such Act (29 U.S.C. 1003(b)) is amended by adding at the end the following: ''Paragraph (3) shall apply subject to section 522(b) (relating to reimbursement of State health security plans by workers compensation carriers).''.

(c) CLERICAL AMENDMENT.—The table of contents in section 1 of such Act is amended by inserting after the item relating to section 521 the following new items:

''Sec. 522. Prohibition of employee benefits duplicative of State health security program benefits; coordination in case of workers' compensation.''.

SEC. 904. REPEAL OF CONTINUATION COVERAGE REQUIREMENTS UNDER ERISA AND CERTAIN OTHER REQUIREMENTS RELATING TO GROUP HEALTH PLANS.

(a) IN GENERAL.—Part 6 of subtitle B of title I of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1161 et seq.) is repealed.

(b) CONFORMING AMENDMENTS.—

(1) Section 502(a) of such Act (29 U.S.C. 1132(a)) is amended—

(A) by striking paragraph (7); and

(B) by redesignating paragraphs (8), (9), and (10) as paragraphs (7), (8), and (9), respectively.

(2) Section 502(c)(1) of such Act (29 U.S.C. 1132(c)(1)) is amended by striking ''paragraph (1) or (4) of section 606,''.

(3) Section 514(b) of such Act (29 U.S.C. 1144(b)) is amended—

(A) in paragraph (7), by striking ''section 206(d)(3)(B)(i)),'' and all that follows and inserting ''section 206(d)(3)(B)(i)).''; and

(B) by striking paragraph (8).

(4) The table of contents in section 1 of the Employee Retirement Income Security Act of 1974 is amended by striking the items relating to part 6 of subtitle B of title I of such Act.

SEC. 905. EFFECTIVE DATE OF TITLE.

The amendments made by this title shall take effect January 1, 2016.

TITLE X—ADDITIONAL CONFORMING AMENDMENTS

SEC. 1001. REPEAL OF CERTAIN PROVISIONS IN INTERNAL REVENUE CODE OF 1986.

The provisions of titles III and IV of the Health Insurance Portability and Accountability Act of 1996, other than subtitles D and H of title III and section 342, are repealed and the provisions of law that were amended or repealed by such provisions are hereby restored as if such provisions had not been enacted.

SEC. 1002. REPEAL OF CERTAIN PROVISIONS IN THE EMPLOYEE RETIREMENT INCOME SECURITY ACT OF 1974.

(a) IN GENERAL.—Part 7 of subtitle B of title I of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1181 et seq.) is repealed and the items relating to such part in the table of contents in section 1 of such Act are repealed.

(b) CONFORMING AMENDMENT.—Section 514(b) of such Act (29 U.S.C. 1144(b)) is amended by striking paragraph (9).

SEC. 1003. REPEAL OF CERTAIN PROVISIONS IN THE PUBLIC HEALTH SERVICE ACT AND RELATED PROVISIONS.

(a) IN GENERAL.—Titles XXII and XXVII of the Public Health Service Act (42 U.S.C. 300bb–1 et seq., 300gg et seq.) are repealed.

(b) CERTAIN PPACA PROVISIONS.—Title I of the Patient Protection and Affordable Care Act (Public Law 111–148) (and the amendments made by such title) is repealed.

(c) ADDITIONAL AMENDMENTS.—

(1) Section 1301(b) of such Act (42 U.S.C. 300e(b)) is amended by striking paragraph (6).

(2) Sections 104 and 191 of the Health Insurance Portability and Accountability Act of 1996 are repealed.

SEC. 1004. EFFECTIVE DATE OF TITLE.

The amendments made by this title shall take effect January 1, 2017.

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