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A REPORT TO THE GOVERNOR AND LEGISLATURE
PREPARED PURSUANT TO CHAPTER 829, STATUTES OF 1989
(AB 350)

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MARCH 1, 1990

To the Governor and Members of the California Legislature:

On October 10, 1989, in accordance with the provisions of AB 350, Governor Deukmejian assigned the secretaries of Business, Transportation and Housing and Health and Welfare the responsibility of preparing a report on health insurance coverage.

We were directed to examine the insurance rating system and general health care delivery, including the potential for achieving savings in medical care costs. This report provides information on those topics.

We hoped at the outset that the process of developing the report could lead to agreements among all groups--employers, health care providers, insurance carriers and labor.

The process produced an examination of the problem unequalled in intensity and thoroughness by anything going on in any state in the country. But it did not produce a consensus.

Nevertheless, it did bring a focus, new information, and some compromises which leave all parties in a better position to pursue this challenge in the future.

If we have set out ideas that will be a part of future discussion and increased understanding, then the work of everyone involved will have been worthwhile.

We want to thank those who assisted us as formal members of the advisory task force we first called together in November and also the many other individuals from associations, academia, and the Legislature who participated diligently in our working group efforts. We would like to especially commend the members of respective agency staffs who devoted many hours to this project: John Ramey, Sandra Shewry, Mark Helmar and Richard Krolack of Health and Welfare, John Sullivan and Anne Eowan of Business, Transportation and Housing.

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PREFACE:

Assembly Bill No 350 (Chapter 929, Statutes of 1989) required the Governor to designate a state agency to report to the Legislature and the Governor, by March 1, 1990, on factors relevant to a solution of problems posed by a large and growing percentage of the state's population that is unsponsored for payment of health related costs. Specifically, the report is to include information on the following items:

1. The number of people in California who lack health insurance coverage;

2. The impact of the lack of health insurance on California employers and those businesses providing health insurance;

3. The impact of Proposition 99 funds on the problem of uncompensated care in California;

4. Fiscal incentives, other than those contained in existing statutes, which might further encourage business to provide health insurance coverage to their workers;

5. Recommendations on how the current system of underwriting the cost of health insurance might be improved;

6. The possibility of cost savings by consolidating workers' compensation health benefits under employer sponsored health care coverage; and

7. Recommendations on the fiscal responsibility of those employers who do not provide basic health care coverage for their employees in order to insure that the cost of uncompensated care to both the public and private sectors is shared as equally as possible.

In addition, the Governor in designating the Secretaries of the Business, Transportation and Housing Agency and the Health and Welfare Agency to make the report, asked also for information on ways to reduce medical care costs. This report addresses all of these items except for numbers 3 and 6. Proposition 99 funds were not examined because they cannot be counted on as a long term source of support. The issue of consolidating workers' compensation health coverage is not discussed because it was generally agreed that it was better to allow a reasonable time for recent changes to that program to have an impact before proposing further modifications.

The Secretaries of the Business, Transportation and Housing Agency and the Health and Welfare Agency requested the assistance of an advisory task force preparing the report called for in AB 350. The task force included representatives from health care providers, employers,

employees, and consumers. After an initial organization meeting in November, 1989 the task force sought to have information developed via working groups focused on cost containment, employer participation, and an affordable benefit package. These groups held a number of open meetings through December. Each meeting was well attended and resulted in multiple opportunities for interested parties to express their concerns, identify additional issues, and propose solutions.

At the conclusion of these focused meetings, the working groups combined for six open meetings to hear about seven alternative proposals offered by various groups as solutions to California's growing health insurance problems. The seven proposals were a modified AB 350 (Brown), a Medi-Cal Buy-In plan, Health Access' Universal Coverage plan, a California Medical Association Employer Mandate proposal, AB 328 (Margolin), Oregon's recent health reforms, and a plan proposed in New York called UNY-CARE.
Following these meetings, staff developed a set of guiding principles and a draft proposal which was used to prepare this document. The AB 350 Task Force members met in mid-February to provide feedback to the Agency Secretaries on the draft. In addition, feedback was obtained from extensive written comment and a three-hour public meeting.

According to 1986 data, 22% of Californians are not insured privately or sponsored by government for health expense. There is good evidence to conclude that the number of these persons is growing at an accelerating rate. This phenomenon causes a significant burden on all sectors of our health care system and society. Existing studies have suggested that the lack of health insurance coverage results in reduced access to medical care and an overall worsening of health status, particularly among those with chronic illnesses and those without access to adequate preventive care. Lack of health insurance also creates additional financial burdens on government, health care providers, and employers who do provide coverage for their employees. As those without coverage rely more and more heavily on the publicly supported county based "safety net," government costs for providing these services continues to escalate. Private providers are similarly impacted as the demands of uncompensated or "charity" care continue to grow. The resultant cost shifts drive up the insurance costs of those who do provide insurance coverage for their employees. This increase in overall costs will in turn likely result in even greater numbers of unsponsored persons creating a spiral of increasing costs and further reductions in coverage. Responsible public policy seeks to alleviate this problem before it escalates to a level that will cause serious disruption to our general welfare and to existing successful health care relationships. The following principles were used to identify options to address the problem.

GUIDING PRINCIPLES

- **BUILD ON EXISTING INSURANCE AND SERVICE DELIVERY SYSTEMS**

The strengths of the existing pluralistic network of service delivery systems are the preferred basis for expanding health care coverage. Although these systems do not currently provide the optimal level of coverage and cost containment, they do provide coverage and care to millions of Californians. The State has seen a dramatic growth in enrollments in managed care systems. The California Department of Corporations reports that more than nine million Californians are enrolled in managed care systems. These systems insure access while placing restraints on unnecessary services and costs. Any new approach should provide incentives for the health care system to provide expanded, affordable coverage through the expansion of managed care systems. It should also provide for a series of evolutionary steps to modify the current system of private insurance and provider rate setting if assumptions regarding access and price stability do not materialize in a reasonable time frame.

Existing state policy rationally seeks to maximize federal participation in health care funding. A proposal should continue that policy for the coverage of all possible eligible persons while standardizing a basic benefit package to all Californians.

- **MINIMUM BENEFIT PACKAGE**

Affordability is the primary obstacle to access to adequate health insurance coverage. A proposal should identify an affordable, medically viable and actuarialy sound package of minimum benefits or a minimum package defined by a cost limit.

- **FAIR TO BUSINESS**

Any proposal should seek to be fair to businesses. Business has a primary fiscal and managerial role in health coverage for most of the population. Affordability is a primary factor in availability. Achieving affordability would be a positive factor in our business climate.

- **AVOID NONPRODUCTIVE EMPLOYMENT INCENTIVES**

A proposal should be designed to enable employers to make employment and personnel decisions based on productivity rather than on avoiding health coverage costs. Any proposal should not encourage employers to cap their number of employees or hours worked by an employee per month. Retaining current flexibility benefits employers and employees alike.

- **COVER EMPLOYEES AND DEPENDENTS**

A workable solution to this complex issue should provide for coverage of dependents as well as employees. Expansion of coverage to dependents is both cost effective and socially responsible. It is cost effective due to economies of scale associated with large risk pools and reduced per capita costs for dependent coverage. Social responsibility is cost effective in the short term and long term because dependent coverage funds health services for an additional quarter of the uninsured population, a significant portion which includes non-working spouses and children.

- **AFFORDABILITY**

Future year costs must directly be addressed. Any proposal without a viable cost containment strategy as an integral part of the package will fail. Future unwarranted cost increases should be guarded against in the strongest possible terms. Managed care should be encouraged to accentuate positive cost containment incentives.

Consideration should be given to low income employees' ability to share the burden of health coverage. Consideration must also be given to the resources available to businesses, particularly small businesses, for their share of the burden.

- **PRUDENT REALLOCATION OF EXISTING RESOURCES**

Major components of a proposal must be appropriately supported to make it viable. To this end, a proposal should prudently allocate resources within the health care insurance and delivery systems.

The combination of cost containment measures, system reforms, and resource allocation should provide both structural and fiscal integrity to a proposal.

- **MAINTAIN SAFETY NET**

A proposal should recognize the importance of maintaining and stabilizing the existing publicly supported "safety net" health care system. This system is crucial in providing needed health care services to any remaining population of uninsured persons.

III. Coverage of Working Californians and Their Families

Voluntary Incentive System for Employers Not Now Offering Health Coverage to Employees and Their Families

This report examines options which are designed to preserve the existing employer-based system of health care coverage of working Californians. In that system, employer participation is voluntary. A plan to bring more employees into employer provided health care under a voluntary system would rely on devising incentives which somehow outrace the disincentives now encountered by the minority of businesses not offering health care. This is a challenging task, given the cost increases being inflicted on firms already providing health coverage.

It is possible that inducements alone -- such as a tax credit would influence some groups on the margin, but the core problem of uncovered Californians would remain. The only way a voluntary approach can work is through inducements coupled with simultaneous implementation of systemic cost containment reforms.

A voluntary, incentive option could be pursued in conjunction with most of the employer/employee subsidies, cost containment, and the "fail safe affordability" options described in the following sections. It would not require an ERISA exemption because there would be no mandatory schedule of benefits. This report envisions "buying" cost containment reforms from providers and insurance carriers in exchange for better Medi-Cal funding and more "paying customers" from the ranks of the uncovered employed. In an incentive approach, the number of new participating employers and employees (and likewise the new health dollars) would be uncertain, making bargaining for cost containment less assured of success.

Mandatory Coverage by Employers of All Working Californians and Their Families

Mandatory coverage of all working Californians guarantees reaching the majority of the uncovered. Under a mandatory option, covering all workers prevents the kind of unproductive employment decisions that can occur if a mandate exempts employers with fewer than five employees, for example, or employees working fewer than a set number of hours per week. A mandate, by making more predictable the level of new resources devoted to health care, makes systemic cost containment reform more achievable. It allows for a fundamental change in health insurance underwriting that guarantees availability of insurance. Importantly, most insurance

carriers assert that these underwriting changes are not achievable without mandatory coverage. Under the mandate model used to help develop this report, employers could choose to offer a minimum level of health care coverage to all employees and their dependents. Employees receiving health care coverage via the Medicare Program (i.e., over 64 years of age) would be excluded from the mandate requirements. All employees would be required to accept and participate in purchasing the minimum level of health care coverage. Employers choosing not to offer coverage would be liable for "first dollar" health care costs of their uninsured employees, plus a penalty charge collected by the State. In either situation, the obligation would begin following the employee's third month of work.

1. Cost Sharing Partnership Among Employers, Employees and Government

Cost of coverage, under the model tested for this report, would be shared by employers, employees and government:

a. Employer contribution: at least 75% of the cost of premiums for individual coverage or 50% of the premium cost for family coverage. If the minimum level of coverage is defined by a list of required benefits, the dollar value of the mandate on employer participation applies to the lowest cost plan made available to employees which meets the basic benefit plan requirements. Employers would pay a pro-rata share of premium cost for part-time workers, i.e., persons working fewer than 35 hours per week.

b. Employee contribution: up to 25% of the cost of premiums for individual coverage or up to 50% of the premium cost for family coverage, under whatever plan agreed upon by employer and employee. Part-time employees would pay a pro-rata share of premium costs.

c. Medi-Cal buy-in: low wage employees, low income self-employed, and low profit employers would be able to buy into a minimum, state program such as the existing Medi-Cal program.

d. The state would assist business in providing the required health coverage through the provision of a tax credit and a direct subsidy of premium costs.

e. The state would subsidize the premium cost for those least able to afford coverage -- full-time employees, part-time employees, and self employed low income persons. These subsidies could be provided on the basis of a sliding scale with graduated subsidies for persons based on a percent of the Federal Poverty Level (FPL). See Chart 1 for current FPLs.

2. Basic Benefits to Cover Essential Health Care Needs

Obtaining an appropriate balance in the design of a benefit package is crucial to overall viability and affordability of legislated health care coverage. The schedule of benefits should be restricted to those services that are medically necessary. During the Task Force deliberations a work group attempted to list essential basic services. A detailed description of such a benefit package is included in this report in the appendix. The benefit package presented in the appendix is, with the exception of the inclusion of advance practice nurses, the one presented by the California Medical Association. Depending on affordability and efficacy, modifications to the benefit package may be desirable.

3. Affordability For Those Least Able to Pay For Coverage

To assure the affordability of health care coverage to employees and employers, the state would subsidize the purchase of coverage for those facing financial hardship. Those individuals and businesses least able to afford coverage will be offered the option of purchasing it through the CAL-CARE Program. CAL-CARE benefits for persons choosing this buy-in option will be restricted to the mandated minimum benefit package and will be available at a significant cost saving over the rates charged by commercial carriers.

Estimated monthly premium costs for the CAL-CARE plan are:

Single adult	$ 84.80
Two person family	$168.11
Family groups of three or more	$278.11

These premiums cover the basic scope of benefits (with the rate increases for CAL-CARE services) and program administrative costs, including a sales commission component. Program administrative costs account for approximately six percent of total premium costs.

a. Affordability for California Businesses

To help insure that the benefits mandated under this proposal are affordable to employers, the CAL-CARE program will be available to business depending on its number of employees and financial circumstances. Businesses which meet the size and fiscal criteria will have the option to purchase health care coverage via the CAL-CARE program, and will also be eligible for partial subsidization of their premium costs.

Charitable organizations will be given the option of purchasing coverage through the CAL-CARE Program. This option will at least be restricted to federally designated 501 (c)3 organizations. No governmental entity will be eligible for this option.

b. Affordability for Full-Time Employees, Part-Time Employees, and Self-Employed Persons of Low-Income.

Those individuals least able to afford coverage will be offered the option of purchasing coverage through the CAL-CARE Program. The benefits will be restricted to a mandated minimum benefit package and will be available at a significant cost saving over the rates charged by commercial carriers. In addition, the state would subsidize purchase of coverage for those facing financial hardship.
This subsidy could be provided on a sliding scale based on the FPL. This subsidy schedule would be available to low

wage employees and low income self-employed individuals. In each case this subsidy would be based on CAL-CARE rates.

All part-time workers will be offered the option of coverage through CAL-CARE. The purpose of offering all part-time workers the CAL-CARE option is to reduce the administrative obligations and associated costs to individual employers. Employers with part-time employees would be spared the need to deal with substantial additional record keeping requirements or the need to coordinate coverage in the case of employees with more than one employer. This option would not preclude any employer from providing coverage if they chose to do so.

Employee and employer responsibility for the cost of premiums for part-time workers and their dependents would be charged on a pro-rata basis. If a worker works one half time, the employer would contribute one half of 75% (50% with family coverage) of the cost of the lowest cost insurance plan available to the employee through the employer. The employee would contribute one half of 25% (50%) of the lowest cost plan available to him/her. The balance of the premium would be contributed through other jobs, through agreement between employee/employer, or through additional state subsidies for low income part-time employees. Premium contributions for persons working more than one part-time job would be aggregated with proportional shares contributed by each employer.

In addition, the state will actively pursue additional federal financial participation for those family units eligible. This action should result in the availability of additional resources to subsidize full-time employees, part-time employees and self-employed persons of low wage.

4. Increased Reimbursement for CAL-CARE Providers

The CAL-CARE Program will increase its provider rates in targeted areas to assure adequate access to services is available throughout the state. $640 million in provider rate increases will be targeted to improve enrollee access and to realign rates toward a resource based relative value scale.

One option for distribution of the funds which achieves these goals is:

Service Category	Full Year Cost	% Adjustment
Physicians (Specific specialties to receive higher or lower percents)	$253,631,500	35%
Other Medical	$ 37,902,175	25%
Emergency Medical Transportation	$ 1,834,500	30%
Other Services	$ 19,916,090	10%
Home Health Agencies	$ 4,125,000	30%
Dental Services	$ 20,837,600	40%
Prepaid Health Plans	$ 24,732,000	15%
CHDP	$ 19,156,000	40%
County Organized Health Systems	$ 8,382,000	15%
Hospital Inpatient/Outpatient	$200,000,000	fixed
fixed dollar amount to be distributed via CMAC negotiations		
Managed care incentives	$ 49,753,135	fixed

5. CAL-CARE Program Benefit Conformity

The benefits provided to CAL-CARE enrollees meeting federal and state Medicaid eligibility requirements will be revised to be consistent with the benefits in this report, with the following supplemental services being provided to publicly sponsored patients: long-term care, unlimited hospitalization, and durable medical equipment. In addition, mental health services provided through the Short-Doyle Medi-Cal Program will continue; mental health fee-for-service CAL-CARE services will be restricted to those offered via a basic benefit package.

Making these changes to the existing Medi-Cal schedule of benefits will result in revenue available for the purpose of this program of $80 million.

6. Cost Containment Measures to Assure the Continued Affordability of Health Care Coverage

A. Fail safe affordability

Long-term and ongoing affordability of mandated coverage costs to employees, employers and the state tax payer is essential to the viability of this proposal. The proposal makes a substantial amount of new dollars available to the health care industry without imposing onerous regulatory mechanisms. There are regulatory schemes such as payroll taxes, or "pay or play" mechanisms that attempt to contain costs by increasing government's role in the financing and delivery of health care. If a comprehensive legislative solution to the coverage of the uninsured is not enacted, it is likely that such an approach will appear on the ballot in the early 1990s. Absent adoption of significant regulatory involvement on the part of state or federal government, assurances must be made that the mandate does not result in an unrestrained demand on resources. Therefore, a strong incentive is needed to engender serious cost containment efforts on the part of providers, insurers and business.

Beginning in the third year of program implementation, a three-year rolling average of California's medical inflation rate (M-CPI) will be compared to the overall California Consumer Price Index (CPI). If the M-CPI exceeds the CPI one of the following options should be adopted. Alternatively, instead of using the M-CPI/CPI "trigger" an appointed commission (e.g., CMAC) or elected official (e.g., Insurance Commissioner) could make an annual determination on whether the mandate continues to be affordable. A finding of "unaffordability" would "trigger" one of the following options.

Option A: Open CAL-CARE

The CAL-CARE Program will become available to any person or entity wishing to purchase it. The existing Medi-Cal Program has demonstrated the State's ability to contain program costs and overall expenditures via rate setting mechanisms, negotiated hospital rates, prior authorization and aggressive utilization review, low administrative costs and automated provider billing. CAL-CARE will continue to make use of these features.

Option B: Eliminate Mandate

The mandate on employers would be repealed. This option presupposes that a more stringent government-dominated system would be implemented as an alternative to the mandate.

Option C: Establish Cost Limits For Employers

The employer mandate would be defined as a specific dollar amount adjusted periodically. Employers would share this cost. The benefit package would include whatever benefits were chosen by employers and employees within the dollars available to purchase coverage.

Option D: Fair Share Fee

A fee on the gross receipts of all benefactors of an excessive medical inflation rate would be levied. The size of the fee would be varied in relation to the excess of medical inflation. Proceeds from the fee could be redistributed to payers of health care costs or to the subsidy system operated by the state for deserving businesses and employees.

B. Underwriting changes to provide available and affordable premiums:

A principal problem with an employer/employee mandate for health insurance has been the disparity in cost in the health insurance market. Under current rating and market conditions two businesses of similar size in the same industry could have differing costs under the mandate by a factor of 10 or more depending on the health history of their employees and dependents, and all with no guarantee of issuance or renewability. Something clearly must change in the small group insurance market before a mandate for health coverage would be practical. The health insurance industry in California has come forward with a proposal which makes consideration of a mandate possible.

As with all proposals of substance, the California health industry's proposal is not without controversy. Detractors have forwarded a counterproposal that combines a Medicaid buy-in concept with changes in the underwriting system not too dissimilar from what is contained in this report. A fundamental point of the detractors' proposal is that there should not be a mandate. There are two problems with the detractors' proposal. First, it assumes that businesses individually will respond to the need for health insurance for their employees. While it is true that most employers do cover their employees, it ignores the recent trend for more employees to be without coverage. This is largely a function of affordability. The detractors assume that individual employers will act counter to their economic interest. We believe that it will take a collective effort represented by the mandate to bring about the change necessary for an alteration in the economy of health care coverage. Secondly, the detractors' proposal advocates the expansion of Medicaid

as a purely government sponsored program for low-income individuals. That does nothing to address the currently existing problems in the Medicaid program, nor does it offer an option for businesses which cannot afford to purchase health insurance.

The California health insurance industry is making a genuine effort to be part of the solution to the problem of the uninsured. Policymakers look forward to the day when other parties which are benefactors of a solution will be equally as inclined to contribute to the solution. Consistent with the proposal made by California's health insurance industry, the report recommends:

- Each carrier participating in the small group (25 or fewer) market would be required to accept applications for enrollment on a guaranteed issue/guaranteed renewable basis, from any small group within the carrier's service area seeking coverage unless the carrier has a lack of delivery system capacity. Such carriers would also have to cease enrolling new large groups.

  Different classes of carriers would have different requirements:

  - "A" Carriers participate in the small group market subject either to Federal HMO Act rating restrictions, or state restrictions on rate categories and a 30 percent rate band between lowest and highest small group rates, with adjustments. "A" carriers are not subject to reinsurance assessments and may not cede expenses to the reinsurer.

  - "B" Carriers participate in the small group market; have broad flexibility in establishing rating categories; may cede a large portion of the cost of high risk small groups to the reinsurer which they collectively finance through assessments; and may not charge small group rates which exceed their lowest small group rates by more than 40 percent, with adjustments.

  - Carriers not writing small group coverage would be required to pay reinsurance assessments where the capacity of "B" carriers to pay those assessments is exceeded or where a "B" carrier demonstrates that an assessment will adversely impact its large group rates.

C. Universal pre-existing condition language

All insurance carriers doing business in the state will be prohibited from imposing pre-existing condition exclusions of longer than six months. Persons changing plans after six months will be considered to have met the pre-existing condition waiting period.

D. Employee cost sharing via premium contributions, copayments, and deductibles

- Employees will be required to pay up to 25% of the cost of premiums for individual coverage or up to 50% of the premium cost for family coverage.

- Copayments will be required for the basic plan as follows:

  - $5 per primary care office visit; no copayment for referral visits, preventive care, or maternity care.
  - $2 per outpatient prescription for generic drugs.
  - $5 per outpatient prescription for brand name drugs.
  - $50 for inpatient admission; no copayment for maternity care, readmission for the same condition within 90 days or for hospital outpatient (except emergency) services.
  - $25 per emergency room visit; no copayment if admitted to hospital (hospital copayment will apply).

Deductibles will be permitted. Unaffordable deductibles should be avoided.

E. Reforms in tort law

The direct costs of malpractice are estimated at two percent of total health care expenditures. This figure does not include the costs of "defensive medicine" (i.e., ordering of excessive or unnecessary tests). Efforts to reduce this cost inflator include:

- Require that plaintiff and defense counsel exercise reasonable inquiry into the facts and the law before taking legal action, including filing complaints. Judges would have discretion to fine lawyers for lack of reasonable inquiry.

- Provide immunity to physicians who provide emergency services to individuals with whom the physician has no

patient relationship and has no reasonable expectation of compensation.

- Clarify in statute that nothing prohibits any carrier/insurer doing business in the state from requiring mediation or arbitration prior to litigation for covered services. This will be required in CAL-CARE.

- Assure that responsible third parties or their casualty carriers reimburse health insurers for all injury-related medical expenses. Participating California health insurers will be assisted by the notice and lien provisions similar to those now in effect for Medi-Cal.

F. Develop data base to support management and evaluation of health coverage

A provider specific data collection system (similar to the hospital discharge data currently collected by OSHPD) will be developed to assist payers in managing their health care resources. Information could be collected from insurance carriers or individual physicians.

G. Hospital employment of physicians

California is the only major state which prohibits hospitals from employing physicians and charging patients for their services. The Business and Professions Code should be amended to permit any licensed health care corporation to practice medicine. This change would allow:

- o Hospitals and skilled nursing facilities to employ physician directors of patient care services to manage the independent medical staff members of those services;

- o Full-time employed physicians having offices in or adjacent to the hospital, being singularly loyal to that hospital, to have their malpractice insurance premiums paid at a much lower cost as part of the hospital's liability coverage;

- o Corporate competition among hospitals to become more intense in bidding for "Preferred Provider" designation from insurance carriers and large business enterprises endeavoring to maintain low premium costs.

- o An increasing number of private hospitals to participate in staff model HMOs.

H. Allow PHPs serving CAL-CARE enrollees to use CMAC negotiated hospital per diem rates

Those prepaid health plans which serve CAL-CARE enrollees would be allowed to purchase hospital coverage using CMAC negotiated rates for CAL-CARE enrollees, thereby benefitting from the state's purchasing power. This change will help to assure the financial viability of prepaid health plans and encourage the expansion of managed health care arrangements for CAL-CARE enrollees.

I. Drug utilization review

The inappropriate use of prescription drugs is a significant factor contributing to the cost of increasing health care expenditures. In addition, the medical community has expressed concerns regarding the adverse health impacts of drug interactions and negative side effects. Outpatient drugs are a part of the proposed minimum benefit plan. Therefore, it may be appropriate to insist on drug utilization review as a part of any health plan.

J. Reduce double coverage

The dollar value of the more costly coverage will be considered to be employee income for those persons who maintain double coverage, i.e., when both spouses receive family coverage through their employers.

The above cost containment provisions should be pursued as a matter of public policy, whether the resulting system includes an employer mandate or not. Business has repeatedly cited the spiraling cost of health insurance as the reason for not providing coverage to their employees. These reforms are critical, not only as an incentive for covering the four million unsponsored employees and their dependents, but to prevent a further erosion in the already inadequate coverage now in place.

7. Federal Cooperation

Implementation of this plan requires a federal exemption be granted to Employee Retirement Income Security Act (ERISA). The exemption will be limited to the benefit plan included in this proposal. Any changes to the mandated benefits will require further Congressional and Presidential action.

Any program which avoids the issue of an ERISA waiver is not viable. At present, the primary vehicle for avoiding an ERISA waiver is a "play or pay" system where employers "voluntarily" choose to directly provide coverage to employees and dependents (play) or pay an additional "tax," with the public sector picking up costs for providing coverage to unsponsored employees and dependents.

It is difficult to consider such a system "voluntary" when the option to not "playing" is to face a tax which is not levied on employers who do provide coverage. Determining the correct rate for the "pay" option is difficult because by definition one could assume that over time, only those employers whose actual costs are less than the pay option would opt to play. This would create an environment where the publicly funded portion of the program would constantly be underfunded, resulting in the need for constant funding adjustments.

Additionally, changes to California's Medicaid state plan and implementing state statutes will be needed to conform the current Medi-Cal scope of benefits to the mandated benefit package and to require mandatory mediation for all persons enrolled in the CAL-CARE Program.

8. Funding

It is assumed that currently existing obligations will be redirected to fund any program changes which will be required. The sources are as follows:

- The existing tax credit authorized under SB 1207 (Chapter 797, Statutes of 1989) scheduled to become operative on January 1, 1992. Current estimates are that this statute will result in a tax expenditure of $1.1 billion.

- Additional funds will become available through redirection of the existing county provided "safety net." As individuals who currently receive health services through the county provided "safety net" are converted to health insurance, some proportion of the resources will become available for this proposal. The maximum available would be half of the state funds now expended for local medically indigent programs. This amount is approximately $700 million.

- Additional federal funds will be available as a result of the Medi-Cal rate adjustments and through any federal participation for those family units which are covered through insurance and who are determined to be eligible for CAL-CARE. The total is at least $320 million.

- $80 million will become available as the existing Medi-Cal benefit schedule is adjusted to reflect the mandated schedule of benefits contained in this proposal.

This information is summarized in Chart 2, attached.

CHART 1: FEDERAL POVERTY LEVEL INDEX

1989

Size of Family (adults & Children)	100% FPL	200% FPL	300% FPL
1 person	$ 5,980	$ 11,960	$17,940
2 people	8,020	16,040	24,060
3 people	10,060	20,120	30,180
4 people	12,100	24,200	36,300
5 people	14,140	28,280	42,420
6 people	16,180	32,360	48,540
7 people	18,220	36,440	54,660
8 people	20,260	40,520	60,780
for each add'l person,:	2,040	4,080	6,120

Chart 2: Resource Allocation

Available Funds ($ in millions)

$1,100	Tax expenditure value of existing SB 1207 tax credit
0 - 700	Redirection of existing local medically indigent program funds
80	Savings from M/C benefit conformity
320	New federal funds for M/C rate increase
$1,500 - 2,200	

Proposed Expenditures ($ in millions)

$860 - 1,560	Employer and employee subsidies and revised SB 1207 tax credit
640	M/C Rate Increase
$1,500 - 2,200	

Basic Benefits to Cover Essential Health Care Needs

The mandated basic benefit package could include:

a. Hospital inpatient care for a period of at least 30 days of hospitalization in a hospital licensed pursuant to subdivision (a) of Section 1250 of the Health and Safety Code in each calendar year, including all of the following:

   1. Semi-private room and board, including meals; private room and special diets when prescribed as medically necessary; and general nursing services.

   2. Hospital services, including use of operating room and related facilities, intensive care unit and services, labor and delivery room; anesthesia; radiology, laboratory and other diagnostic services.

   3. Drugs and medications administered while an inpatient.

   4. Dressings; casts; equipment; oxygen services; and radiation therapy.

   5. Inhalation therapy following prior authorization.

b. Medical and surgical services, which shall be provided on an out-patient basis when medically appropriate, including all of the following:

   1. Surgical services performed by a physician and surgeon licensed pursuant to Chapter 5 of Division 2 of the Business and Professions Code or the Osteopathic Initiative Act, or by a podiatrist within his or her scope of practice.

   2. Radiology, nuclear medicine, ultrasound, laboratory and other diagnostic services.

   3. Dressings, casts and use of castroom; anesthesia and oxygen services when medically necessary.

   4. Blood derivatives and their administration, and whole blood when a volunteer blood program is not available to the enrollee.

   5. Home, office, and hospital visits by a physician and surgeon licensed pursuant to Chapter 5 of Division 2 of the Business and Professions Code or the Osteopathic Initiative Act, or by a podiatrist within his or her scope of practice.

6. Radiation therapy; chemotherapy of proven benefit.

7. Preventive services for health maintenance of minors, including well-child examinations, health evaluations, physical examinations for early detection and diagnosis of disease or other conditions, and immunizations and vaccinations in accordance with the Guidelines for Health Supervision of Children and Youth as adopted by the American Academy of Pediatrics in September 1987.

8. Medical and surgical consultation by a physician and surgeon licensed pursuant to Chapter 5 of Division 2 of the Business and Professions Code or the Osteopathic Initiative Act, or by a podiatrist within his or her scope of practice.

9. Sterilization.

10. Nothing in this section shall preclude the use of advance practice nurses in providing covered services.

c. Comprehensive maternity and perinatal care, including the services of a physician and surgeon licensed pursuant to Chapter 5 of Division 2 of the Business and Professions Code or the Osteopathic Initiative Act all necessary hospital services. Nothing in this section shall preclude the use of advance practice nurses in providing covered services.

d. Emergency care, including emergency ambulance transportation.

e. One hundred days of skilled nursing, and home health care benefits limited to skilled home nursing services provided on a part-time, intermittent basis as prescribed by the patient's physician.

f. Hospice services.

g. Plastic and reconstructive services limited to the following:

1. To correct a physical functional disorder resulting form a congenital disease or anomaly;

2. To correct a physical functional disorder following an injury or incidental to surgery covered by the basic health care coverage;

3. For reconstructive surgery and associated procedures following a mastectomy which resulted from disease, illness or injury. Internal breast prostheses required incidental to the surgery will be provided.

h. Preventive care including periodic routine physical exams and proven preventive procedures and screenings for well-children in accordance with the Guidelines for Health Supervision of Children and Youth as adopted by the American Academy of Pediatrics in September 1987, when prescribed by a physician and surgeon licensed pursuant to Chapter 5 of Division 2 of the Business and Professions Code or the Osteopathic Initiative Act.

i. Mental health benefits, including all of the following:

1. Inpatient care or acute residential care for a period of at least 10 days in each calendar year.

2. At least 15 outpatient visits in each calendar year.

j. Prescription drugs, limited to drugs approved by the federal Food and Drug Administration for approved indications, generic equivalents listed as substitutable in the federal Food and Drug Administration publication, "Approved Drug Products With Therapeutic Equivalence Evaluation."

Plans may impose cost containment measures such as use of generics or a formulary on this service.

k. At least 10 outpatient visits in each calendar year for speech, occupational and/or physical therapy.

l. Preventive child dental services.

SERVICES NOT REQUIRED AS PART OF MANDATE: The following services will not be required as part of mandated basic benefits. Coverage of such services will remain subject to labor negotiations, individual choice, or the out-of-pocket responsibility of individuals.

a. Services which are not medically necessary for the diagnosis, treatment or prevention of injury or illness, or to improve the functioning of a malformed body member, even though such services are not specifically listed as exclusions;

b. Any services which are received prior to the enrollee's effective date of coverage;

c. Custodial, domiciliary care, or rest cures for which facilities of an acute care general hospital are not medically required. Custodial care is care that does not require the regular services of trained medical or allied health professionals and that is designed primarily to assist in activities of daily living. Custodial care includes, but is not limited to, help in walking, getting in and out of

bed, bathing, dressing, preparation and feeding of special diets, and supervision of medications which are ordinarily self-administered;

d. Personal or comfort items, or a private room in a hospital unless medically necessary;

e. Emergency facility services for non-emergency conditions;

f. Medical, surgical (including implants and transplants), or other health care procedures, services, drugs or devices which are either: 1) not recognized in accord with generally accepted medical standards as being safe and effective for use in the treatment in question, or 2) outmoded, not efficacious or not sufficiently cost effective to be covered by the basic benefit package.

g. Transportation except as specified in subdivision (d) of listed benefits.

h. Implants, except pacemakers, intraocular lenses, and artificial hips.

i. Any transplants and directly associated services for the patient and donor, including, but not limited to, organ, bone marrow, skin and cornea;

j. Prescription and non-prescription drugs, except those provided as an in-patient hospital benefit and as specified in subdivision (j) of listed benefits. Any exclusion of drugs and medicines also excludes their administration;

k. Sex change operations; investigation of or treatment for infertility; reversal of sterilization; conception by artificial means; and contraceptive supplies and devices;

l. Eyeglasses, contact lenses (except the first intraocular lens following cataract surgery); routine eye examinations, including eye refractions, except provided as part of a routine examination under "preventive care;" hearing aids; orthopedic shoes; orthodontic appliances; and routine foot care;

m. Speech, occupational and physical therapy except as specified in subdivision (k) of listed benefits;

n. Durable medical equipment including, but not limited to, hospital beds, wheelchairs, walk-aids, or other medical equipment and supplies not specifically listed in the schedule of benefits, except while in the hospital;

o. Dental services and services for temporomandibular joint problems, except as specified in subdivision (l) of listed benefits and for repair necessitated by accidental injury to sound natural teeth or jaw, provided such repair commences within 90 days of the accidental injury or as soon thereafter as is medically feasible and provided the enrollee is eligible for covered services at the time that services are provided.

p. Mental health services except as specified in subdivision (i) of listed benefits.

q. Treatment of chemical dependency, except for acute in-patient detoxification.

r. Obesity treatment; weight loss programs.

s. Cosmetic surgery, including treatment for complications of cosmetic surgery, except as specifically provided in subdivision (g) of listed benefits.

t. Medical services received from or paid for by the Veterans' Administration; benefits to the extent that benefits are payable under the terms of any automobile medical, automobile no-fault or liability, under-insured or uninsured motorist or similar contract of insurance; benefits paid under the Workers' Compensation Act or any employers' liability law or federal law for the injury or illness.

u. Conditions resulting from acts of war (declared or not);

v. Any service or supply not specifically listed as a covered service.

This benefit package is not to be construed to prohibit a carrier's ability to impose cost control mechanisms such as prior authorization.

feb

RECOMMENDATIONS TO THE CONGRESS

BY

THE PEPPER COMMISSION

U.S. BIPARTISAN COMMISSION ON COMPREHENSIVE HEALTH CARE

"Access to Health Care and Long-Term Care for All Americans"

March 2, 1990

Summary: Recommendations on Access to Health Care

THE PEPPER COMMISSION PROPOSAL ASSURES UNIVERSAL HEALTH CARE COVERAGE FOR ALL AMERICANS THROUGH A JOB-BASED/PUBLIC SYSTEM.

1. Businesses with 100 or fewer employees are encouraged to provide health insurance for their employees and non-working dependents.

   * To make insurance more available and affordable:

     -- The private insurance market is reformed.
     -- A minimum package is available.
     -- Tax credits/subsidies for certain small employers are available.
     -- Self-employed and unincorporated businesses can deduct 100% of their premiums.

   * If employers purchase coverage and achieve a specified coverage target, there is no requirement to provide private insurance or participate in the federal public health insurance plan ("public plan").

2. All businesses with more than 100 employees must provide private health insurance (for a specified benefit package) or contribute to the public plan for all employees and non-working dependents.

3. The public plan will cover employees and dependents that contribute and non-working individuals who buy in or are subsidized.

   * The plan replaces Medicaid for the specified services and pays providers according to Medicare rules.

   * The fully phased-in plan is financed and administered primarily by the federal government, although states can opt to administer it.

4. The minimum benefit package includes primary and preventive care, physician and hospital care and other services. Services are subject to cost-sharing, with subsidies for low-income people and limits on out-of-pocket spending.

5. System reforms include measures to contain costs, assure quality and initiate innovative delivery systems for the underserved.

6. For both administrative and fiscal reasons, the plan will be phased in, beginning with making coverage available for children through the public plan.

7. At full implementation, all Americans will be required to have health insurance through their employer or the public plan.

Phase-In Schedule and Cost of the Commission Health Care Proposal

(Dollars are in Billions, 1990)

Year 1

- Initiate Insurance Reforms.
- Allow all uninsured pregnant woman and children through age 6, to enroll in the public plan (fully subsidized to 185 percent of poverty).
- Raise Medicaid reimbursement rates for obstetrical and pediatric care.

Total Net New Federal Cost:	$3.4
% of Americans Without Health Insurance:	14%

Year 2

- Firms with fewer than 25 employees and average payrolls below $18,000 become eligible to receive a 40% tax credit/subsidy for the cost of health insurance that is provided. Employees of these firms with family income of less than 200 percent of poverty receive a subsidy.
- Public plan is available to uninsured children up to age 18.
- Improve physician reimbursement.

Total Net New Federal Costs:	$13.5-16.8
Additional Cost from Year 1:	$10.1-13.4
% of Americans Without Health Insurance:	8%-11%*

Year 3

- Firms with 100 or more employees are required to provide health insurance or contribute a portion of payroll to cover employees and dependents in the public plan.

Total Net New Federal Costs:	$17-20.3
Additional Cost from Year 2:	$3.5
% of Americans Without Health Insurance:	6%-8%*

Year 4

- If 80% of uninsured employees of firms with 25-100 employees (as of year 1) are not insured through their employers, along with their dependents, all employers of this size are required to provide coverage or contribute toward the cost of their coverage in the public plan.
- Raise Medicaid hospital reimbursement rates.

Total Net New Federal Costs:	$19.8 - 23.1
Additional Cost from Year 3:	$2.8
% of Americans Without Health Insurance:	5%-7%*

Year 5

- o If 80% of uninsured employees of firms with fewer than 25 employees (as of year 1) are not insured through their employers, all employers of this size are required to provide coverage or contribute toward the cost of their coverage in the public plan.
- o Allow all uninsured adults into the public plan.
- o Retain subsidy to small firms with low wage employees.

Total Net New Federal Costs:	$31.8
Additional Cost from Year 4:	$11.8
% of Americans Without Health Insurance:	0%**

Year 6

- o Retain subsidy to small firms with low wage employees and their employees.

Total Net New Federal Costs:	$31.8
Additional Cost from Year 5:	$0

Year 7

- o Eliminate explicit subsidy to small firms with low wage workers and their employees.

Total Net New Federal Costs:	$23.4
Additional Cost from Year 6:	($8.4)

* Depends on how many smaller firms voluntarily choose to purchase health insurance.

** If 80 percent of uninsured workers and their dependents in firms of fewer than 25 are now insured the Secretary of Health and Human Services must submit to Congress a plan to insure any remaining uninsured. If employers with fewer than 25 do not meet this target, then the imposition of a requirement to cover all workers and their dependents or contribute to a public plan will ensure that all Americans now have health insurance.

Summary: Recommendations on Long-Term Care

THE PEPPER COMMISSION PROPOSAL PROVIDES HOME AND COMMUNITY-BASED LONG-TERM CARE SERVICES AND PROTECTION AGAINST IMPOVERISHMENT FOR PEOPLE IN NURSING HOMES.

1. The plan has three components.

   * Severely disabled persons of all ages are eligible for social insurance for home and community-based care.

   * The plan establishes a Nursing Home Program (NHP) for nursing home care to provide an ample floor of financial protection, ensuring that no one faces impoverishment.

   * In addition, all nursing home users are entitled to social insurance for the first three months of nursing home care. This "front-end" insurance allows people who have short stays to return home with resources intact.

2. Financing and administration

   * The federal government finances the home and community-based care program and the three-month "front-end" nursing home care.

   * The federal and state governments share financial responsibility for the NHP.

   * All three components of the plan are administered by the states according to federal guidelines.

   * States are responsible for cost containment, quality assurance and consumer protection within federal standards.

3. Private sector role

   * Private long-term care insurance fills gaps not covered by this plan, subject to government standards and oversight.

   * The federal government encourages the development of private long-term care insurance through clarification of the tax code.

4. The benefits will be phased in over time.

Phase-In Schedule and Cost of Commission Long-Term Care Proposal

(Dollars are in Billions, 1990)

Phase I

- Home Care to 200 hours per year

Home Care	$10.8
Nursing Home Care	$ 0.0
Total Costs Phase I	$10.8

Phase II

- Implement 3 Month Front-end Nursing Home
- Implement Nursing Home Program

Home Care	$10.8
Nursing Home Care	$12.8
Net Increase From Phase I	$12.8
Total Costs Phase II	$23.6

Phase III

- Increase Home Care to 400 hours per year
- Begin to Improve Nursing Home Reimbursement Rates

Home Care	$18.6
Nursing Home Care	$15.6
Net Increase From Phase II	$10.6
Total Costs Phase III	$34.2

Phase IV (Year 4)

- Fully Implement the Home Care Program
- Further Improve Nursing Home Reimbursement Rates

Home Care	$24.0
Nursing Home Care	$18.8
Net Increase from Phase III	$ 8.6
Total Costs Phase IV	$42.8

Net New Federal Costs of the Commission Proposal
(Billions of Dollars, 1990)

SOURCE OF EXPENDITURE	
Access to Health Care	
Public health insurance of non-workers	$12.4
Federal Contribution to the public plan	6.3
Tax Expenditure	6.7
Augmented Medicaid Physician and Hospital Payments	4.0
Less savings from Medicare, CHAMPUS, Medicaid	(6.0)
Sub-Total (Access to Health Care)	**$23.4***
Access to Long-Term Care	
Home Health Care for the Severely Disabled Elderly (includes cost-sharing)	15.0
Home Health Care for the Severely Disabled Non-Elderly (includes cost-sharing)	9.0
Nursing Home Care for the Severely Disabled Elderly	16.8
Nursing Home Care for the Severely Disabled Non-Elderly	2.0
Sub-Total (Access to Long-Term Care)	**$42.8**
Total Net New Federal Expenditures	**$66.2****

*Phase-in plan includes the cost of temporary tax credits/subsidies for certain small businesses. Those costs are not reflected in these totals, which represent the cost at full implementation.

**Program costs are larger than the net new federal expenditures. On health care, states maintain Medicaid spending on services absorbed by the new public plan. On long-term care, states share in the cost of the Nursing Home Program with initial amounts equivalent to state Medicaid spending on long-term care services covered by the overall plan.

Structure of Job-Based/Federal Public Health Insurance Plan

1. Employer Responsibilities (in businesses with more than 100 employees and smaller businesses only if a specified coverage target is not met):

   * All businesses are required to provide private health insurance for at least the specified benefit package to all employees (and non-working dependents) or contribute to the public plan on their behalf.

   * If employers choose to provide private insurance, they must pay at least 80% of the premium for full-time workers and their non-working dependents and a share of the premium for part-time workers and their non-working dependents.

   * Alternatively, employers may contribute to the public plan for coverage for their employees and non-working dependents. The contribution will be equal to a percentage of payroll. The percentage will be set at a level that encourages employers who now purchase private insurance to retain that coverage and establish a fair balance of additional coverage responsibilities between the private and public sectors.

   * Employers may choose to purchase private insurance for their full-time workers and contribute to the public plan for part-time workers.

2. Individual responsibilities

   * All workers receive the specified benefit package through their own employer, although they may receive extra benefits from their spouse's employer. Rules, consistent with tax policy, determine the plan to which children are assigned.

   * Individuals pay up to 20% of the premium for private insurance.

   * To participate in the public plan, individuals who are working pay a percentage of wages as their share of the premium. Self-employed and non-working individuals pay the cost of the plan, subject to their ability to pay. People with incomes below 100% of poverty pay nothing and no one with an income below 200% of poverty would pay more than three per cent of income for the premium for adults or one percent of income for the premium for children and pregnant women.

   * For low income people, whether covered by the public plan or private insurance, premiums and cost-sharing are subsidized by the federal government. Individuals or families whose income is under 100% of the federal poverty level pay no premiums, deductibles or coinsurance. Individuals or families whose income is up to 200% of poverty at a minimum will pay premiums, deductibles and coinsurance on a sliding scale.

* At full implementation, individuals must obtain health insurance through their employer or the public plan.

3. Public Plan

* At full implementation, the public plan is financed and administered primarily by the federal government. As under Medicare, insurers may administer claims and may, under contract, offer managed care options. States also may administer claims.

* The public plan pays providers for the specified services with rates set according to the rules of the Medicare program.

* The public plan subsumes Medicaid for the specified benefits. Medicaid remains intact for all services not covered by the package.

* Participation in the public plan is financed through:

  -- employer contributions
  -- individual contributions
  -- federal revenues
  -- state contributions equal to Medicaid expenditures for covered services, adjusted for general inflation

4. State Role

* State governments no longer have responsibility for providing the specified benefit package for their low income residents. The new public plan replaces Medicaid for those services. Medicaid is retained for services not included in the package.

* States contribute to the public program as specified above.

* A state, at its option and subject to federal rules, can administer the public plan. All aspects of the administration must be conducted through a new agency which is unconnected to the welfare or Medicaid departments.
* States retain the responsibility for regulating financial stability of insurers.

5. Specified Benefit Package

* Basic services including hospital and surgical services, physician services, diagnostic tests and limited mental health services (45 inpatient days and 25 outpatient visits).

* Preventive services including prenatal care, well-child care, mammograms, pap smears, colorectal and prostate cancer screening procedures and other preventive services that evidence shows are effective relative to cost.

* Early, periodic, screening, diagnosis and treatment services (EPSDT) are included for children in the public program. Privately insured families can buy this coverage for their children from the public plan at cost (or at a subsidized rate for families under 200% of poverty).

* Deductibles are $250 for an individual and $500 for a family. Coinsurance is 20% for all services except prenatal care, well-child care, mammograms and pap smears, which have no coinsurance, and limited mental health services which have 50% coinsurance. The maximum a person or family must spend out of pocket is $3,000 in a year.

* One year after the effective date of this plan, the Office of Technology Assessment shall report to the Secretary on an assessment of the cost-effectiveness of prescription drugs for the purpose of inclusion in the benefit package as a preventive service.

Assistance for Small Business

1. Insurance reforms and a minimum benefit package will make obtaining private insurance for small groups more predictable and affordable. (See below.)

2. To stimulate voluntary coverage, employers with fewer than 25 workers and average payroll below $18,000 will be eligible for tax credits/subsidies for 40% of the cost of health insurance for workers and their dependents. After the tax credit/subsidy for employers of ten employees or less ends, businesses of ten employees or less, previously eligible for the credit, who are at extreme financial risk would be allowed to purchase coverage from the public plan at a percentage of payroll. This specific percentage of payroll would be consistently set at a relatively low rate to ensure affordability.

3. No employer with fewer than 100 workers would be required to purchase coverage or contribute to the cost of coverage if coverage targets were met voluntarily. (See phase-in schedule for details.)

Insurance Market Reform

1. For all employment-based health insurance:

   * No pre-existing conditions exclusions.

   * No denial of coverage for any individual in the group.

2. For those who wish to sell a health insurance product to employers in the small group market new rules would apply:

   * Guaranteed acceptance of all groups wishing to purchase insurance.

   * Insurers would set rates on the same terms to all groups in specified areas.

* Rates may not be increased selectively for any group enrolled in a plan.

* Enrollment would be for a specified minimum period.

* States would be restricted from regulating the content of health insurance benefits, but benefits would be standardized, to the extent possible, across carriers. At least one basic benefit package would have to be offered by each insurer in the small group market.

* Managed care plans would be required to be offered to small groups if such plans are available to larger employers in the area.

* A self-financed voluntary reinsurance mechanism through which insurers could reinsure high-risk persons or groups would be established.

Quality Assurance

1. The federal government should develop and implement a comprehensive national system of quality assurance which includes:

   * The development of national practice guidelines and standards of care, already begun by the newly created Agency for Health Care Policy and Research. Physicians and physician organizations should be widely utilized in establishing and reviewing practice guidelines and standards of care.

   * The development and implementation of a uniform data system that covers all health care encounters, regardless of payment source or setting. These data would provide a common foundation for all payers' quality assessment activities and for examining the effectiveness of medical care and identifying health policy and research concerns.

   * The development and testing of new, more effective methods of quality assurance and assessment.

   * The development and oversight of local review organizations that have skills in data integration and analysis, quality assessment and quality assurance.

2. The appropriate committees of jurisdiction in Congress should hold hearings on the malpractice issue. The Prospective Payment Assessment Commission and the Physician Payment Review Commission will be directed to review costs under the new program. The cost containment commission described below will convene experts, providers, lawyers and consumers to study and conduct demonstration projects related to medical malpractice reform in order to make recommendations to Congress on actions to be taken on the federal level.

Cost Containment Initiatives

1. Insuring all Americans through a job-based/public program and reforming the private insurance market will distribute the costs of insurance more fairly by:

   * Reducing the cost-shift that now occurs from the uninsured to the insured population.

   * Reducing the cost-shift that now occurs from employers who do not provide insurance to employers who cover their workers and dependents.

   * Assuring small business access to a minimum benefit package at predictable rates, regardless of employees' health status.

2. Adoption of a quality assurance strategy (described above) and reform of the medical malpractice system will assure greater value for the dollar in the delivery of medical services.

3. Measures to promote efficiency in provider payment would include:

   * Cost-sharing in the minimum benefit package that makes consumers sensitive to price.

   * Insurance reform that leads insurers to compete around efficient service delivery, rather than competing for "good" risks.

   * Extending "managed care" to small employers and including "managed care" as a means to provide the minimum benefit package in private insurance and the public plan.

   * Extending Medicare payment rules to the public program, which, in turn, serves as a model for private insurance.

   * Recommending that the appropriate committees of jurisdiction in Congress hold hearings on the costs associated with medical malpractice liability, that the Prospective Payment Assessment Commission and the Physician Payment Review Commission review costs under the program proposed by the Commission and that a National Cost Containment Commission, made up of experts, public and private payers, providers and consumers, be created to assess cost experience and initiatives to contain costs in the public and private sectors and to make periodic recommendations to the Congress on federal initiatives.

Delivery Issues

1. Expanding health care insurance coverage should reinforce --not replace -- support for primary care delivery systems targeted at the poor and underserved. Organized primary care providers (e.g., local health departments and community health centers) should be recognized and reimbursed by private and public payors on the same basis as all other providers.

2. The federal government should:

* Promote an adequate supply and appropriate mix of personnel and facilities for underserved areas and populations through mechanisms including:

  -- Provider payment methods in public programs that promote the availability of primary care practitioners and facilities and assure access to other needed services;

  -- Special initiatives (such as the National Health Service Corps and other financial incentives) to attract a range of providers (physicians and other practitioners) to underserved areas, and to assist such providers through mechanisms such as professional backup systems and support networks for rural providers (e.g., telecommunications with other professionals and facilities, mobile medical services).

* Support local efforts to develop outreach and facilitating services, for example, health education, transportation, home visiting, and translation services -- preferably linked to health care delivery programs -- to facilitate access to services and to encourage patients to seek and continue participation in health care.

* Support local efforts to reduce organizational and bureaucratic barriers to access through efforts such as the coordination and/or co-location of medical, welfare and social services (e.g., medical referrals, nutrition counseling and eligibility determinations for welfare and housing programs).

* Undertake and support research and evaluation efforts to determine the effectiveness of primary care models and services aimed at addressing the needs of underserved communities.

* Support programs of health promotion, disease prevention, risk reduction and health education toward the reduction of excess morbidity and mortality and toward the increase of healthy lifestyles. Federal support for such programs should total at least $1 billion annually beyond current federal efforts.

* Support an effective continuum of care, including short-term hospital-based and/or longer-term community based alcoholism and other drug treatment services.

<u>Phase-In Schedule</u>

<u>Phase I (Year 1)</u>

* Institute insurance reform.

* Allow all uninsured pregnant women, and children ages 0-6, to enroll in public plan, if they are from non-working families or in families of workers whose employers do not provide coverage. Costs would be subsidized, according to ability to pay, at least for those with family incomes below 200% of poverty.

* Begin to improve reimbursement to providers for persons now served by Medicaid.

Phase II (Year 2)

* Firms with 0-25 workers and average payrolls below $18,000 become eligible to receive a 40% tax credit/subsidy for cost of coverage if they provide it. The subsidy would be available for five years.

* The public plan is made available to uninsured children up to age 18 (those from non-working families or families where workers' employers do not offer coverage). Subsidies would be available based on ability to pay, at least for those with family incomes below 200% of poverty.

Phase III (Year 3)

* Firms with 100 or more workers are required to provide private insurance coverage or contribute a portion of payroll toward the cost of covering employees and dependents in the public plan.

Phase IV (Year 4)

* If 80% of uninsured employees of firms with 25-100 workers (as of Year 1) are not insured through their employers, along with their dependents, all employers of this size are required to provide private insurance coverage or contribute toward the cost of their coverage in the public plan.

* If coverage target is met, the Secretary of Health and Human Services is required to recommend to Congress ways to cover those still left out.

Phase V (Year 5)

* If 80% of uninsured employees of firms with 0-25 workers (as of Year 1) are not insured through their employers, all employers of this size are required to provide coverage or contribute toward the cost of their coverage in the public plan.

* If coverage target is met, the Secretary of Health and Human Services is required to recommend to Congress ways to increase coverage options for employees (and their non-working dependents) who are not covered by their employers.

* All non-working adults are covered through the public plan.

Phase VI (Year 6)

* Congress considers the Secretary's recommendations.

* All individuals are required to have insurance coverage through their employers or through the public plan.

Revenues for Health Care

A. Although some of the revenues necessary to support the above recommendations could come from savings achieved elsewhere in the federal budget, the Commission is committed to raising whatever additional revenues are necessary.

B. In considering what revenue options to adopt, the Commission recommends that the choice be guided by the following three criteria:

1. The final tax package ought to be progressive, requiring a higher contribution from those most able to bear increased tax burdens. That is, families with higher incomes would be asked to contribute a greater share of their incomes than required of lower income families.

2. Since persons of all ages would benefit, persons of all ages should contribute to financing the recommendations.

3. Revenues chosen should grow fast enough to keep up with benefit growth so that new sources of revenue will not need to be enacted over time. Rates of growth would need to be in excess of 8% to 9% per year.

C. Various combinations of revenue sources may be used that together meet these criteria even if individual tax sources may fall short in one category.

Structure of the Plan

1. Social Insurance for Home and Community-based Care

* Severely disabled individuals of all ages are eligible for this program. This includes individuals who need hands-on or supervisory assistance with three out of five ADL's (Activities of Daily Living) (eating, transferring, toileting, dressing, bathing), or who are severely cognitively impaired.

* Eligibility is determined by a state/local government or federally-funded non-profit assessment agency using standardized assessment criteria. This agency conducts annual audits of case managers (described below) and monitors the quality of care.

* Case managers determine the number of hours of care and mix of services the beneficiary receives.

  -- The case manager develops an individual care plan tailored to needs of the beneficiary. The availability of informal supports is included in the decision to allocate resources.

  -- The case manager operates within a budget set by the federal government, and conducts periodic reassessments of the beneficiary with special consideration to be given to cost containment. The case manager budget, in conjunction with other available services, will be sufficient to provide all services, needed by the patient.

* The benefits include:

  -- Home health care
  -- Physical, occupational, speech and other appropriate therapy services.
  -- Personal care services (feeding, transferring, personal hygiene)
  -- Homemaker chore services (meal preparation, laundry, housework)
  -- Grocery shopping and transportation
  -- Medication management
  -- Adult day health and social day care
  -- Respite care for caregivers
  -- Cost-effective training of family members for delivery of home-based family care, and support counseling of family caregivers.

2. Nursing Home Program (NHP)

* Individuals of all ages who are determined eligible for nursing home care by a federally certified assessment agency are covered by this program for the entire length of their stay.

* The plan treats income and assets as follows:

  -- The plan protects $30,000 in non-housing assets for single individuals and $60,000 for couples.
  -- The plan provides a housing allowance equal to 30% of monthly income for the first year of a nursing home stay for single persons and, for married persons, as long as the spouse is alive, but at least a year.
  -- The plan provides a $100/month personal needs allowance.
  -- The plan provides income protection for the spouse living in the community up to 200% of the poverty level for a couple.
  -- Any remaining income goes toward the cost of the nursing home care.

3. Three-Month Front-end Coverage: Protection to Return Home

* All nursing home users are covered for the first three months of care with full protection for their income and assets, except for a modest copayment.

* Benefits include:

  -- Skilled nursing care
  -- Custodial care

Individual Role

1. Home and Community-based Care

* Individuals pay 20% of the costs of care up to a maximum of the national average cost of home and community-based care.

* The federal government subsidizes the coinsurance at least for persons with incomes below 200% of the federal poverty level.

2. Nursing Home Program

* Individuals contribute their income toward the cost of care minus the housing and personal needs allowances.

* Individuals contribute non-housing assets above $30,000 for single persons and $60,000 for married persons.

3. Three-month "Front-end" Nursing Home Care

   * Individuals pay 20% of the costs of care up to a maximum of the national average cost of nursing home care.

   * The federal government subsidizes the coinsurance at least for persons with incomes below 200% of the federal poverty level.

Financing

1. The federal government is responsible for the home and community-based care program and the three-month "front-end" nursing home care program.

2. The federal and state governments share the financial responsibility for the NHP.

Administration

1. The federal government contracts with states to administer all three components of the plan.

2. The federal government sets standards and guidelines for administration. These include the following:

   * Standardized assessment criteria for determining eligibility for home and community-based care and nursing home care.

   * Certification of assessment agencies.

   * Guidelines for certifying case managers.

   * Determination of case manager budgets.

   * Determination of provider payment rates for home and community-based care and nursing home care.

3. State administrative functions include the following:

   * Building on the current infrastructure for management and delivery of services, where long-term care programs already exist.

   * Designing and implementing the system for managing and delivering services, in states without existing programs.

   * Certifying providers.

   * Establishing the review and appeals process.

Private Sector Role

1. Private long-term care insurance fills gaps not covered by this plan.

2. The federal government encourages the development of private long-term care insurance through clarification of the tax code. This includes:

   * Treating, for tax purposes, the premiums paid and the benefits received as health insurance.

   * Enabling qualified long-term care policies to be sold in employers' cafeteria plans.

3. The federal and state governments share responsibility for standards and oversight of the private long-term care market.

   * The federal government establishes minimum standards which private long-term care policies must meet to be eligible for the tax clarification. It establishes methods of disseminating to consumers non-biased, professional information regarding private long-term care policies.

   * States regulate private long-term care insurance, using federal or stricter standards. The federal government will encourage states to strengthen civil penalties for misrepresenting policy standards, knowingly selling duplicative insurance or marketing unapproved policies by direct mail. In addition, states should train benefits specialists regarding private long-term care insurance and the availability of state information on that insurance.

Phase-In Schedule

Phase I

   * A maximum of 200 hours of home care per year is made available to all severely disabled persons.

Phase II

   * The three-month "front-end" nursing home care benefit is made available to all eligible nursing home users.

   * The nursing home program is implemented providing income and asset protection for all eligible nursing home users.

Phase III

   * The maximum hours of home care available per year is increased to 400.

   * Begin to improve nursing home reimbursement rates.

Phase IV

   * The home care program is fully implemented.

   * Further improve nursing home reimbursement rates.

Research Agenda for Long-Term Care

1. The federal government should move aggressively to contain costs and mitigate human suffering by funding a research and development program aimed at preventing, delaying and dealing with long-term illnesses and disabilities. This effort should include research on outcome measures and national practice guidelines in long-term care. That effort should move toward a funding level of $1 billion annually and should do the following:

   * Explore how to reduce the risk for certain physical and mental disorders (e.g, Alzheimer's disease, osteoporosis, breast cancer, urinary incontinence) that are associated with increased need for long-term care

   * Examine how to enhance the quality of long-term care including the integration of services and case management.

   * Improve functional assessment tools to best target services to populations in need of care

   * Examine the special long-term care problems of subpopulations such as disadvantaged racial and ethnic minorities and the rural elderly and nonelderly disabled.

   * Evaluate the implementation of the home and community-based care program.

Revenues for Long-Term Care

A. Although some of the revenues necessary to support the above recommendations could come from savings achieved elsewhere in the federal budget, the Commission is committed to raising whatever additional revenues are necessary.

B. In considering what revenue options to adopt, the Commission recommends that the choice be guided by the following three criteria:

   1. The final tax package ought to be progressive, requiring a higher contribution from those most able to bear increased tax burdens. That is, families with higher incomes would be asked to contribute a greater share of their incomes than required of lower income families.

   2. Since persons of all ages would benefit, persons of all ages should contribute to financing the recommendations.

   3. Revenues chosen should grow fast enough to keep up with benefit growth so that new sources of revenue will not need to be enacted over time. Rates of growth would need to be in excess of 8% to 9% per year.

C. Various combinations of revenue sources may be used that together meet these criteria even if individual tax sources may fall short in one category.

Health Access America

The AMA proposal to improve access to affordable, quality health care

Summary of Purpose

Americans desire access to a health care system that delivers quality services to every American at affordable prices. And, we want a system that is easy to understand and use.

The American health care system is now under review by a number of groups. These reviews are being undertaken because many Americans lack health insurance coverage. The increasing cost of health insurance for many Americans who have coverage, particularly the increasing costs within the Medicare program and employment-related coverage is of increasing concern.

The physicians of America, who are represented by the American Medical Association, believe that improvements need to be made promptly to our health care system, especially addressing the access and cost problems.

Thus, the AMA has developed a proposal to ensure access to the benefits of the American health care system for every citizen. The diversity of those without insurance necessitates a broad-based approach, utilizing both the public and private sectors, to fashion solutions. Many difficult decisions regarding the allocation of society's resources will need to be made to accomplish the goal of extending access to everyone.

It is a challenge. A challenge to decide whether such expanded access is something society is willing to pay for, to transfer revenues from other programs for, and to provide sufficient support within the legislative process to bring about concrete results.

The AMA believes that a national dialogue must take place to address these challenges and critical issues. The problems facing the American health care system cannot be solved by any one organization. A collaborative process should be pursued, working with government and others.

The AMA is committed to the process of debate and negotiation. In the months ahead, we will meet with other health care providers and representatives of government, labor, business, the insurance industry and other interested groups to develop refinements and modifications to our proposal as needed.

America's physicians, committed to delivering quality care, want to work with all decision-makers toward positive solutions. We recognize that, primarily due to cost constraints, priorities will need to be established to accomplish different elements of our proposed plan. Our proposal lays out an outline for action — and the time for action is now.

In developing the specific provisions of this proposal, the AMA has considered what it believes are a number of fundamental principles that should underscore the national discussion on improving our health care system. These fundamental principles are:

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- Improvements to the American health care system should preserve the strengths of our current system.
- Affordable coverage for appropriate health care should be available to all Americans, regardless of income.
- Particular efforts are needed to assure continued access by the elderly to affordable health care services.
- Health care services should be delivered with high quality at appropriate costs.
- Patients should be free to determine from whom and the manner in which health care benefits are delivered.
- All physicians should be committed to the highest ethical standards in the delivery of care to patients.

The specific provisions of the AMA proposal build on the above principles. The specific provisions are designed to accomplish the goal of expanding access to affordable, quality health care for all Americans.

Health Access America

The AMA proposal to improve access to affordable, quality health care

Backgrounder

After several decades of scientific and technological advance, the United States has become the premier nation in providing high quality, comprehensive medical care and education. No health care system in the world can match the high caliber of medicine practiced throughout this country, nor the widespread availability of medical procedures and technology now considered common in the U.S.

However, the outstanding level of care found in our system has not provided solutions to serious problems that leave millions of Americans without health insurance coverage. Despite national spending of over $500 billion and 11 percent of the U.S. gross national product on health care each year, 33 million Americans do not have access to affordable medical insurance for themselves and their families. Public opinion polls find Americans are discontented with this inequity despite the very high level of satisfaction with the quality of medical care practiced in the United States.

Americans desire access to high quality health care services at affordable prices and a health care system that is easy to understand and use. Public opinion polls show that Americans favor a system of employer-provided health care insurance that would slow rising costs, improve access for the poor and elderly, and remove the bureaucratic paperwork that serves only to complicate and stretch the resources of the system.

Who are the uninsured? Approximately 213 million or 87 percent of Americans today enjoy access to fine health care services through private or public insurance. Unfortunately, that leaves about 13 percent or 33 million without adequate access to care because they can not afford private insurance and public assistance is unavailable. About 70 percent of the uninsured, around 24 million, are working Americans and their families. About three million persons, some of whom are employed, are considered "medically uninsurable" by private companies due to health conditions. The Medicaid system, designed to aid those below poverty levels, assists only about 40 percent of our poor, many of whom are children.

While many in our society lack sufficient access to the system, an overwhelming percentage of Americans who do have proper access are satisfied with the level of care they receive. It is a system that allows many persons to remain uninsured, and rising costs trouble many Americans.

American physicians, who are represented through the American Medical Association, share the view that improvements need to be made promptly to our health care system, especially

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addressing the access and cost problems. In basic terms, certain principles should underscore the national discussion on improving our health care system:

- **Strength.** Improvements to the American health care system should preserve the strengths of our present system.
- **Access.** Affordable coverage for appropriate health care should be available to all Americans, regardless of income.
- **Freedom.** The right to determine the manner in which health care benefits are delivered.
- **Affordability.** Health care services delivered at appropriate cost and without excessive liability costs and paperwork interference.
- **Security.** Continued access to health care for the elderly.
- **Quality.** Access to care through physicians who are committed to the highest ethical standards.

After an extensive review of the strengths and weaknesses of the American system, the AMA has developed a 16-point proposal to expand access to health care coverage to all Americans, while controlling inappropriate cost increases, and reducing paperwork and bureaucracy. Many of the elements contained in the AMA plan have already taken legislative form, such as the Medicare Reform package introduced by Rep. Charles Rose (D-N.C.). Other elements are part of a legislative approach calling for additional action to bring about needed reforms.

Primary to the AMA proposal is the belief that improving our system of health care must be based upon the strengths and successes of our present system. These strengths include:

- The vast majority of Americans are satisfied with their physicians and the health care services they receive.
- Most patients have the ability to freely choose their physician, hospital and system of care.
- Technology is widely available and science remains free to conduct research in the best interests of the patient.
- The medical education system continues to produce highly trained, competent physicians.
- Medical professionals remain free to act as patient advocates rather than agents of the government or other interests.

These strengths are the foundation on which the American Medical Association has based its proposal for reform. The individual's freedom of choice, combined with a free and independent medical profession, remain as the cornerstones of our system — a system that does not allow government to dictate choices to patients.

Clearly, our health care system needs substantive revision to provide access to every American, but it would be counterproductive to "fix" aspects of the system that work well. And so, the AMA has selected to begin a process that will ask for the participation of all interested parties — government, the insurance industry, other health care providers, and the public — contribute to the dialogue on improving the U.S. health care system.

The sixteen-point proposal

The AMA proposal is a blueprint for extending access, controlling inappropriate health care cost increases, and sustaining the Medicare program to assure proper health care for all. It is summarized as follows:

1. Effect major Medicaid reform to provide uniform adequate benefits to all persons below the poverty level.
2. Require employer provision of health insurance for all full-time employees and their families, creating tax incentives and state risk pools to enable new and small businesses to afford such coverage.
3. Create risk pools in all states to make coverage available for the medically uninsurable and others for whom individual health insurance policies are too expensive and group coverage is unavailable.
4. Enact Medicare reform to avoid future bankruptcy of the program by creating an actuarially sound, prefunded program to assure the aging population of continued access to quality health care. The program would include catastrophic benefits and be funded through individual and employer tax contributions during working years. There would be no program tax on senior citizens.
5. Expand long-term care financing through expansion of private sector coverage encouraged by tax incentives, with protection for personal assets, and Medicaid coverage for those below the poverty level.
6. Enact professional liability reform essential to reducing inordinate costs attributable to liability insurance and defensive medicine, thus reducing health care costs.
7. Develop professional practice parameters under the direction of physician organizations to help assure only appropriate, high quality medical services are provided, lowering costs and maintaining quality of care.
8. Alter the tax treatment of employee health care benefits to reward people for making economical health care insurance choices.
9. Develop proposals which encourage cost-conscious decisions by patients.
10. Seek innovation in insurance underwriting, including new approaches to creating larger rather than smaller risk spreading groups and reinsurance.
11. Urge expanded federal support for medical education, research and the National Institutes of Health, to continue progress toward medical breakthroughs which historically have resulted in many lifesaving and cost-effective discoveries.
12. Encourage health promotion by both physicians and patients to promote healthier lifestyles and disease prevention.
13. Amend ERISA or the federal tax code so that the same standards and requirements apply to self-insured (ERISA) plans as to state-regulated health insurance policies, providing fair

competition.

14. Repeal or override state-mandated benefit laws to help reduce the cost of health insurance, while assuring through legislation that adequate benefits are provided in all insurance, including self-insurance programs.
15. Seek reductions in administrative costs of health care delivery and diminish the excessive and complicated paperwork faced by patients and physicians alike.
16. Encourage physicians to practice in accordance with the highest ethical standards and to provide voluntary care for persons who are without insurance and who cannot afford health services.

Strengthening the American health care system through the elements contained in this proposal will present an enormous challenge to all concerned. For its part, the AMA intends to move forward vigorously on legislative and other fronts, as well as encouraging every interested party to join in the dialogue toward this goal. Our common objective will continue to be providing high quality care at reasonable cost, and access for every American.

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Health Access America

The AMA proposal to improve access to affordable, quality health care



American Medical Association

Health Access America

An AMA proposal to improve access to affordable, quality health care

Americans desire access to high quality health care services at affordable prices and a health care system that is easy to understand and use. Improvements to our current system are needed to meet these desires of the American people.

The American health care system is currently under review by two blue-ribbon commissions, several national medical associations, various health policy professionals, as well as by the Administration and by the Congress of the United States. Primarily, this review has been prompted because a large number of Americans lack health insurance coverage. The increasing cost of health insurance for many Americans with coverage, particularly employment-related coverage, also is of major concern, as are increasing costs within the Medicare program.

The physicians of America who are represented through the American Medical Association share the view that improvements need to be made promptly to our health care system, especially by addressing cost issues and the lack of insurance coverage.

Thus, the AMA has developed a proposal to ensure access by every citizen to the benefits of the American health care system. The diversity of those without insurance necessitates a broad-based approach, utilizing both the public and private sectors, to fashion solutions. Many difficult decisions regarding the allocation of society's resources will need to be made to accomplish the goal of extending access to health care to all Americans. This beneficial goal cannot be achieved without substantial cost.

Thus, in many ways, this proposal presents a challenge to society. A basic challenge for society is whether it is willing to pay for access to coverage by all citizens.

Societal priorities will have to be considered. Revenues may have to be transferred from current programs, or new sources of revenue found. Public support for legislation necessary to bring about concrete results will have to be stimulated, and Congress and the Administration will have to take the lead to bring the legislative goals to fruition. Are the goals of this proposal — the continuation and improvement of our health care system — worthy of the costs involved? The AMA believes the answer is an unequivocal yes.

The AMA believes that a national dialogue must take place to address these challenges and critical issues. The problems facing the American health care system cannot be solved by any one organization. A collaborative process should be pursued, working with government and others.

The AMA is committed to the process of debate and negotiation. We are discussing this proposal with other health care organizations and representatives of labor, business, the insurance industry and other interested groups, as well as the government, and we will be developing refinements and modifications as needed. America's physicians, committed to delivering quality care, want to work with government and other decision makers toward positive solutions. We recognize that modifications to our proposal will be necessary and that, primarily due to cost constraints, priorities and phase-in strategies will need to be established in the accomplishment of different elements of the proposal. But the proposal lays out an outline for action — and the time for action is now.

In developing the specific provisions of this proposal, the AMA has taken into consideration what it believes are a number of fundamental principles that should underscore the national discussion on improving the health care system in this country. These fundamental principles are:

- **Improvements to the American health care system should preserve the strengths of our current system.**
- **Affordable coverage for appropriate health care should be available to all Americans, regardless of income.**
- **Particular efforts are needed to assure continued access by the elderly to affordable health care services.**
- **Health care services should be delivered with high quality at appropriate costs.**
- **Patients should be free to determine from whom and the manner in which health care benefits are delivered.**
- **All physicians should be committed to the highest ethical standards in the delivery of care to patients.**

Each of the above principles is restated below, followed by the relevant specific points of the AMA's 16-point proposal which build upon that principle and which are designed to accomplish the goal of expanding access to affordable quality health care to all Americans. The specific 16 points are then summarized at the end of this proposal. Some elements referred to are already in legislative form — such as the Medicare Reform elements, introduced in the Congress as H.R. 2600 by Rep. Charles Rose (Dem. - N.C.). Other elements will form part of a legislative approach calling for development of legislative proposals or support for proposals already developed by others. Some elements of this proposal require further developmental work, which will be proceeding rapidly.

The AMA's Proposal

Improvements to the American health care system should preserve the strengths of our current system.

Our health care system needs improvement, but such improvement needs to be accomplished in a manner that does not jeopardize the access to quality care enjoyed by the vast majority of Americans.

Widespread health care insurance exists — but many are left uninsured

Approximately 213 million or 87 percent of all Americans today have private or public health insurance coverage providing them access to the highest quality of health care services of any country in the world. Employment-related insurance provides coverage for 60 percent of all Americans, with an additional 27 percent of Americans being covered by government programs or individual policies. Unfortunately, the fact remains that for 13 percent, or about 33 million Americans, access is limited or even unavailable because of a lack of public or private health insurance coverage [based on most recent preliminary estimates from the Bureau of the Census].

Most individuals who lack insurance coverage also lack regular contact with a physician. Without insurance, they often delay medical care until they are very sick and have no alternative but to seek treatment in clinics or emergency rooms. This, of course, is not the most desirable way to deliver care. It increases use of the most expensive care, further driving up health care costs. Delaying care can also result in additional discomfort, increased health risks and greater financial impact for the individuals involved.

Broad public satisfaction with health care

National polls demonstrate that the overwhelming majority of Americans are satisfied with their physicians and the health care services they receive. Yet a significant number are not happy with the cost of health care services, nor are they satisfied with a system that allows so many to go without health insurance. It is clear that the system requires improvement. However, efforts to improve the system should not place at risk the access to quality care currently enjoyed by the vast majority of Americans.

Additional strengths

There are a number of other strengths of our current system, including:

- The ability of most patients to choose the physician, hospital, and system of health care delivery they want.
- The widespread availability of new technologies to Americans.
- The freedom to conduct medical and scientific research in the best interests of patients and to individualize the treatment of patients according to the best interests of each patient.
- A superior medical education system, which seeks to attract the best and brightest and which provides a rigorous and comprehensive learning process to assure the public of well-trained physicians.
- An independent medical profession where physicians are able to act as patient advocates rather than as agents of the government, which is concerned mainly about the budget.

The individual patient's freedom of choice to pursue services which meet his or her health care needs, combined with a free and independent medical profession, are firmly based on the American recognition of the importance of the individual and are cornerstones for our strong American health care system. For the most part, unless the patient selects a delivery system with limited choice, our system does not restrict where or from whom the patient can seek medical services. Unlike other types of health care systems, our system does not place arbitrary limitations or overall spending caps on medical services. All of this is not to say there is no proper role for the government.

Government's role should be: (1) to encourage the private sector to provide health care coverage for the most people possible; (2) to assist the private sector to deliver the highest quality of care for the most reasonable cost; and (3) to provide financial assistance for those Americans who otherwise lack health care coverage. Clearly, to address the access problems existing today, government programs of assistance must be expanded and properly targeted. However, it would be just as clearly counterproductive if government were to extend its efforts to "fix" aspects of the system which are not broken and, in fact, are operating well.

Despite some major problems, our health care system is strong. Never before has the lifesaving medical care and technology found in our system been able to do so much for so many to improve and save lives. Despite this overall success, however, the American Medical Association is deeply committed, along with many other groups in this country, to finding solutions to the problems that do exist. We must find ways to extend needed health insurance coverage to those who lack it. We must also develop better methods to control inappropriate rising costs.

Affordable coverage for appropriate health care costs should be available to all Americans, regardless of income.

All Americans should be assured of affordable coverage of their appropriate health care costs, regardless of their income, through private insurance and through partially or fully government-financed programs for those of low income.

In order to extend coverage to those who are currently uninsured, it is helpful to understand in brief who the uninsured are. It is working Americans and their families who lack health insurance coverage that make up the large majority of the uninsured. About 24 million of the 33 million uninsured persons are workers and their families. For the most part, the remaining uninsured are unemployed persons and their families who are below the federally established poverty level but are not covered by Medicaid. Medicaid actually only covers about 40 percent of those in poverty. An additional category of the uninsured includes persons at various income levels, some of whom are employed and some of whom are not, who are considered by insurance companies as "medically uninsurable" because of health conditions. Recent estimates indicate there are about three million persons in this category.

To accomplish the extension of access to insurance coverage to those without it, several specific actions are needed:

Point 1

Effect major *Medicaid* reform to provide uniform adequate benefits to all persons below the poverty level. The AMA Medicaid Reform proposal would set new national requirements to assure that in all states persons below poverty income levels are eligible for and receive a

uniform set of adequate benefits, so that no poor person is left without access to needed health care. The AMA believes strongly that federal and state governments must assure access to and funding for medical care for persons with incomes below the poverty level.

The federal poverty level should be adjusted by a state cost-of-living modifier to assure that Medicaid eligibility truly reflects the economic realities in the various states. Income status should be the only eligibility criterion; other existing categorical requirements should be repealed. At the same time, using one national formula by which eligibility will be determined in the various states will eliminate state discretion in setting the economic level of eligibility. This will avoid perpetuating the widespread inequities existing across state boundaries in the Medicaid program today.

Medicaid benefits need to assure provision of all medically necessary physician and hospital services — and should not differ across state lines. Because of the impoverished status of Medicaid beneficiaries, added coverage for prescription drugs, rehabilitative services, and emergency services must be provided. Because unrealistically low reimbursement levels reduce access, Medicaid reimbursement levels should be increased to the Medicare level.

Recognizing the substantial costs of Medicaid expansion, some phased-in approach probably will be necessary. One initial approach would include: expanding Medicaid coverage for women and children by requiring a phased-in coverage for pregnant women and children; phasing in a requirement that Medicaid eligibility shall equal 100 percent of the poverty level (state adjusted); and creating a basic national level of Medicaid benefits that must be covered, including necessary inpatient and outpatient hospital and emergency services; rural health clinic and other laboratory and x-ray services; home health services; early and periodic screening, diagnosis, and treatment for individuals under 21; family planning; physician services; prescription drugs; and rehabilitative services.

This AMA uniform benefit package consists of the presently required services plus prescription drugs, rehabilitative services, and emergency services. States, solely at their own expense, could cover additional benefits beyond the basic national level.

There is widespread support for needed Medicaid reforms, including that evidenced by the report of the Health Policy Agenda for the American People (HPA), a broad-based group of organizations representing consumers, business, labor, government, health care professionals, hospitals and insurance companies.

Point 2

Require *employer provision of health insurance* for all full-time employees and their families, with tax help to employers. About 24 million of the 33 million uninsured are employed individuals and their families. Tax incentives must be provided and risk pools created so that new and small businesses can afford the cost of such coverage. At first only larger businesses should be subject to this requirement.

To make the transition manageable for all businesses, the program should be phased in over several years. Additional elements in a legislative program to bring about required employer coverage include:

a. Preempt state-mandated benefit laws for employer health benefit plans to assist small businesses to afford a basic program. Such plans would be required to meet minimum standards of coverage, including basic hospital, physician, diagnostic, prenatal and well-baby care, with reasonable annual limits on employees' incurred expenses for premiums, co-insurance and deductibles.

b. Amend the Internal Revenue Code or ERISA to allow states to require self-insured employers to participate in private, not-for-profit uninsured and uninsurable risk pools established pursuant to state law.

c. Establish a Federal incentive program for states to enact legislation to set up private, not-for-profit health benefit pools (including uninsurable, uninsured and small business).

d. Require such pools to offer to small businesses (less than 25 employees) access to basic benefits policy at group rates.

e. Make permanent the temporary 25 percent income-tax deduction for premiums for health benefits plans for the self-employed. Expand deduction to 100 percent of premium payment for self-employed and others who must pay 100 percent of a health benefit premium.

f. Expand COBRA continuation coverage to require employers to pay the same share of an employee health benefit premium that was paid by the employer, prior to termination, for up to four months after the qualifying event.

g. Require employers to offer an enrollment period for employees who lose coverage because a spouse or other family member lost coverage due to change of employment.

h. Eliminate provisions excluding pre-existing conditions from employee health benefit plans.

Because of the particular importance of the relationship of a basic benefits package to the affordability of required insurance, the AMA is making additional efforts to construct a package that is affordable. It is the essential basic benefits in any health insurance program which impact most on saving lives and improving the quality of life.

Point 3

Create state-level risk pools in all states to make available coverage for the medically uninsurable, for whom access to coverage is not available, and for others for whom individual health insurance policies are too expensive and group coverage is not available.

A state risk pool is a legislatively created insurance program that can be funded in a variety of ways including state tax revenues or insurance company contributions. Risk pools help assure that no American would be unable to obtain affordable health insurance because of a health condition. Small employers should have access to such risk pools so that they could acquire coverage for their employees at affordable rates if it was unavailable for a better price in the private market. Rates should be set at standard group rates. Premium assistance from the state would be provided for those persons not covered through employment and who were between 100 percent and 150 percent of the poverty level. (Only about 15 states currently have risk pools designed to make coverage available to the medically uninsurable.)

Elements of a phased-in legislative approach which can accomplish extension of access to the medically uninsurable and for those otherwise unable to obtain coverage include:

a. Requiring, as a condition of federal tax deduction, that all payors for employee health benefits (payment of premium, or direct payment for services by self-insured plan) must participate in a private not-for-profit risk pool established pursuant to state law. The pool would provide subsidized coverage for those who have been denied coverage or have lost coverage because of a medical condition and underwriting rules.

b. Allowing a 100 percent tax deduction of premium payment for individuals who purchase insurance coverage through the pool.

Particular efforts are needed to assure continued access by the elderly to affordable health care services.

To assure continued access by the elderly to affordable health care services, two major actions are needed:

Point 4

Enact Medicare reform to avoid the future financial bankruptcy of the program by creating an actuarially sound prefunded program to assure senior citizens continued access to quality health care. Today four workers' tax contributions support a single Medicare beneficiary. As our population ages, there will be only two workers paying taxes to support each beneficiary by the middle of the next century. A shrinking worker base means substantially higher premiums in the years to come. Without further support, the system will collapse. This reform measure would include a new approach to catastrophic benefits. The program would be funded through individual and employer tax contributions during working years. There would be no program tax on senior citizens and all persons reaching eligibility age would be entitled to a voucher for purchase in the private sector of a comprehensive health insurance policy meeting federal standards. Senior citizens would retain freedom to choose their system of delivery of care (e.g., fee-for-service, HMO, PPO). The creation of an enhanced trust fund beyond immediate payout needs (prefunding) would create investment income and thus end up costing taxpayers much less than continuation of the current system.

The reform elements noted above are in legislative form, introduced in the Congress as H.R. 2600 by Rep. Charles Rose (Dem.-N.C.).

Point 5

Expand *long-term care* financing through expansion of private sector coverage encouraged by tax incentives and an asset protection program, and provide Medicaid coverage for those below poverty. The "asset protection" approach in essence means that individuals who purchase long-term care insurance would be able to protect designated assets up to the dollar value of the insurance benefits from being included in any eligibility determination for Medicaid coverage for long-term care. This kind of program has been introduced in the Congress by Rep. Barbara Kennelly (Dem.-Conn.), as H.R. 4631. Sliding scale subsidies should be provided for the purchase of long-term care insurance for individuals with incomes between 100 percent and 200 percent of poverty level. Employer-provided long-term care insurance should be treated in the same tax fashion as health insurance coverage. A tax deduction or credit should be created to encourage family care giving.

A phased-in legislative approach to accomplish the above elements would call for:

a. Amending the Internal Revenue Code to allow businesses and individuals to treat payment for long-term care insurance policies in the same manner as health benefit plans are now treated.
b. Allowing individuals to deduct for income tax purposes 100 percent of the cost of long-term care insurance premiums without meeting the 7 percent floor for health costs or the 2 percent for miscellaneous deductions.
c. Amending the tax code to allow for penalty-free and tax-free withdrawals from individual retirement accounts (IRAs) for purchase of long-term care insurance policies.
d. Amending Medicaid to allow for an asset protection program so that resource eligibility requirements are adjusted to allow an individual to retain assets up to the amount that private sector insurance pays on his or her behalf for long-term care.

Health care services should be delivered with high quality at appropriate costs.

Inappropriate costs include costs for defensive medicine, excessive administrative costs which include unnecessarily complicated hurdles for patients to receive care and benefits and interfere with the doctor-patient relationship, and costs brought about by delivery of services which are outside of professionally developed practice parameters and which are not justified after appropriate peer review.

To address the above issues, certain specific actions are needed:

Point 6

Reduce health care costs through professional liability reform to reduce the inappropriate cost of such insurance and defensive medicine. Defensive medicine, the ordering of tests and procedures which might not otherwise be ordered but for liability concerns, drives up the cost of medical services. It has been estimated that liability insurance premiums and defensive medicine add about 15 percent to the average physician's bill. In addition, the AMA has developed legislative reforms and has also developed a pilot program for administrative adjudication of liability claims which is designed to lower the costs of liability insurance while preserving the rights of injured patients. Elements of a legislative approach include:

a. Support federal funding to states to demonstrate alternative dispute resolution systems for medical professional liability cases.
b. Adopt federal legislation that would establish the following selected tort reforms:
   —limitations of $250,000 or lower on recovery of noneconomic damages
   —the mandatory offset of collateral sources (e.g., health insurance and disability benefits) of plaintiff compensation
   —decreasing sliding scale regulation for attorney contingency fees
   —periodic payment for future awards of damages
   —limiting the period for tolling statutes of limitations for minors
   —requiring a certificate of merit as a prelude to filing medical liability cases
   —adoption of basic medical expert witness criteria

Such legislation should override conflicting state laws.

Point 7

Develop professional practice parameters to help assure that only high quality appropriate medical services are provided, thus impacting favorably on the quality and cost of medical care. Such parameters are professionally developed strategies for patient care developed to assist physicians in clinical decision making.

Practice parameters include guidelines, standards and other patient care strategies. Guidelines are recommendations for patient care, which may identify a particular care strategy or a range of care strategies. Standards are generally accepted principles for patient care. Practice parameters may outline a range of appropriate tests and procedures for management of a given clinical condition or may identify a range of clinical conditions for which a given procedure or treatment may be appropriate. It remains the physician's responsibility to choose what is most appropriate for the individual patient.

The primary benefit of parameters is appropriate patient care. Secondary advantages include improved use of resources, reduced liability, and better review criteria. The AMA, in conjunction with national specialty societies, is currently working diligently to facilitate the development of practice parameters, as part of its long-standing efforts to foster high quality care and appropriate utilization.

To accomplish the above goals, legislative support is needed on a continuing basis for adequate appropriations for health care assessment research and professionally developed practice parameters. One significant step in this direction has been taken in legislation enacted in 1989 (P.L. 101-239). Efforts will also seek adoption by HHS, quality assurance programs and utilization review organizations of parameters developed by professional organizations.

Point 8

Alter the tax treatment of employee health care benefits to reward people for making economical health care insurance choices. This reduces the tendency to overinsure which occurs when an excessive number of ordinary, routine and highly predictable health services are covered by insurance. The AMA supports two tax reforms to reduce incentives to overinsure. The first would place a limit on the amount of the employer-provided health insurance that is tax-exempt to the employee. The second would provide tax-exempt rebates to employees who select health insurance plans with premiums less than their employer's contribution to more expensive plans. Such plans would still be required to contain coverage for basic benefits.

Point 9

Encourage cost-conscious decisions by patients, for example, through insurance companies, employers and government programs providing patients more information, prior to service, of the amount insurance or the program will cover.

The enactment in Congress of the resource-based relative value system (RBRVS) for physician payment under Medicare, which was largely supported by AMA, ultimately should help to provide patients with information ahead of time as to what Medicare will pay for a service. This system will also create a more rational basis of physician payment under the Medicare program.

Point 10

Seek innovation in insurance underwriting, including new approaches to creating larger risk spreading groups and reinsurance.

Point 11

Urge expanded federal support for medical education, research and the National Institutes of Health (NIH), to help bring about continuing medical breakthroughs which historically have resulted in many lifesaving discoveries. The American people have benefited greatly from scientific discoveries and technological developments derived from our nation's past support for medical research. Cost-saving as well as lifesaving medical advances made in our country have improved both the quality and duration of life for countless persons both in our own nation and around the globe. We must continue to strongly support such medical research to remain on the leading edge of advancing the state of medical knowledge.

Point 12

Encourage health promotion and disease prevention. Both physicians and patients need to be encouraged to become more active participants in health promotion and disease prevention, including healthier lifestyles. Such activities favorably affect not only the extent and quality of life but also significantly reduce the cost of care. For example, one recent estimate indicates that 35 percent of all hospitalized patients are there due to an alcohol or drug abuse problem. Health-related problems due to other life-style choices, such as smoking, have been widely documented in recent years. Recent estimates by the Centers for Disease Control's Office of Smoking and Health indicate that 390,000 Americans die each year from tobacco-related illness and that the direct health care dollar costs related to such illness is about $22 billion per year. The AMA has been very active and continues to promote programs to eliminate smoking, discourage alcohol and drug abuse, reduce cholesterol, encourage better adolescent health, and other similar programs which are all aimed at improving health and reducing costs of health care.

Point 13

Amend ERISA or the federal tax code so that the same standards and requirements apply to self-insured (ERISA) plans that apply to state-regulated health insurance policies. Currently, employers who self-insure the health care of their employees are exempt from most state requirements that apply to commercial and Blue Cross/Blue Shield insurance policies. This "unequal playing field" removes the self-insured plans from equitable participation in state risk pools, leaving many people without access to affordable health insurance, including small employers. The amendment called for regarding ERISA would not mean that self-insured plans would be subject to state-mandated benefits, since another provision of this proposal calls for a repeal or override of such mandates.

Patients should be free to determine from whom and the manner in which health care benefits are delivered.

Patients should remain free to choose their physician and health care delivery system (e.g., indemnity, HMO, PPO). The individual patient's freedom of choice to pursue his or her health care needs combined with a free and independent medical profession are based on the American recognition of the importance of the individual and are the cornerstones for our strong American health care system.

Several particular actions are needed in pursuit of these goals:

Point 14

Repeal or override state-mandated benefit laws, to help reduce the cost of health insurance, while assuring through legislation that adequate benefits are provided in all insurance, including self-insurance programs. Individuals should be free to choose, at their own cost, additional coverages if desired but such coverages should not be mandated as part of all policies.

Currently, health insurance policies must comply with a myriad of mandated benefit laws in the various states — over 700 such mandates nationwide according to the Health Insurance Association of America (HIAA). The HIAA estimates that, but for such mandates, 16 percent of the small firms that do not offer health insurance would do so and that 51 percent of the firms that converted to self-insurance between 1981 and 1984 would not have done so.

Point 15

Seek reductions in the administrative costs of health care delivery and the *excessive and complicated paperwork nightmare* faced by patients and their families who seek to obtain benefits. There has developed in the last several years a burgeoning multiplicity of unrestrained insurance conditions and paperwork requirements. The frustration of physicians in dealing with the differing managed care requirements of multiple insurance companies, self-insureds, and government programs results in increased costs and interference with the physician-patient relationship.

All physicians should be committed to the highest ethical standards in the delivery of care to patients.

Point 16

Encourage physicians to practice in accordance with the highest ethical standards and to provide voluntary care. In times of strain upon the health care delivery system, where physicians are called upon to deal with multiple competing pressures — particularly from insurance carriers and the government — it is well to note that the AMA will continue its efforts to encourage all physicians to:

- Treat their patients as individuals.
- Use their best professional judgment in every case.
- Inform their patients of the benefits, risks and estimated costs of treatment.
- Treat their patients with courtesy, dignity, respect, compassion and timely attention to their medical needs.

The AMA will also continue its long-standing efforts to encourage physicians to provide health care services without charge or at reduced rates for persons who are without insurance and cannot afford health services. Numerous medical society sponsored efforts to provide free or reduced-fee care to the needy are in place in many but not all areas of the nation. However, these efforts are not enough to provide such care to all of those in need. Recent AMA surveys indicate physicians provide an average of 150 hours of care annually free of charge — coming close to $11 billion of uncharged care. Such efforts will clearly need to continue for the foreseeable future.

Summary of AMA Proposal

The elements of the AMA proposed plan may be summarized in the following 16 points:

1. Increase access by enacting major *Medicaid Reform.*
2. Increase access by requiring *employer provision of health insurance.*
3. Increase access by creating *state-level risk pools in all states.*
4. Maintain access and reduce costs for the elderly by enacting *Medicare Reform.*
5. Increase access and reduce costs for the elderly by enacting necessary legislation to *finance expanded long-term care coverage.*
6. Reduce health care costs through *professional liability reform.*
7. Maintain quality and reduce costs through *development of professional practice parameters.*
8. Reduce health care costs through *altering the tax treatment of employee health care benefits.*
9. Reduce costs by *encouraging cost-conscious decisions by patients.*
10. Reduce costs by seeking *innovation in insurance underwriting.*
11. Maintain quality through expanded *federal support for medical education, research and the National Institutes of Health (NIH).*
12. Maintain quality and reduce costs through *increased health promotion and disease prevention.*
13. Reduce costs and increase access by *amending ERISA or the federal tax code to equalize treatment of self-insured and insurance plans.*
14. Reduce costs and increase access by *repealing or overriding state-mandated benefit laws.*
15. Reduce costs by *reducing administrative costs and paperwork.*
16. Maintain quality and access through *encouraging physicians to practice in accordance with the highest ethical standards and to provide voluntary care.*

Conclusion

Accomplishing the goal of strengthening the American health care system through the elements contained in this AMA proposal will present an enormous challenge to all concerned. For its part, the AMA intends to move forward vigorously on legislative and other fronts. The AMA welcomes and encourages the support of others to help bring about an improved American health care system.

February 1990

American Medical Association
535 North Dearborn Street Chicago, Illinois 60610

ZAA:90-171:20M:3/90

101ST CONGRESS
2D SESSION

S. 2246

To amend title XVIII of the Social Security Act to provide improved medicare home health benefits, and for other purposes.

IN THE SENATE OF THE UNITED STATES

MARCH 7 (legislative day, JANUARY 23), 1990

Mr. BRADLEY (for himself, Mr. MATSUNAGA, Mr. DURENBERGER, and Mr. MOYNIHAN) introduced the following bill; which was read twice and referred to the Committee on Finance

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A BILL

To amend title XVIII of the Social Security Act to provide improved medicare home health benefits, and for other purposes.

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 "Medicare Home Benefits Improvement Act of 1990".

SEC. 2. IN-HOME RESPITE CARE FOR CERTAIN CHRONICALLY DEPENDENT INDIVIDUALS.

(a) IN GENERAL.—Section 1832(a) of the Social Security Act (42 U.S.C. 1395k(a)), as restored by section 201(a)(1)

of the Medicare Catastrophic Coverage Repeal Act of 1989, is amended—

(1) in paragraph (2)(A)—

(A) by inserting "(i)" after "(A)", and

(B) by inserting before the semicolon at the end the following: ", and (ii) in-home respite care for up to 80 hours in any period described in section 1861(jj)(4), but not to exceed 80 hours in any calendar year"; and

(2) by adding at the end the following new sentence: "In the case of in-home respite care (described in paragraph (2)(A)(ii)) provided on any day, such care provided for 3 hours or less on the day shall be counted (for purposes of the limitation in such paragraph) as 3 hours of such care.".

(b) IN-HOME RESPITE CARE FOR CHRONICALLY DEPENDENT INDIVIDUAL DEFINED.—Section 1861 of such Act (42 U.S.C. 1395x), as restored by section 201(a)(1) of the Medicare Catastrophic Coverage Repeal Act of 1989 and as amended by the Omnibus Budget Reconciliation Act of 1989, is amended by inserting after subsection (ii) the following new subsection:

"(jj)(1) The term 'in-home respite care' means the following items and services furnished, under the supervision of a registered professional nurse, to a

chronically dependent individual (as defined in paragraph (2)) during the period described in paragraph (4) by a home health agency or by others under arrangements with them made by such agency in a place of residence used as such individual's home:

"(A) Services of a homemaker/home health aide (who has successfully completed a training program approved by the Secretary).

"(B) Personal care services.

"(C) Nursing care provided by a licensed professional nurse.

"(2) The term 'chronically dependent individual' means an individual who—

"(A) is dependent on a daily basis on a primary caregiver who is living with the individual and is assisting the individual without monetary compensation in the performance of at least 2 of the activities of daily living (described in paragraph (3)), and

"(B) without such assistance could not perform such activities of daily living.

"(3) The 'activities of daily living', referred to in paragraph (2), are as follows:

"(i) Eating.

"(ii) Bathing.

"(iii) Dressing.

"(iv) Toileting.

"(v) Transferring in and out of a bed or in and out of a chair.

"(4)(A) The period described in this paragraph begins on the date that the Secretary determines that a chronically dependent individual has incurred out-of-pocket part B cost sharing (as defined in paragraph (5)(A)) in an amount equal to the part B limit (as determined under paragraph (5)(B)) for the calendar year in which such date occurs.

"(B) In the case of an individual who qualifies under subparagraph (A), if the hour limitation for the calendar year applies, the period described in subparagraph (A) shall begin on the first day of the succeeding calendar year.

"(5) For purposes of this subsection—

"(A) The term 'out-of-pocket part B cost sharing' means, with respect to an individual covered under part B, the amount of expenses that the individual incurs that is attributable to—

"(i) the deductions established under section 1833(b), and

"(ii) the difference between the payment amount provided under part B and the pay-

ment amount that would be provided under part B if '100 percent' and '0 percent' were substituted for '80 percent' and '20 percent', respectively, each place either appears in sections 1833(a), 1833(i)(2), 1834(c)(1)(C), 1835(b)(2), 1866(a)(2)(A), 1881(b)(2), and 1881(b)(3).

"(B)(i) The part B limit for 1991 is $1,780. The part B limit for any succeeding year shall be such an amount (rounded to the nearest multiple of $1) as the Secretary estimates, for that succeeding year, will reflect a level of out-of-pocket part B expenses that only 5.5 percent of the average number of individuals enrolled under part B (other than individuals enrolled with an eligible organization under section 1876 or an organization described in section 1833(a)(1)(A)) will equal or exceed in that succeeding year.

"(ii) Not later than September 1 of each year (beginning with 1991), the Secretary shall promulgate the part B limit under this subparagraph for the succeeding year.".

(c) PAYMENT.—Section 1833(a) of such Act (42 U.S.C. 1395l(a)), as restored by the Medicare Catastrophic Coverage Repeal Act of 1989, is amended—

(1) in paragraph (2), by inserting "(A)(ii)," after "subparagraphs" the first place it appears,

(2) in paragraph (3), by striking "(D)" and inserting "(A)(ii), (D),", and

(3) by adding at the end the following:

"Payment for in-home respite care for chronically dependent individuals shall be paid on the basis of an hour of such care provided. In applying paragraph (2) in the case of an organization receiving payment under subparagraph (A) of paragraph (1) or under a reasonable cost reimbursement contract under section 1876 and providing coverage of in-home respite care, the Secretary shall provide for an appropriate adjustment in the amount of payments otherwise made to reflect the aggregate increase in payments that would otherwise be made with respect to enrollees in the organization if payments were made other than under such clause or such a contract if payments were to be made on an individual-by-individual basis.

(d) CERTIFICATION.—Section 1835(a)(2) of such Act (42 U.S.C. 1395n(a)(2)), as restored by the Medicare Catastrophic Coverage Repeal Act of 1989, is amended—

(1) in subparagraph (E), by striking "and" at the end;

(2) in subparagraph (F), by striking the period at the end and inserting "; and"; and

(3) by inserting after subparagraph (F) the following new subparagraph:

"(G) in the case of in-home respite care provided during a period described in section 1861(jj)(4), the individual was a chronically dependent individual during the 3-month period immediately preceding the beginning of the period described in such section.".

(e) STANDARDS FOR UTILIZATION.—

(1) Section 1862(a) of such Act (42 U.S.C. 1395y(a)), as restored by section 201(a)(1) of the Medicare Catastrophic Coverage Repeal Act of 1989, is amended—

(A) in paragraph (1)—

(i) in subparagraph (D), by striking "and" at the end,

(ii) in subparagraph (E), by striking the semicolon at the end and inserting ", and", and

(iii) by adding at the end the following new subparagraph:

"(F) in the case of in-home respite care, which is not reasonable and necessary to assure the health and condition of the individual is main-

tained in the individual's noninstitutional residence;"; and

(B) in paragraph (6), by inserting "and except, in the case of in-home respite care, as is otherwise permitted under paragraph (1)(F)" after "paragraph (1)(C)".

(2) The Secretary of Health and Human Services shall take appropriate efforts to assure the quality, and provide for appropriate utilization of, in-home respite care under the amendments made by this section.

(f) EFFECTIVE DATE.—The amendments made by this section shall apply to items and services furnished on or after January 1, 1991.

SEC. 3. EXTENDING HOME HEALTH SERVICES.

(a) IN GENERAL.—Section 1861(m) of the Social Security Act (42 U.S.C. 1395x(m)), as restored by section 201(a)(1) of the Medicare Catastrophic Coverage Repeal Act of 1989, is amended by adding at the end the following new sentence:

"For purposes of paragraphs (1) and (4) and sections 1814(a)(2)(C) and 1835(a)(2)(A), nursing care and home health aide services shall be considered to be provided or needed on an 'intermittent' basis if they are provided or needed less than 7 days each week and, in the case they are

provided or needed for 7 days each week, if they are provided or needed for a period of up to 38 consecutive days.".

(b) PAYMENT UNDER PART B.—Section 1833(d) of the Social Security Act (42 U.S.C. 1395l(d)), as restored by section 201(a)(1) of the Medicare Catastrophic Coverage Repeal Act of 1989, is amended—

(1) by striking "(d) No payment" and inserting "(d)(1) Except as provided in paragraph (2), no payment"; and

(2) by adding at the end the following new paragraph:

"(2) In the case of home health services furnished to an individual enrolled under this part for which payment is made only as a result of the application of the last sentence of section 1861(m), payment shall be made under this part.".

(c) EFFECTIVE DATE.—The amendments made by this section shall apply to services furnished in cases of initial periods of home health services beginning on or after January 1, 1991.

SEC. 4. EXPANSION OF HOSPICE BENEFIT.

(a) IN GENERAL.—Section 1812 of the Social Security Act (42 U.S.C. 1395d), as restored by section 101(a)(1) of the Medicare Catastrophic Coverage Repeal Act of 1989 and

as amended by the Omnibus Budget Reconciliation Act of 1989, is amended—

(1) in subsection (a)(4), by striking "90 days each" and all that follows through "with respect to" and inserting the following: "90 days each, a subsequent period of 30 days, and a subsequent extension period with respect to"; and

(2) in subsection (d)—

(A) in paragraph (1), by striking "90 days each" and all that follows through "lifetime" and inserting the following: "90 days each, a subsequent period of 30 days, and a subsequent extension period during the individual's lifetime", and

(B) in paragraph (2)(B), by striking "a 90- or 30-day period," and inserting "a 90- or 30-day period or a subsequent extension period,".

(b) CONFORMING AMENDMENT.—Section 1814(a)(7)(A) of such Act (42 U.S.C. 1395f(a)(7)(A)), as restored by section 101(a)(1) of the Medicare Catastrophic Coverage Repeal Act of 1989, is amended—

(1) in clause (i), by striking "and" at the end;

(2) in clause (ii), by striking the semicolon at the end and inserting ", and"; and

(3) by adding at the end the following new clause:

"(iii) in a subsequent extension period, the medical director or physician described in clause (i)(II) recertifies at the beginning of the period that the individual is terminally ill;".

(c) EFFECTIVE DATE.—The amendments made by this section shall apply with respect to care and services furnished on or after January 1, 1991.

SEC. 5. COVERAGE OF HOME INTRAVENOUS DRUG THERAPY SERVICES.

(a) IN GENERAL.—Section 1832(a)(2)(A) (42 U.S.C. 1395k(a)(2)(A)) as amended by section 2(a)(1) of this Act, is further amended—

(1) by striking ", and (ii)" and inserting ", (ii)"; and

(2) by striking "calendar year" and inserting ", calendar year, and (iii) home intravenous drug therapy services".

(b) HOME INTRAVENOUS DRUG THERAPY SERVICES DEFINED.—Section 1861 (42 U.S.C. 1395x) as amended by section (2)(b) of this Act, is further amended by adding at the end the following new subsection:

"(kk)(1) The term 'home intravenous drug therapy services' means the items and services described in paragraph (2) furnished to an individual who is under the care of a physician—

"(A) in a place of residence used as such individual's home;

"(B) by a qualified home intravenous drug therapy provider (as defined in paragraph (4)) or by others under arrangements with them made by such provider; and

"(C) under a plan established and periodically reviewed by a physician.

"(2) The items and services described in this paragraph are such nursing, pharmacy, and related services (including medical supplies, intravenous fluids, delivery, and equipment) as are necessary to conduct safely and effectively an intravenously administered drug regimen through use of a covered home intravenous drug.

"(3)(A) The term 'covered home intravenous drug' means a drug dispensed to an individual that—

"(i) is an antibiotic drug and the Secretary has not determined, for the specific drug or for the indication to which it is applied, that the drug cannot be administered safely and effectively in a home setting, or,

"(ii) is not an antibiotic drug and the Secretary has determined, for the specific drug and indication for which the drug is being applied, that the drug can generally be administered safely and effectively in a home setting.

"(B) Not later than January 1, 1991 (and periodically thereafter), the Secretary shall publish a list of the drugs that are covered home intravenous drugs with respect to which home intravenous drug therapy may be provided under this title.

"(4) The term 'qualified home intravenous drug therapy provider' means any entity that the Secretary determines meets the following requirements:

"(i) The entity is capable of providing or arranging for the items and services described in paragraph (2) and covered home intravenous drugs.

"(ii) The entity maintains clinical records on all patients.

"(iii) The entity adheres to written protocols and policies with respect to the provision of items and services.

"(iv) The entity makes services available (as needed) 7 days a week on a 24-hour basis.

"(v) The entity coordinates all services with the patient's physician.

"(vi) The entity conducts a quality assessment and assurance program, including drug regimen review and coordination of patient care.

"(vii) The entity assures that only trained personnel provide covered home intravenous drugs (and any

other service for which training is required to safely provide the service).

"(viii) The entity assumes responsibility for the quality of services provided by others under arrangements with the agency or entity.

"(ix) In the case of an entity in any State in which State or applicable law provides for the licensing of entities of this nature, (I) is licensed pursuant to such law, or (II) is approved, by the agency of such State or locality responsible for licensing entities of this nature, as meeting the standards established for such licensing.

"(x) The entity meets such other requirements as the Secretary may determine are necessary to assure the safe and effective provision of home intravenous drug therapy services and the efficient administration of the home intravenous drug therapy benefit.".

(c) PAYMENT.—

(1) IN GENERAL.—Part B of such Act, as restored by section 201(a)(1) of the Medicare Catastrophic Coverage Repeal Act of 1989, is amended—

(A) in subsection (a)(2)(B) of section 1833 (42 U.S.C. 1395l), by striking "or (E)" and inserting "(E), or (F)";

(B) in subsection (a)(2)(D) of such section, by striking "and" at the end;

(C) in subsection (a)(2)(E) of such section, by striking the semicolon and inserting "; and";

(D) by inserting after subsection (a)(2)(E) of such section the following new subparagraph:

"(F) with respect to home intravenous drug therapy services, the amounts described in section 1834(d)(1);"

(E) in subsection (b) of such section, by striking "services, (3)" and inserting "services and home intravenous drug therapy services, (3)"; and

(F) by adding at the end of section 1834, the following new subsection:

"(c) HOME INTRAVENOUS DRUG THERAPY SERVICES.—

"(1) IN GENERAL.—With respect to home intravenous drug therapy services, subject to paragraph (3), payment under this part shall be made in an amount equal to the lesser of the actual charges for such services or the fee schedule established under paragraph (2).

"(2) ESTABLISHMENT OF FEE SCHEDULE.—The Secretary shall establish by regulation before the beginning of calendar year 1991 and each succeeding

calendar year a fee schedule for home intravenous drug therapy services for which payment is made under this part. A fee schedule established under this subsection shall be on a per diem basis.

"(3) LIMITATION ON ACCEPTANCE OF, AND PAYMENTS FOR, CERTAIN REFERRALS.—

"(A) IN GENERAL.—Except as provided in subparagraph (B), a home intravenous drug therapy provider may not provide home intravenous drug therapy services under this part to an individual if the individual's referring physician (as defined in subparagraph (D)), or an immediate family member of the physician—

"(i) has an ownership interest in the provider, or

"(ii) receives compensation from the provider.

"(B) EXCEPTIONS.—

"(i) Subparagraph (A)(i) shall not apply—

"(I) if the ownership interest is the ownership of stock which is traded over a publicly-regulated exchange and was purchased on terms generally available to the public, or

"(II) if the provider is a sole home intravenous drug therapy provider (as defined by the Secretary) in a rural area.

"(ii) Subparagraph (A)(ii) shall not apply if the compensation is reasonably related to items or services actually provided by the physician and does not vary in proportion to the number of referrals made by the referring physician, but such exception shall not apply to compensation provided for direct patient care services.

"(iii) Subparagraph (A) shall not be construed to apply to a referring physician whose only ownership or financial relationship with the provider is as an uncompensated officer or director of the provider.

"(iv) Subparagraph (A) also shall not apply in such cases, established by the Secretary in regulations, in which the nature of the ownership or compensation does not pose a substantial risk of program abuse.

"(C) SANCTIONS.—

"(i) DENIAL OF PAYMENT.—No payment may be made under this part for home

intravenous drug therapy services which are provided in violation of subparagraph (A).

"(ii) CIVIL MONEY PENALTY FOR IMPROPER CLAIMS.—Any person (including a home intravenous drug therapy provider or physician) that presents or causes to be presented a claim for an item or service that such person knows or should know is for an item or service for which payment may not be made under subparagraph (A) shall be subject to a civil money penalty of not more than $15,000 for each such item or service. The provisions of section 1128A (other than the first sentence of subsection (a) and other than subsection (b)) shall apply to a civil money penalty under the previous sentence in the same manner as such provisions apply to a penalty or proceeding under section 1128A(a).

"(D) REFERRING PHYSICIAN DEFINED.—In this paragraph, the term 'referring physician' means, with respect to providing home intravenous drug therapy services to an individual, a physician who—

"(i) prescribed the covered home intravenous drug for which the services are to be provided, or

"(ii) established the plan of care for such services.".

(2) PROPAC STUDY.—The Prospective Payment Assessment Commission shall conduct a study, and make recommendations to Congress and the Secretary of Health and Human Services by not later than March 1, 1992, concerning appropriate adjustment to the payment amounts provided under section 1886(d) of the Social Security Act for inpatient hospital services to account for reduced costs to hospitals resulting from the amendments made by this section.

(3) INSPECTOR GENERAL REPORT ON POTENTIALLY ABUSIVE OWNERSHIP OR COMPENSATION ARRANGEMENTS.—The Inspector General of the Department of Health and Human Services shall study and report to Congress, by not later than May 1, 1991, concerning—

(A) physician ownership of, or compensation from, an entity providing items or services to which the physician makes referrals and for which payment may be made under the medicare program;

(B) the range of such arrangements and the means by which they are marketed to physicians;

(C) the potential of such ownership or compensation to influence the decision of a physician regarding referrals and to lead to inappropriate utilization of such items and services; and

(D) the practical difficulties involved in enforcement actions against such ownership and compensation arrangements that violate current anti-kickback provisions.

Such report shall include such recommendations as may be appropriate to strengthen current law provisions to prevent program abuse.

(d) CERTIFICATION.—

(1) IN GENERAL.—Section 1835(a)(2) of such Act (42 U.S.C. 1395n(a)(2)) as amended by section 2(d) of this Act, is further amended—

(A) by striking "and" at the end of subparagraph (F);

(B) by striking the period at the end of subparagraph (G) and inserting "; and"; and

(C) by inserting after subparagraph (G) the following new subparagraph:

"(H) in the case of home intravenous drug therapy services, (i) such services are or were re-

quired because the individual needed such services or the administration of a covered home intravenous drug, (ii) a plan for furnishing such services has been established and is reviewed periodically by a physician, (iii) such services are or were furnished while the individual is or was under the care of a physician, (iv) such services are administered in a place of residence used as such individual's home, and (v) with respect to such services initiated before January 1, 1993, such services have been reviewed and approved by a utilization and peer review organization under section 1154(a)(16) before the date such services were initiated (or, in the case of services first initiated on an outpatient basis, within 1 working day (except in exceptional circumstances) of the date of initiation of the services).".

(2) PRIOR APPROVAL REQUIRED.—Section 1154(a) of such Act (42 U.S.C. 1320c–3(a)), as restored by section 201(a)(1) of the Medicare Catastrophic Coverage Repeal Act of 1989, is amended by adding at the end the following new paragraph:

"(16) The organization shall perform the review described in paragraph (1) with respect to home intravenous drug therapy services (as defined in section

1861(kk)(1)) initiated before January 1, 1993, within 1 working day of the date of the organization's receipt of a request for such review. The Secretary shall establish criteria to be used by such an organization in conducting reviews with respect to the appropriateness of home intravenous drug therapy services under this paragraph.".

(e) CERTIFICATION OF HOME INTRAVENOUS DRUG THERAPY PROVIDERS; INTERMEDIATE SANCTIONS FOR NONCOMPLIANCE.—

(1) TREATMENT AS PROVIDER OF SERVICES.—Section 1861(u) of such Act (42 U.S.C. 1395x(u)), as restored by section 201(a)(1) of the Medicare Catastrophic Coverage Repeal Act of 1989, is amended by inserting "home intravenous drug therapy provider," after "hospice program,".

(2) CONSULTATION WITH STATE AGENCIES AND OTHER ORGANIZATIONS.—Section 1863 of such Act (42 U.S.C. 1395z), as restored by section 201(a)(1) of the Medicare Catastrophic Coverage Repeal Act of 1989, is amended by striking "and (dd)(2)" and inserting "(dd)(2), and (kk)(4)".

(3) USE OF STATE AGENCIES IN DETERMINING COMPLIANCE.—Section 1864(a) of such Act (42 U.S.C. 1395aa(a)), as restored by section 201(a)(1) of

the Medicare Catastrophic Coverage Repeal Act of 1989, is amended—

(A) in the first sentence, by inserting "or a home intravenous drug therapy provider," after "hospice program", and

(B) in the second sentence, by striking "or hospice program" and inserting "hospice program, or home intravenous drug therapy provider".

(4) APPLICATION OF INTERMEDIATE SANCTIONS.—Section 1846 of such Act (42 U.S.C. 1395w–2), as restored by section 201(a)(1) of the Medicare Catastrophic Coverage Repeal Act of 1989, is amended—

(A) in the heading, by adding "AND FOR QUALIFIED HOME INTRAVENOUS DRUG THERAPY PROVIDERS" at the end;

(B) in subsection (a), by inserting "or that a qualified home intravenous drug therapy provider that is certified for participation under this title no longer substantially meets the requirements of section 1861(kk)(4)" after "under this part"; and

(C) in subsection (b)(2)(A)(iv) by inserting "or home intravenous drug therapy services" after "clinical diagnostic laboratory tests".

(f) USE OF REGIONAL INTERMEDIARIES IN ADMINISTRATION OF BENEFIT.—Section 1816 of such Act (42 U.S.C. 1395h), as restored by section 201(a)(1) of the Medicare Catastrophic Coverage Repeal Act of 1989, is amended by adding at the end thereof the following new subsection:

"(k) With respect to carrying out functions relating to payment for home intravenous drug therapy services and covered home intravenous drugs, the Secretary may enter into contracts with agencies or organizations under this section to perform such functions on a regional basis.".

(g) EFFECTIVE DATE.—The amendments made by this section shall apply to items and services furnished on or after January 1, 1991.

SEC. 6. FINANCING THROUGH INCREASE IN MEDICARE PART B PREMIUM.

(a) INCREASE IN PREMIUM.—Section 1839 of the Social Security Act (42 U.S.C. 1395r), as restored by section 202(a) of the Medicare Catastrophic Coverage Repeal Act of 1989, is amended by adding at the end the following new subsection:

"(g)(1) Except as provided in subsection (f), the monthly premium for each individual enrolled under this part otherwise determined, without regard to this subsection, shall be increased (for months occurring in 1991 through 1995) by the following additional premium or (for months after Decem-

ber 1995) by such an additional premium determined in accordance with paragraph (2):

"(A) For months in 1991, $.55.

"(B) For months in 1992, $.95.

"(C) For months in 1993, $1.08.

"(D) For months in 1994, $1.29.

"(E) For months in 1995, $1.57.

"(2)(A) The Secretary shall, during September of 1995 and of each year thereafter, determine and promulgate the additional premium under this subsection for months in the succeeding year. Such premium amount shall be equal to the amount the Secretary estimates to be necessary so that the aggregate amount of premiums collected under this subsection for months in the year will equal the total of the benefits and administrative costs which the Secretary estimates will be payable in such year from the Federal Hospital Insurance Trust Fund and the Federal Supplementary Medical Insurance Trust Fund that are attributable to the amendments made by the Medicare Home Benefits Improvement Act of 1990. In calculating such additional premium, the Secretary shall include an appropriate amount for a contingency margin, and shall adjust such premium to take into account the amounts by which the additional premiums established under this subsection with respect to months in any year are greater or less than the amounts required to pay for benefits

paid and such administrative costs incurred in such year that are attributable to the Medicare Home Benefits Improvement Act of 1990.

"(B) If any premium increase for a month under this paragraph is not a multiple of 10 cents, the Secretary shall round the increase to the nearest multiple of 10 cents.".

(b) CONFORMING AMENDMENTS.—

(1) Section 1839 of such Act (42 U.S.C. 1395r), as restored by section 202(a) of the Medicare Catastrophic Coverage Repeal Act of 1989, is amended—

(A) in the second sentence of subsections (a)(1) and (a)(4), by inserting "(other than costs relating to the amendments made by the Medicare Home Benefits Improvement Act of 1990)" before the period;

(B) in subsection (a)(2), by striking "and (e)" and inserting ", (e), and (g)";

(C) in subsection (a)(3), by striking "subsection (e)" and inserting "subsections (e) and (g)";

(D) in subsection (b), by striking "determined under subsection (a) or (e)" and inserting "otherwise determined under this section (without regard to subsections (f) and (g))"; and

(E) in subsection (e)(1), by inserting "except as provided in subsection (g)," after "subsection (a)".

(2) Section 1844(a) of such Act (42 U.S.C. 1395w(a)), as restored by section 202(a) of the Medicare Catastrophic Coverage Repeal Act of 1989, is amended by adding at the end the following:

"In computing the amount of aggregate premiums and premiums per enrollee under paragraph (1), there shall not be taken into account premiums attributable to section 1839(g).".

(c) EFFECTIVE DATE.—The amendments made by this section shall apply to monthly premiums for months beginning with January 1991.

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and reimbursing long-term home care services for seriously mentally ill individuals and family caregivers.

"(b) DEFINITION.—As used in section, the term 'seriously mentally ill individual' means an individual who a licensed mental health professional in the individual's State of residence certifies—

"(1) has schizophrenia, bipolar or unipolar disorder or other significant mental illness that restrict the ability of the individual to function in activities of daily living, employment, and social interaction;

"(2) has been previously institutionalized or is at risk of being institutionalized in the absence of the services provided under this section; and

"(3) is not institutionalized at the time of the certification.

"(c) REQUIREMENTS.—Demonstration projects conducted under this section shall—

"(1) each be conducted over a period of 3 years;

"(2) be conducted in sites that are chosen to be geographically diverse and include at least one rural site;

"(3) be sensitive to the needs of racial and ethnic minorities;

"(4) include outreach and case management activities;

"(5) be responsive to family needs and concerns and appropriately involve and consult with family members regarding the provision of services under this section;

"(6) specify, at the time of application, specific outcome expectations to be met by the project and identify appropriate mechanisms for measuring such outcomes; and

"(7) include testing the use of different agencies as Case Management Agencies and providing for the selection of such agencies in consultation with the Comptroller General.

"(d) OTHER SERVICES.—Demonstration projects conducted under this section may—

"(1) provide services or reimbursement for nursing care, homemaker or homehealth aide services, psychosocial services, medical services, including the provision, monitoring, and testing of necessary medications, client and family education, training, and counseling, respite care, crisis intervention, information and referral services, and rehabilitation; and

"(2) provide services to seriously mentally ill individuals or provide services to home caregivers (including family members) when such services augment and

support home caregivers in the care of seriously mentally ill individuals.

"(e) EVALUATION.—The Secretary shall provide for the evaluation of the projects on a concurrent basis and shall prepare and submit to the appropriate Committees of Congress, not later than 18 months after the initiation of the projects and on the completion of the projects, a report on the findings of the evaluation. Such evaluation shall measure the cost and effectiveness of funded projects against the outcome expectations identified in the initial applications and include relevant data on client and family satisfaction and perceived benefits, together with such additional information as the Secretary may consider appropriate.

"(f) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated from the Federal Hospital Insurance Trust Fund for each of the fiscal years 1991, 1992, and 1993, not to exceed $10,000,000 to carry out demonstration projects under this section and not to exceed $1,000,000 to carry out the evaluation of such projects under subsection (e).

"SEC. 2152. DEMONSTRATION PROJECTS FOR WORKING AGE INDIVIDUALS WITH SEVERE FUNCTIONAL LIMITATIONS.

"(a) IN GENERAL.—The Secretary shall conduct at least 5 and not more than 10 demonstration projects to deter-

mine the feasibility of providing long-term home care benefits under title XVIII of this Act for working-age individuals with severe functional limitations (as defined in subsection (b)).

"(b) DEFINITION.—As used in this section, the term 'working-age individual with severe functional limitations' means an individual who is over 18 years of age, but under 65 years of age, who is not entitled to benefits under title XVIII but who is a chronically ill individual, within the meaning of section 1861(jj)(1)(A)(i).

"(c) REQUIREMENTS.—Demonstration projects under this section—

"(1) shall include, in the items and services covered under long-term home care, personal care services, short term respite, and emergency assistance and shall permit coverage of items and services provided either by home health agencies or by other qualified persons;

"(2) may provide for limited cost-sharing for long-term home care;

"(3) shall provide that payment rates for long-term home care provided by persons other than home health agencies shall be comparable to the payment rates for such care provided by home health agencies;

"(4) shall provide that each plan of care for an individual shall take into account the capability of the individual to direct the long-term home care of the individual and to train persons in providing that care;

"(5) shall test the effectiveness of consumer-directed living centers that are primarily engaged in assisting working age individuals with severe functional limitations in maximizing their independence;

"(6) shall, to the maximum extent practicable, cover working age individuals with severe functional limitations who—

"(A) are at imminent risk of institutionalization within 30 days if such individual is not provided long-term home care;

"(B) are institutionalized but who, if provided long-term home care, could be discharged from the institution; or

"(C) need long-term home care to secure or continue employment, to increase independence, to enable present caregivers to secure or continue employment, or to stabilize families;

"(7) shall include projects under which personal care services are made available away from the primary residence of the individual, as well as at that residence; and

"(8) shall include projects under which family members may be employed as caregivers if the family members would be employed if not providing such care or if the individual requires more than 20 hours a week of long-term home care.

"(d) CONSULTATION, EVALUATION, REPORT.—

"(1) CONSULTATION.—In designing and evaluating the projects conducted under this section, the Secretary shall consult with experts in the field of disability policy and independent living and with groups representing working age individuals with severe functional limitations.

"(2) EVALUATION.—The Secretary shall provide for the evaluation of the projects conducted under this section on a concurrent basis. Such evaluation shall include an evaluation of the size of the demand, cost, relative effectiveness, and impact on quality of life, of providing long-term home care to working age individuals with severe functional limitations.

"(3) REPORT.—Not later than 18 months after the date on which the projects conducted under this section are completed, the Secretary shall prepare and submit, to the appropriate Committees of Congress, a report concerning the findings of the evaluation under paragraph (2). The Secretary shall include in such

report recommendations for appropriate legislative changes.

"(e) FUNDING.—The Secretary shall make available from the Federal Hospital Insurance Trust Fund—

"(1) for each of fiscal years 1991, 1992, and 1993 not to exceed $10,000,000 to carry out demonstration projects under this section; and

"(2) for the 3-fiscal-year period beginning with fiscal year 1991 not to exceed $1,000,000 to carry out the evaluation of such projects under this section.

"SEC. 2153. GENERAL AUTHORITY.

"(a) PAYMENTS.—Payments under demonstration projects under this part may be made in advance or by way of reimbursement, as may be determined by the Secretary, and shall be made in such installments and on such conditions as the Secretary finds necessary to carry out the purpose of this section.

"(b) MEDICARE WAIVERS.—The Secretary may waive such requirements of title XVIII as may be required to carry out demonstration projects under this section.".

SEC. 1003. EFFECTIVE DATE.

(a) IN GENERAL.—Except as otherwise provided in this section, this division and the amendments made by this division, shall become effective on the date of enactment of this Act.

(b) COVERAGE OF HOME AND COMMUNITY-BASED CARE SERVICES.—Part B of title XXI of the Social Security Act (as added by section 1002 of this Act) shall require payment for services provided in accordance with such part after 1 year after the date of enactment of this Act.

(c) COVERAGE FOR NURSING HOME CARE.—Part C of such title shall apply to nursing home care provided in accordance with such part on or after January 1 of the third year that begins after the date of enactment of this Act.

(d) FEDERAL LONG-TERM CARE INSURANCE PROGRAM.—Part D of such title shall require the establishment of a Federal long-term care insurance program in accordance with such part on and after January of the second year that begins after the date of enactment of this Act. Payment for nursing care under such part shall begin on January 1 of the third year that begins after the date of enactment of this Act.

(e) TRAINING AND RESEARCH.—Part E of such title shall require training and research programs in accordance with such part on and after January 1, 1991.

Division C—Grants to States for Establishment and Implementation of State Health Objectives Plans

SEC. 2001. SHORT TITLE.

This division may be cited as the "Health Objectives 2000 Act".

SEC. 2002. REFERENCES.

Whenever in this division 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 Public Health Service Act (42 U.S.C. 201 et seq.).

SEC. 2003. PURPOSE.

It is the purpose of this division to implement the Year 2000 National Health Objectives through the provision of assistance to Designated Official State Public Health Agencies to—

(1) provide sufficient capacity and resources to States and localities to assist such States and localities in achieving the Year 2000 National Health Objectives, including—

(A) reducing tobacco, alcohol, and other drug use and abuse;

(B) improving nutrition;

(C) increasing physical activity and fitness;

(D) improving mental health and preventing mental illness;

(E) reducing environmental health hazards, improving occupational safety and health, and preventing and controlling unintentional injuries;

(F) reducing violent and abusive behavior;

(G) preventing and controlling HIV infection and AIDS and sexually transmitted diseases;

(H) immunizing against and controlling infectious diseases;

(I) improving maternal and infant health;

(J) improving oral health;

(K) reducing adolescent pregnancy and improving reproductive health;

(L) preventing, detecting, and controlling high blood cholesterol and high blood pressure;

(M) preventing, detecting, and controlling cancer and other chronic diseases and disorders;

(N) maintaining the health and quality of life of older individuals;

(O) improving health education and access to preventive health services; and

(P) improving surveillance and data systems;

(2) create and develop a partnership of Federal, State, and local health agencies, voluntary health organizations, and other health groups to develop initiatives for preventing disease and illness;

(3) enable States and localities to address national health policy issues; and

(4) assess the health status of the population of the United States.

SEC. 2004. AMENDMENT TO PUBLIC HEALTH SERVICE ACT.

Title XIX of the Public Health Service Act (42 U.S.C. 300w et seq.) is amended by adding at the end thereof the following new part:

"PART D—NATIONAL HEALTH OBJECTIVES GRANTS TO STATES

"SEC. 1941. DEFINITIONS AND ADMINISTRATION.

"(a) DEFINITIONS.—As used in this part:

"(1) ADVISORY COMMITTEE.—The term 'Advisory Committee' means the National Health Objectives Advisory Committee established under section 1948(a).

"(2) CORE PRIORITIES.—The term 'Core Priorities' means the National Health Priorities that are designated by the Secretary as 'Core National Health Priorities' and that must be included in the State health objectives provided in the State health objectives plan of each State.

"(3) NATIONAL HEALTH PRIORITIES.—The term 'National Health Priorities' means the priorities established under section 1948(b).

"(4) STATE AGENCY.—The term 'State agency' means the department, agency, commission, or other entity designated and vested with authority under State law over matters concerning public health.

"(5) STATE PLAN.—The term 'State plan' means the health objectives plan of a State submitted under section 1946.

"(6) STATE REPORT.—The term 'State report' means the annual report of a State required under section 1947.

"(b) ADMINISTRATION.—The Secretary shall carry out this part through the Centers for Disease Control.

"SEC. 1942. AUTHORIZATION OF APPROPRIATIONS.

"For the purpose of making allotments to States to carry out this part, there are authorized to be appropriated—

"(1) $600,000,000 for fiscal year 1991;

"(2) $700,000,000 for fiscal year 1992;

"(3) $800,000,000 for fiscal year 1993;

"(4) $900,000,000 for fiscal year 1994; and

"(5) $1,000,000,000 for fiscal year 1995.

"SEC. 1943. ALLOTMENTS.

"(a) AMOUNT.—

"(1) IN GENERAL.—The Secretary shall use not to exceed 90 percent of the amounts appropriated under section 1942 for each fiscal year to make allotments in accordance with paragraphs (2) and (3).

"(2) POPULATION.—From amounts available for allotments under paragraph (1), the Secretary shall

allot in each fiscal year to each State an amount that equals—

"(A) $25,000, if the population of the State does not exceed 50,000;

"(B) $75,000, if the population of the State exceeds 50,000 but does not exceed 450,000;

"(C) $1,000,000, if the population of the State exceeds 450,000 but does not exceed 1,000,000;

"(D) $1,500,000, if the population of the State exceeds 1,000,000 but does not exceed 3,000,000;

"(E) $2,000,000, if the population of the State exceeds 3,000,000 but does not exceed 6,000,000;

"(F) $2,500,000, if the population of the State exceeds 6,000,000 but does not exceed 10,000,000;

"(G) $3,000,000, if the population of the State exceeds 10,000,000 but does not exceed 15,000,000; and

"(H) $4,000,000, if the population of the State exceeds 15,000,000.

"(3) RELATIVE POPULATION.—To the extent that all amounts available for allotment under para-

graph (1) for each fiscal year are not otherwise allotted to States under paragraph (2), such excess shall be allotted to each State in an amount that bears the same ratio to such excess amount for such fiscal year as the total population of the States bears to the population of all States.

"(4) ADJUSTMENT.—If for any fiscal year the amount appropriated under section 1942 is less than the total of all amounts listed under paragraph (2), the amount allotted to each State shall be an amount that bears the same ratio to the total of all amounts available for allotment under such section as the amount of the allotment that the State is entitled to under paragraph (2) bears to the total of all such amounts under such paragraph.

"(b) UNALLOTTED AMOUNTS.—To the extent that all the amounts appropriated under section 1942 for a fiscal year and available for allotment in such fiscal year are not otherwise allotted to States because one or more State has notified the Secretary that such State does not intend to use the full amount of their allotment, such excess shall be allotted among each of the remaining States in proportion to the amount otherwise allotted to such States for such fiscal year under subsection (a)(3).

"(c) ADMINISTRATION AND TRAINING.—The Secretary shall use not to exceed 10 percent of the amounts appropriated under section 1942 for each fiscal year as provided for in section 1948(f).

"SEC. 1944. PAYMENTS UNDER ALLOTMENTS TO STATES.

"(a) IN GENERAL.—

"(1) PLAN REQUIREMENT.—For each fiscal year, the Secretary shall make payments from amounts appropriated for that fiscal year, as provided for in section 6503(a) of title 31, United States Code, to each State, if such State has submitted an approved State plan, from its allotment under section 1943.

"(2) CARRYOVER FUNDS.—Any amount paid to a State for a fiscal year and remaining unobligated at the end of such year shall remain available for the next fiscal year to such State for the purposes for which it was made.

"(b) REDUCTION IN AMOUNT.—

"(1) IN GENERAL.—The Secretary, at the request of a State, may reduce the amount of payments that a State is entitled to under subsection (a) in an amount equal to—

"(A) the fair market value of any supplies or equipment furnished the State; and

"(B) the total amount of any pay, allowances, and travel expenses of any officer or employee of the Federal government when detailed to the State and the amount of any other costs incurred in connection with the detail of such officer or employee;

when the furnishing of such supplies or equipment or the detail of such officers or employees is for the convenience and at the request of the State and for the purpose of conducting activities described in section 1945.

"(2) USE OF REDUCTION.—The amount by which any payment is reduced under paragraph (1) shall be available for payment by the Secretary of the costs incurred in furnishing the supplies or equipment or in detailing the personnel, on which the reduction of the payment is based, and the amount shall be considered to be part of the payment and to have been paid to the State.

"SEC. 1945. USE OF ALLOTMENTS.

"(a) STATE PLAN.—Except as provided in subsections (b) and (c), a State shall utilize amounts paid to it under section 1944, from the allotment of such State under section 1943(a), to develop and implement a State plan, in accordance with section 1946, for—

"(1) each of the fiscal years 1991 and 1992, that—

"(A) develops and collects data to assess the public health needs and status of the individuals that reside in the State;

"(B) requires and provides assistance for planning necessary to assist projects and programs described in the State plan; and

"(C) provides for the availability of assistance to projects and programs described in the State plan; and

"(2) fiscal year 1993, and for each fiscal year thereafter during which the State receives payments under section 1944, that in addition to the activities described in paragraph (1), provides for the funding of projects and programs authorized under sections 1904 and 1910.

"(b) LIMITATIONS.—A State shall not use amounts paid to it under section 1944, to—

"(1) provide inpatient services;

"(2) make cash payments to intended recipients of health services;

"(3) purchase or improve land, purchase, construct, or permanently improve (other than minor re-

modeling) any building or other facility, or purchase major medical equipment; or

"(4) satisfy any requirement for the expenditure of non-Federal funds as a condition for the receipt of Federal funds.

"(c) ADMINISTRATION.—Not more than 10 percent of the total amount paid to a State under section 1944 from the State allotment under section 1943(a) for any fiscal year shall be used for administering the funds made available under section 1944. The State shall pay from non-Federal sources any additional costs of administering such funds. For purposes of this subsection, the term 'administration' shall not be construed to include collection or assessment of data.

"SEC. 1946. STATE HEALTH OBJECTIVES PLAN AND DESCRIPTION OF ACTIVITIES.

"(a) IN GENERAL.—To receive a payment under section 1944 from the State allotment for a fiscal year under section 1943(a), a State shall prepare and submit, to the Secretary, a State health objectives plan at such time, in such manner, and containing such information as the Secretary shall require. Such State plan shall meet the requirements of subsection (b) and shall contain assurances satisfactory to the Secretary that the State will meet the requirements of subsection (c).

"(b) REQUIREMENTS.—A State plan submitted under subsection (a) shall—

"(1) contain a specific set of not less than five State health objectives that shall be chosen from the National Health Priorities described by the Secretary under section 1948, and that shall include all Core Priorities identified under such section;

"(2) contain an annual budget that describes the manner in which the payments made under section 1944 are to be used by the State, and such budget shall—

"(A) specify the portion of such funds that are to be used at each level of the State or local government, and the portion of such funds that are to be allocated for grants to local agencies of public health, community-based health organizations, voluntary nonprofit health organizations, and other entities selected by the State help meet State objectives under paragraph (6); and

"(B) commit the State to use not less than 80 percent of such payments to meet State objectives that, as determined by the State agency after an analysis of the National Health Priorities, and based on the available State data described in paragraph (3), are critical to improving the health

status of the individuals who reside within the State;

"(3) in terms of each State objective—

"(A) provide assurances satisfactory to the Secretary that there is a minimum set of data available to satisfactorily measure the health status of individuals who reside within the State;

"(B) utilize the date described in subparagraph (A) to identify the improvement that the State expects to make in the health status of individuals who reside within the State during the term of the State plan;

"(C) specify the particular strategies, projects and programs intended to be used by the State to improve the health status of individuals who reside within the State;

"(D) specify the methods intended to be used by the State to evaluate the progress made by the State in improving the health status of individuals who reside within the State; and

"(E) provide services targeted at improving the health status of individuals who reside within the State at the level of State or local government that the State determines is most likely to be effective in achieving the State objectives;

"(4) provide for the establishment of procedures through which the State shall monitor the progress of local health agencies, community-based organizations, and health organizations in implementing the State objectives;

"(5) identify public health personnel requirements that the State determines are reasonably necessary and appropriate to permit the State to achieve the State objectives;

"(6) identify the mechanism by which the State shall select, and allocate assistance provided under this part to local units of government, local agencies of public health, community-based health organizations, voluntary nonprofit health organizations, and other entities within the State to help meet the State objectives; and

"(7) contain a description (that may be revised throughout the year as may be necessary to reflect substantial changes in the projects and programs assisted by the State) of the intended use of the payments the State will receive under section 1944 for the fiscal year for which the State plan is submitted, including information concerning the projects and programs to be supported and services to be provided, which shall be made available to the public within the

State in a manner that will facilitate comment from any individual during the period of the development of the description and after the transmittal of such.

"(c) ASSURANCES.—As part of the State plan required under subsection (a), a State shall provide assurances satisfactory to the Secretary that such State—

"(1) shall use the amounts allotted to it under section 1943 in accordance with the requirements of the State plan and of this part;

"(2) shall establish reasonable criteria for the evaluation of the effective performance of entities that receive assistance from the allotment to the State under this part;

"(3) shall identify those populations, areas, and localities in the State that demonstrate a need for the services for which funds may be provided by the State under this part; and

"(4) shall use amounts made available under section 1944 for any period to supplement and increase the level of State, local, and other Federal assistance that would, in the absence of amounts available under section 1944, be made available for the programs and activities for which funds are provided for under this part, and shall not use funds made available under this

part to supplant such State, local, and other Federal funds.

"SEC. 1947. STATE HEALTH OBJECTIVES REPORT.

"(a) IN GENERAL.—Not later than 120 days after the end of each fiscal year for which assistance is provided under this part, each State, in cooperation with participating local units of government, shall prepare and submit, to the Secretary, an annual State health objectives report concerning the activities of the State under this part, that meets the requirements of this section.

"(b) REQUIREMENTS.—A State report submitted under subsection (a) shall be in such form and contain such information as the Secretary determines, after consultation with the heads of the State agencies and the Comptroller General, to be necessary—

"(1) to determine whether funds were expended by the State in accordance with this part and consistent with the needs within the State as proscribed in the State plan;

"(2) to secure a description of the projects and programs within the State operated or assisted with amounts provided under allotments made under this part; and

"(3) to secure a record of—

"(A) the purposes for which amounts provided under this part were expended;

"(B) the recipients of such funds; and

"(C) the progress made toward achieving the purposes for which such funds were provided.

"(c) UNIFORM DATA ITEM.—A State report submitted under subsection (a) shall include information concerning at least one uniform data item on each National Health Priority addressed in the State plan, to be determined in consultation with the Secretary.

"(d) ADDITIONAL CONTENTS.—The Secretary may require States to include additional information in the State report submitted under this section if such requirements are not unduly burdensome.

"(e) AVAILABILITY.—The State shall ensure that the State report is available for public inspection within the State, and the Secretary shall provide copies, on request, to any interested individual.

"SEC. 1948. RESPONSIBILITIES OF THE SECRETARY.

"(a) ADVISORY COMMITTEE.—

"(1) ESTABLISHMENT.—The Secretary shall establish an advisory committee, to be known as the 'National Health Objectives Advisory Committee', to advise the Secretary concerning National Health Priorities.

"(2) COMPOSITION.—The Advisory Committee shall be composed of 9 members, of which—

"(A) one member shall be the Assistant Secretary for Health, who shall serve as chairperson;

"(B) two members shall be appointed by the Secretary from the general public;

"(C) one member shall be appointed by the Administrator of the Environmental Protection Agency;

"(D) two members shall be appointed by the Association of State and Territorial Health Officials;

"(E) one member shall be appointed by the National Association of County Health Officials;

"(F) one member shall be appointed by the United States Conference of Local Health Officials; and

"(G) one member shall be appointed by the Association of Schools of Public Health.

"(3) MEETINGS AND DUTY.—The Advisory Committee shall meet not less than once each year for the purpose of providing advice to the Secretary concerning the selection, revision, implementation, and evaluation of the National Health Priorities.

"(b) NATIONAL HEALTH PRIORITIES.—The Secretary, in consultation with the heads of other Federal agencies and the Advisory Committee, and taking into account the 'Year 2000 Health Objectives' developed by the United States Public Health Service, shall establish—

"(1) National Health Priorities that shall form the basis for all activities that receive assistance under this part;

"(2) from the priorities established under paragraph (1), a set of Core Priorities that shall be included in each State plan; and

"(3) in cooperation with other appropriate national organizations, an estimate of the personnel and training that will be needed throughout the United States to accomplish the priorities established under paragraph (1).

"(c) REVIEW OF STATE PLANS.—The Secretary shall review each proposed State plan, and each proposed amendment thereto, submitted by a State under section 1946, and approve each such plan or amendment, or each portion of such plan or amendment, that the Secretary determines complies with the requirements of this part.

"(d) STATE REPORT.—The Secretary shall receive and review each State report submitted by a State under section 1947, and shall compile, evaluate, and prepare and submit, to

the appropriate Committees of Congress, and the President, an annual National Health Objectives Report concerning the data and information contained in such State.

"(e) OTHER ASSISTANCE.—The Secretary shall provide consultation, guidance, and technical assistance to State and local units of government, and to other entities participating in the programs created under this part, to—

"(1) assist in the development of data sets as required under section 1946, and uniform data items required under section 1947; and

"(2) assist States with State plans, or amendments to such plans, that the Secretary determines does not comply with the requirements of this part, in revising such plans or amendments to comply with the requirements of this part.

"(f) RESEARCH AND TRAINING.—From amounts made available under section 1943(c), the Secretary shall—

"(1) utilize not more than 5 percent, or $5,000,000 whichever is less, to administer the assistance made available to States under such section;

"(2) utilize 50 percent of all such remaining amounts to provide assistance for the professional training of public health personnel, including—

"(A) the identification of new knowledge bases and skills for State and local public health

personnel that are reasonably necessary and appropriate to permit the States to achieve the National Health Priorities; and

"(B) encouraging the training and education of appropriate numbers of such personnel in such knowledge bases and skills by establishing operative agreements with schools of public health and other institutions that train and educate such personnel; and

"(3) utilize all such remaining amounts to provide assistance for research, pilot and demonstration projects and programs that the Secretary determines to show the potential impact of regional or national significance with respect to the National Health Priorities.".

SEC. 2005. REPEAL.

Effective October 1, 1992, sections 1901, 1902, 1903, 1905, 1906, 1907, 1908, 1909, and 1910A of the Public Health Service Act (42 U.S.C. 300w, 300w–1, 300w–2, 300w–4, 300w–5, 300w–6, 300w–7, 300w–8, 300w–9) are repealed.

"(ii) to require both a medical device to compensate for the loss of a vital body function that is necessary to avert death or major loss of bodily functional capacity and substantial and ongoing nursing care to avert death or further disability;

"(3) the individual (or legal guardian) has filed an application for such benefits, and is in need of, benefits covered under this title;

"(4) receiving nursing home services in a nursing facility would be in the best interest of the individual; and

"(5) the Secretary determines that the individual meets the eligibility requirements imposed under this subsection.

"(b) CURRENT INDIVIDUALS.—An individual who is in a hospital or nursing home on the date of the enrollment of the individual in the program established by this part shall be ineligible for coverage under this section until the individual's first spell of illness beginning after such date.

"SEC. 2123. LIMITATIONS ON PAYMENT.

"(a) IN GENERAL.—Monthly reimbursement for nursing home services covered under this part shall be an amount the Secretary determines to be reasonable and appropriate,

taking into account the average cost of providing appropriate care.

"(b) PROSPECTIVE PAYMENT.—To the extent feasible, the Secretary shall establish a prospective payment mechanism for payment for nursing home services covered under this part that takes into account the expected resource utilization of individual patients based on the degree of impairment of the patients and other factors affecting service requirements.

"SEC. 2124. REIMBURSEMENT.

"Certified nursing homes shall accept payment for services rendered under this part as payment in full and shall not be allowed to pass on additional charges to beneficiaries for covered services.

"SEC. 2125. RELATIONSHIP TO OTHER ENTITLEMENT PROGRAMS.

"Notwithstanding any other provision of law, in the case of any service covered under this part that is also covered under any other Federally administered entitlement program, the Secretary shall act as a secondary payer under this part.

"PART D—INSURANCE COVERAGE FOR NURSING HOME CARE THAT EXCEEDS 6 MONTHS

"SEC. 2131. ESTABLISHMENT OF FEDERAL LONG-TERM CARE INSURANCE PROGRAM.

"The Secretary shall establish an optional insurance program for individuals 45 years of age and older (and, under section 2137, for individuals of any age) to cover nursing home stays that exceed 6 months.

"SEC. 2132. ELIGIBILITY.

"(a) DETERMINATION.—

"(1) IN GENERAL.—A Screening Agency shall determine whether an individual is eligible to receive benefits covered under this part.

"(2) SCREENING TOOL.—The agency shall use the same screening the first 6 months of nursing home care under part C in order to determine the continued need of an individual for nursing home care and therefore eligibility for benefits under this part.

"(3) PERIODIC EVALUATION.—The Case Management Agency shall continue to make such an evaluation periodically, pursuant to regulations of the Secretary, as long as an individual remains in a nursing home.

"(b) ELECTION OF COVERAGE.—

"(1) IN GENERAL.—Subject to the other provisions of this subsection and section 2137, an individual

shall have the option to purchase coverage under this part at 45 years of age or at 65 years of age.

"(2) INITIAL YEAR.—During the 1-year period beginning on the effective date of this part, an individual who is 45 years of age or over shall be eligible to purchase insurance under this part, except that such an individual shall not be eligible to purchase insurance while confined to a hospital or nursing home or within 6 months after a period of confinement in a nursing home or 90 days after a period of confinement in a hospital.

"(3) EXTENSION BEYOND INITIAL YEAR.—If an individual is confined to a nursing home or hospital during a period that extends beyond the first year after the effective date of this part, an individual shall be eligible to enroll in the program established by this part during the 60-day period beginning after the individual's first spell of illness.

"(4) SUBSEQUENT YEARS.—During years subsequent to the period referred to in paragraph (2), an individual shall be eligible to purchase insurance under this part within 6 months of the 45th or 65th birthday of the individual.

"(5) ACTIVATION OF BENEFITS.—To receive coverage under the insurance program established by this

part, an individual shall have purchased such coverage at least 1 month prior to admission to a nursing facility, unless the reason for the need of services is because of an accident or stroke subsequent to the date that such individual signed up for coverage under this part.

"SEC. 2133. PREMIUM RATES.

"(a) IN GENERAL.—Except as provided under section 2137(b), the Secretary shall determine one premium rate for individuals electing to purchase coverage under this part at age 45 (or between ages 45 and 64 during the initial enrollment period) and a separate rate for those who elect such coverage at age 65 (or at age 65 and over during the initial enrollment period).

"(b) REVISION.—The Secretary shall revise the premiums annually.

"(c) RATES.—In developing premium rates under the program established by this part, the Secretary shall establish rates that are expected to cover 45 percent of the estimated costs of nursing home stays that exceed 6 months for those individuals enrolled in the program.

"(d) COST SHARING FOR LOW-INCOME INDIVIDUALS.—

"(1) IN GENERAL.—Subject to paragraph (2), the Secretary shall pay—

"(A) an amount equal to 100 percent of the amount of the premium charged an eligible individual under this section if the income of the individual does not exceed 100 percent of the poverty line for a single individual (as defined in section 673(2) of the Community Services Block Grant Act (42 U.S.C. 9902(2)));

"(B) an amount equal to 75 percent of the amount of the premium charged an eligible individual under this section if the income of the individual is between 100 percent and 150 percent of the poverty line for a single individual (as defined in section 673(2) of the Community Services Block Grant Act (42 U.S.C. 9902(2))); and

"(C) an amount equal to 50 percent of the amount of the premium charged an eligible individual under this section if the income of the individual is between 150 percent and 200 percent of the poverty line for a single individual (as defined in section 673(2) of the Community Services Block Grant Act (42 U.S.C. 9902(2))).

"(2) MINIMUM PAYMENT.—Notwithstanding paragraph (1), an eligible individual who elects to purchase insurance under this part shall pay not less than

$5 per month as part of the premium for such insurance.

"SEC. 2134. BENEFITS.

"(a) TYPES.—An eligible individual who elects to purchase insurance under this part shall be eligible to receive from a nursing facility for an unlimited period of time (contingent on the continued need of the individual for services)—

"(1) nursing care, provided by or under the supervision of a registered professional nurse;

"(2) physical, occupational, or speech therapy furnished by the facility or by others under arrangements with the facility;

"(3) medical social services;

"(4) drugs, biologicals, supplies, appliances, and equipment for use in the facility, that are ordinarily furnished by the facility for the care and treatment of inpatients;

"(5) medical services of interns and residents-in-training under an approved teaching program of a hospital with which the facility has in effect a transfer agreement and other diagnostic or therapeutic services provided by a hospital with which the facility has in effect a transfer agreement; and

"(6) such other health services necessary to the health of patients as are generally provided by nursing facilities.

"(b) DURATION.—The duration of benefits covered under this part shall be unlimited as long as the Case Management Agency determines, through its periodic review of a patient, that the patient continues to require nursing home services.

"SEC. 2135. QUALIFIED SERVICE PROVIDERS.

"(a) IN GENERAL.—Covered nursing home services under this part shall be provided by qualified service providers.

"(b) TYPES.—A provider shall be considered a qualified service provider under this part if the provider is a nursing facility that is certified by the State and meets the requirements of this part and any other standards established by the Secretary by regulation for the safe and efficient provision of services covered under this part.

"SEC. 2136. REIMBURSEMENT.

"(a) AMOUNT.—Monthly reimbursement for nursing home services under this part shall be 65 percent of the amount the Secretary determines to be reasonable and appropriate to cover the cost of care provided under this part, taking into account the average cost of providing appropriate care in the most efficient manner.

"(b) PROSPECTIVE PAYMENT.—To the extent feasible, the Secretary shall establish a prospective payment mechanism for payment for nursing home services under this part that takes into account the expected resource utilization of individual patients based on their degree of disability and other factors determining service requirements.

"(c) ROOM AND BOARD.—

"(1) IN GENERAL.—Notwithstanding section 2132(b)(2), payment for room and board under this part shall be made by an individual participating in the program established by this part for those days spent in a nursing facility beyond 6 months.

"(2) MANNER OF PAYMENT.—Subject to paragraph (4), such payments for room and board shall be made by an individual directly to the nursing facility and shall be reduced by the amount of payments made by the Secretary under paragraph (4).

"(3) RATES.—Charges for room and board shall be 35 percent of the average per diem rate paid by the Secretary to nursing facilities receiving reimbursement under this part.

"(4) PAYMENT BY SECRETARY FOR CERTAIN LOW-INCOME INDIVIDUALS.—The Secretary shall pay directly to the nursing facility—

"(A) an amount equal to 100 percent of the amount of the room and board charges imposed under this subsection for an eligible individual under this section if the income of the individual does not exceed 100 percent of the poverty line for a single individual (as defined in section 673(2) of the Community Services Block Grant Act (42 U.S.C. 9902(2)));

"(B) an amount equal to 75 percent of the amount of such room and board charges for an eligible individual whose income is between 100 percent and 150 percent of the poverty line for a single individual (as defined in section 673(2) of the Community Services Block Grant Act (42 U.S.C. 9902(2))); and

"(C) an amount equal to 50 percent of the amount of such room and board charges for an eligible individual whose income is between 150 percent and 200 percent of the poverty line for a single individual (as defined in section 673(2) of the Community Services Block Grant Act (42 U.S.C. 9902(2))).

"SEC. 2137. EXTENSION OF ELIGIBILITY TO INDIVIDUALS OF ANY AGE.

"(a) IN GENERAL.—Notwithstanding the previous provisions of this part, the Secretary shall provide, in accordance with this section, the option for individuals to purchase coverage under this part without regard to age.

"(b) SEPARATE PREMIUM RATES.—In the case of individuals who purchase coverage under this section, the Secretary shall apply premium rates (which may vary for classes of such individuals) that provide for average, per individual subsidies that approximate the average, per individual subsidies that are provided under this part for individuals not enrolled under this section.

"(c) EFFECTIVE DATE OF OPTION.—This section shall only apply to benefits for periods beginning on or after January 1 of the fifth year beginning after the date of the enactment of this section.

"PART E—TRAINING AND RESEARCH

"SEC. 2141. GRANTS FOR TRAINING FOR HOME AND COMMUNITY-BASED CARE FOR THE ELDERLY.

"(a) IN GENERAL.—The Secretary shall make grants to schools of nursing, social work, allied health, and public health of accredited universities to develop and conduct programs to train individuals in the provision, supervision, planning, and analysis of home and community-based care and

nursing home care for the elderly, disabled, and chronically ill children and in the administration of such programs.

"(b) USE OF FUNDS.—Funding made available under this section may be used for curriculum development, faculty support, and traineeships and fellowships.

"(c) GRANT PREFERENCES.—In awarding grants under this section, the Secretary shall give a preference to programs that—

"(1) provide for the development or conduct of programs for continuing education and certification of professionals currently working in the field of geriatric health in the provision of services to the chronically impaired and working in the field of pediatric care specialization in the provision of care services to chronically ill, disabled, and medical technology dependent children;

"(2) have established or will establish affiliations with nursing homes, agencies providing home and community-based care, senior citizen centers, adult day care centers, and other institutions and agencies providing health and social services to the impaired elderly, for the purpose of providing in-service training to individuals being trained at the grant-receiving institution and technical assistance to the institution providing services; and

"(3) have established or will establish affiliations with programs of geriatric training based in accredited medical schools or schools of nursing, or both.

"(d) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated to carry out this section $15,000,000 for fiscal year 1991, $20,000,000 for fiscal year 1992, and $25,000,000 for fiscal year 1993.

"SEC. 2142. GRANTS FOR HOME HEALTH AIDES.

"(a) IN GENERAL.—The Secretary shall make grants to State approved programs (that meet requirements established by the Secretary relating to minimum course hours, curriculum content, competency evaluation, and qualifications of instructors) to develop and conduct programs to train individuals in the provision of home health aide services. Such training programs shall be designed and conducted according to guidelines and requirements established by the Secretary by regulation.

"(b) GRANT PREFERENCES.—Preference shall be given to programs that have established or will have established affiliations with nursing homes, agencies providing home and community-based care, senior citizen centers, adult day health care centers, and other institutions providing health and social services to the impaired elderly, for the purpose of providing in-service training to individuals being trained at

the grant-receiving program and technical assistance to the institution providing services.

"(c) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated to carry out this section $10,000,000 for each of the fiscal years 1991 and 1992 and $25,000,000 for fiscal year 1993.

"SEC. 2143. GRANTS FOR MODEL CONSUMER TRAINING PROGRAMS.

"(a) IN GENERAL.—The Secretary shall make grants available to accredited university schools of nursing to develop model consumer training programs. Such programs shall provide information and training about the delivery of home care services for caregivers as well as general information about the home and community-based care service system for consumers or potential consumers of home care or home health services, or both, pursuant to regulations established by the Secretary.

"(b) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated to carry out this section $5,000,000 for fiscal year 1991, $10,000,000 for fiscal year 1992, and $15,000,000 for fiscal year 1993.

"SEC. 2144. CENTERS FOR LONG-TERM CARE PLANNING AND TECHNICAL ASSISTANCE.

"(a) IN GENERAL.—The Secretary shall through grants or contracts, or both, assist public or private nonprofit enti-

ties in meeting the costs of planning and developing new centers, and operating existing and new centers, for multidisciplinary health planning development and assistance under this section for the purpose of—

"(1) assisting the Secretary in carrying out this part;

"(2) providing such technical and consulting assistance as States may require;

"(3) conducting research, studies, and analysis of planning and resource development for the provision of long-term care services; and

"(4) developing long-term care planning approaches, methodologies, policies, and standards.

"(b) NUMBER OF CENTERS.—The Secretary shall provide assistance under this section so that at least 6 such centers shall be in operation by January 1, 1991.

"(c) CASE-MANAGEMENT AGENCIES.—Agencies assisted under this section—

"(1) may enter into arrangements with Case Management Agencies for the provision of such services as may be appropriate and necessary in assisting the agencies in performing their functions under this part; and

"(2) shall develop and use methods (satisfactory to the Secretary) to disseminate to such agencies long-

term care planning approaches, methodologies, policies, and standards.

"(d) STAFF.—

"(1) DIRECTOR.—Each center shall have a full-time director who possesses a demonstrated capacity for substantial accomplishment and leadership in the field of planning and resource development in the area of long-term care.

"(2) ADDITIONAL STAFF.—Each center shall employ such other additional staff as may be appropriate. The staff of the center shall meet such additional requirements as the Secretary may by regulation prescribe.

"(e) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated to carry out this section $10,000,000 for fiscal year 1992 and $15,000,000 for each of the fiscal years 1993 and 1994.

"PART F—DEMONSTRATION PROJECTS

"SEC. 2151. DEMONSTRATION PROJECTS FOR SERIOUSLY MENTALLY ILL INDIVIDUALS.

"(a) IN GENERAL.—The Secretary shall conduct at least 5 (but not more than 10) demonstration projects to determine the relative effectiveness, cost, and impact on quality of long-term home care of using different models of providing

scribed in section 2112(a)(2)(B)(ii), who resides in a State shall be an amount that the Secretary estimates is equal to 100 percent of the amount that would be payable, under the plan of the State approved under title XIX during the month if such individual were provided appropriate care in an appropriate institutional setting, if no limit on amount, duration, or scope of covered institutional services applied other than medical necessity.

"SEC. 2116. HOME AND COMMUNITY-BASED CARE ADVISORY COUNCIL.

"(a) ESTABLISHMENT.—No later than 60 days after the date of enactment of this title, there shall be established an independent body to be known as the 'Home and Community-Based Care Advisory Council' (hereinafter referred to in this section as the 'Council').

"(b) MEMBERSHIP.—

"(1) IN GENERAL.—The Council shall be composed of 13 individuals appointed by the Secretary.

"(2) EXPERTISE.—To the maximum extent practicable, the Council shall include individuals with expertise in pediatrics, geriatrics, gerontology, disability, case management of home and community-based services and home and community-based care reimbursement, home and community-based care consumers and

their representatives, home and community-based care providers and their representatives, professionals with expertise in long-term care including nurses, social workers, discharge planners, third party payors, long-term care ombudsmen, and State and local health and social service agency representatives.

"(3) TERM.—An appointment to the Council shall be for a term of not to exceed 4 years.

"(c) PURPOSE.—The purpose of the Council shall be—

"(1) to assist the Secretary in assuring the prompt and efficient implementation of this part;

"(2) to regularly review the implementation of this part; and

"(3) to recommend to the Secretary and Congress any necessary modifications of this part.

"(d) CONSULTATION.—The Secretary shall regularly and closely consult with the Council in the implementation and administration of this part.

"(e) MEETINGS.—To carry out this section, the Secretary shall meet with the Council at least once every month during the 24-month period beginning 60 days after the date of enactment of this title and at least quarterly after such period.

"SEC. 2117. QUALITY ASSURANCE BOARDS AND COMMUNITY ADVISORY BOARDS.

"(a) QUALITY ASSURANCE BOARD.—A State shall establish and appoint members to a quality assurance board that will monitor the quality of care provided under this part in a given area of the State, pursuant to procedures established by the Secretary by regulation.

"(b) COMMUNITY ADVISORY BOARD.—A State shall establish and appoint members to a community advisory board for each Case Management Agency pursuant to regulations by the Secretary. The advisory board shall be composed of consumers of services and their families, representatives of agencies and organizations, professionals providing services to the elderly, and public members. Public members and consumers and their families shall form a majority of the members of the advisory board.

"SEC. 2118. HOME AND COMMUNITY-BASED CARE QUALITY ASSURANCE.

"(a) HOME AND COMMUNITY-BASED CARE SERVICES CONSUMERS' BILL OF RIGHTS.—The Secretary shall promulgate regulations that shall establish a bill of rights for consumers of home and community-based services (hereafter referred to in this section as the 'consumer'), that shall recognize the following as the rights of consumers that may be asserted by the consumer or the representative or guardian of the consumer:

"(1) TREATMENT OF INDIVIDUAL.—To be treated with courtesy, respect, and full recognition of one's dignity, individuality, and right to control one's own household and lifestyle.

"(2) FULL INFORMATION.—To be fully informed by the individual's case management team of his or her condition.

"(3) REFUSAL OF TREATMENT.—To refuse all or part of any treatment, care, or service, and to be informed of the likely consequences of such refusal.

"(4) NONDISCRIMINATION.—To receive treatment, care, and services in compliance with all State and local laws and regulations without discrimination in the provision or quality of services based on race, religion, gender, age, or creed (except as provided under the Age Discrimination Act of 1975 (42 U.S.C. 6101 et seq.)), or because of a change in the source of payment.

"(5) FREEDOM FROM ABUSE.—To be free from mental and physical abuse, neglect, and exploitation, and to be free from chemical and physical restraints.

"(6) RESPECT AND PRIVACY.—To receive respect and privacy in the home care consumer's treatment, care, and services in caring for personal needs, in communications, and in all daily activities.

"(7) CONFIDENTIALITY.—To be assured of the confidential treatment of personal and financial records and to approve or refuse the release of such records to any individuals outside the agency except as otherwise required by law or third-party payment contract.

"(8) EXERCISE OF RIGHTS.—To be free to fully exercise the consumer's civil rights and to be assisted in doing so when assistance is needed.

"(9) TRANSITION OF SERVICES.—To receive assistance to assure a smooth transition in services consistent with the welfare of the home care consumer.

"(b) HOME AND COMMUNITY-BASED PROVIDER QUALITY ASSURANCE REQUIREMENTS.—

"(1) IN GENERAL.—In addition to such other requirements as may apply, the Secretary shall promulgate regulations that require that in order to receive funding under this title for the provision of home or community-based services (hereinafter referred to in this section as 'services'), all qualified providers shall, not later than 6 months after the date of the publication of such regulations—

"(A) comply with the consumers' bill of rights promulgated under subsection (a);

"(B)(i) implement procedures for promptly reviewing and resolving the grievances of consumers; and

"(ii) provide an oral notification and a written copy of such procedures to each consumer (or the representative or guardian of the consumer) who receives services provided by a qualified provider;

"(C) ensure that each provider employed by or under contract with a home care or home health agency receives training—

"(i) sufficient to meet a level of proficiency established by the Secretary in regulations (in consultation with representatives of the elderly, disabled, and children, home health and home care agencies, and experts in the fields of geriatric nursing, pediatric nursing, geriatric social work, pediatric social work, mental health, rehabilitation, and other appropriate health care professionals) that are appropriate in content and amount as are consistent with the requirements of section 4021(b) of the Omnibus Budget Reconciliation Act of 1987;

"(ii) that develops separate levels of proficiency in and is reflective of the range of skills required of providers that provide different levels of services; and

"(iii) the extent of which shall be made available on request to each consumer with respect to the amount of training or level of certification achieved by each provider;

"(D) supervise all care providers employed by or under contract with a qualified provider in accordance with regulations promulgated by the Secretary (including regular random on-site supervisory visits by registered nurses or other appropriate health care professionals); and

"(E) perform annual evaluations of the quality of services provided by providers employed by or under contract with a qualified provider that shall document consumer involvement through a process that shall include client interviews.

"(2) DURABLE MEDICAL EQUIPMENT SERVICES.—In addition to such other requirements as may apply, to receive funding for the provision of durable medical equipment services under this title, a qualified provider shall in each case of a consumer to which such services are provided—

"(A) issue written instructions for the operation of such equipment;

"(B) provide sufficient training to the consumer, the family of the consumer, and the staff to permit the appropriate and safe operation of all such equipment; and

"(C) formulate an emergency plan that is appropriate for the services provided to the home care consumer.

"(c) CASE MANAGEMENT AGENCY QUALITY ASSURANCE REQUIREMENTS.—In addition to such other requirements as may apply, the Secretary shall promulgate regulations requiring that an agency, to receive funding for the provision of case management services under this title, shall, not later than 6 months after the date of the publication of such regulations—

"(1)(A) comply with the consumers' bill of rights promulgated under subsection (a); and

"(B) provide an oral notification and a written copy of such bill of rights to each consumer (or the representative or guardian of the consumer) who receives services under this title;

"(2)(A) implement procedures for the prompt review and resolution of the grievances of consumers; and

"(B) provide an oral notification and a written copy of such procedures to each consumer (or the representative or guardian of such consumer) who receives services from the agency;

"(3) provide to each consumer (or the representative or guardian of the consumer) a written statement of the services to be provided to the consumer and the schedule for the provision of such services, as agreed on by the consumer;

"(4) provide to each consumer a clear written statement as to how the consumer (or the representative or guardian of the consumer), may appeal the benefit and level decisions made by the agency;

"(5) maintain procedures that assure prompt access by eligible consumers to services;

"(6) ensure that the personnel that provide case management services to each consumer have received adequate training as prescribed in regulations promulgated by the Secretary, in consultation with the appropriate Home Care Quality Assurance Board; and

"(7) establish and implement case management procedures that shall include—

"(A) a plan of care that establishes reasonable and measurable client objectives and the services to be provided to meet such objectives;

"(B) a plan of care that employs outcome measures of care insofar as they are appropriate and available for each consumer served;

"(C) methods for a review that shall be conducted at least once during every 3-month period of—

"(i) the needs of the consumer; and

"(ii) the plan of care for the consumer;

"(D) methods for follow-up and on-going monitoring of patient and services delivery; and

"(E) a statement of the criteria and procedures to be applied for the discharge or transfer of the consumer to another agency, program, or service.

"(d) STANDARD AND EXTENDED SURVEY.—Sections 1891 (c) and (d) shall apply to home health agencies certified to receive payments for services provided under this title.

"(e) SURVEY.—The Secretary shall develop and implement a standard and extended survey of home care agencies certified to receive payments for services provided under this title.

"SEC. 2119. CERTIFICATION.

"(a) REQUIREMENT.—

"(1) IN GENERAL.—A State shall—

"(A) survey home care agencies, home health agencies, and adult day health care centers to determine their eligibility to participate in the program established under this part; and

"(B) certify such an agency or center as eligible to participate in such program if the agency meets the requirements of this part and regulations prescribed by the Secretary.

"(2) FREQUENCY.—A State shall conduct the survey and certification required under paragraph (1) not less than once during each fiscal year.

"(b) INDIVIDUAL PROVIDERS.—

"(1) IN GENERAL.—To be eligible to be reimbursed for services covered under this part, a qualified service provider referred to in section 2114 shall be licensed or, if applicable, certified by the State in which the provider practices pursuant to the requirements of this part and regulations prescribed by the Secretary.

"(2) HOMEMAKERS AND HOME HEALTH AIDES.—To be reimbursed for services covered under this part, a homemaker or home health aide must be a trained employee of a certified home care or home health agency working under professional supervision.

"(3) WAIVER.—The Secretary may waive the certification requirement for providers that do not provide direct patient care.

"SEC. 2120. REIMBURSEMENT.

"(a) ACCEPTANCE OF REFERRALS AND REIMBURSEMENT.—

"(1) IN GENERAL.—Except as provided in paragraph (2), a home health or home care agency or other provider certified by a State to provide services reimbursable under this part shall provide services to all individuals referred to the provider by a Case Management Agency or by an organization under contract with the agency to provide case management services and accept as payment in full the reimbursement amounts provided under this part.

"(2) EXCEPTION.—The service requirement imposed under paragraph (1) shall not apply if the requirement would be in conflict with the operating policies under which the provider was certified (such as the maximum number of individuals an agency may care for at any time).

"(b) ADDITIONAL SERVICES.—Nothing contained in this part shall be construed to preclude any individual who is eligible to receive services under this part from purchasing home and community-based services that are more generous

than services provided for in the care plan of the individual. If an individual purchases more generous services, a provider may not charge such individual higher rates for such services than the amount the provider is reimbursed under this part.

"(c) RELATIONSHIP TO OTHER ENTITLEMENT PROGRAMS.—Notwithstanding any other provision of law, in the case of any service covered under this part that is also covered under another Federally administered entitlement program, the Secretary shall act as a secondary payer under this part.

"(d) REIMBURSEMENT.—Reimbursement for services provided under this part shall be subject to the requirements of this part and regulations prescribed by the Secretary.

"PART C—COVERAGE OF FIRST 6 MONTHS OF NURSING HOME CARE

"SEC. 2121. BENEFITS.

"(a) IN GENERAL.—Subject to subsections (c) and (d), an individual who meets the eligibility criteria prescribed in section 2122 shall be eligible under the program established by this part for coverage for services described in subsection (b) provided to the individual by a nursing facility that are required by the individual, while the individual is an inpatient of the facility, for a period of time not to exceed 6 months for a spell of illness.

"(b) TYPES.—Coverage may be provided under this part for—

"(1) nursing care provided by or under the supervision of a registered professional nurse;

"(2) bed and board in connection with the furnishing of nursing care;

"(3) physical, occupational, or speech therapy furnished by a facility or by others under arrangements with a facility;

"(4) medical social services;

"(5) drug, biological, supply, appliance, and equipment for use in the facility, that is ordinarily furnished by the facility for the care and treatment of an inpatient;

"(6) medical service of an intern or resident-in-training under an approved teaching program of a hospital with which a facility has in effect a transfer agreement or other diagnostic or therapeutic service provided by a hospital with which a facility has in effect a transfer agreement; and

"(7) such other health services necessary to the health of a patient as are generally provided by a nursing home facility.

"(c) BENEFITS AFTER COVERED STAYS.—An individual shall be eligible for additional nursing home coverage under this part subsequent to a covered stay if—

"(1) the individual has not been an inpatient in a hospital or nursing facility for at least 6 consecutive months after any covered stay; and

"(2)(A) the individual has a diagnosis that is different from that provided for the preceding nursing home stay; or

"(B) there has been a substantial worsening of the condition of the individual since the latest discharge of the individual.

"SEC. 2122. ELIGIBILITY.

"(a) IN GENERAL.—An individual shall be eligible for benefits under this part if—

"(1)(A) for benefits provided before January 1 of the fourth year that begins after the date of the enactment of this title, the individual is—

"(i) 65 years of age or older; or

"(ii) eligible for benefits under part A of title XVIII as the result of disability; and

"(B) has been determined by a Screening Agency through a screening process (conducted in accordance with section 2102) to be—

"(i) completely dependent with respect to at least one age-appropriate activity of daily living or unable to perform two or more age-appropriate activities of daily living without human assistance or supervision; or

"(ii) so cognitively impaired (due to adult onset, acquired chronic organic disease of the brain occurring in clear consciousness, and including those individuals who would meet such criteria except for the presence of a transient delirium in such individuals) as to require constant supervision from another individual because such impaired individual engages in inappropriate behavior patterns that pose a substantial health and safety hazard to such impaired individual or to others;

"(2) the individual is—

"(A) under 19 years of age; and

"(B) has been determined by a Screening Agency through a screening process (conducted in accordance with section 2102)—

"(i) to be unable to perform one or more age-appropriate activities of daily living without human assistance or supervision; or

tered professional social worker to direct its social services program.

"(15) RESPITE CARE.—The term 'respite care' means a temporary break provided to an individual who supplies regular care to a dependent relative or friend. For purposes of this title, the break may not exceed 30 days or 720 hours, in a calendar year. The term includes institutional or noninstitutional patient supervisory services to temporarily relieve the caregiver of an eligible individual as determined by a Care Management Agency and included in the care plan of the individual.

"(17) SPELL OF ILLNESS.—The term 'spell of illness' means a period of consecutive days beginning with the first day on which an individual is furnished a covered service and ending with the close of the first 6 consecutive months thereafter during which the individual is not an inpatient of a hospital or a nursing facility.

"SEC. 2102. LONG-TERM CARE AGENCIES.

"(a) LONG-TERM CARE SCREENING AGENCY.—

"(1) ESTABLISHMENT.—The Secretary shall contract with entities to act as Long-Term Care Screening Agencies (hereinafter referred to in this title as the 'Screening Agency') for each designated area of a

State. It shall be the responsibility of such agency to assess the eligibility of individuals residing in the geographic jurisdiction of the agency, for services provided under this title according to the requirements of this title and regulations prescribed by the Secretary.

"(2) ELIGIBILITY.—The Screening Agency shall determine the eligibility of an individual based on the results of a preliminary telephone or written questionnaire (completed by the applicant, by the caregiver of the applicant, or by the legal guardian or representative of the applicant) that shall be validated through the use of a screening tool administered in person by a physician, nurse practitioner, or registered professional nurse, to each applicant determined eligible through initial telephone or written questionnaire interviews not later than 15 days from the date on which such individual initially applied for services under this part.

"(3) QUESTIONNAIRES AND SCREENING TOOLS.—

"(A) IN GENERAL.—The Secretary shall establish a telephone or written questionnaire and a screening tool to be used by the Screening Agency to determine the eligibility of an individual for services under this title consistent with re-

quirements of this title and standards established by the Secretary by regulation.

"(B) QUESTIONNAIRES.—The questionnaire shall include questions about the functional impairment, mental status, and living arrangement of an individual and other criteria that the Secretary shall prescribe by regulation.

"(C) SCREENING TOOLS.—The screening tool should measure functional impairment caused by physical or cognitive conditions as well as information concerning cognition disability, behavioral problems (such as wandering or abusive and aggressive behavior), the living arrangement of an individual, availability of caregivers, and any other criteria that the Secretary shall prescribe by regulation. The screening tool shall be administered in person.

"(4) NOTIFICATION.—Not later than 15 days after the date on which an individual initially applied for services under this part (by phone or written questionnaire), the Screening Agency shall notify such individual that such individual is not eligible for benefits, or that such individuals must schedule an in-person screening to determine final eligibility for benefits under this title. The Screening Agency shall notify

such individual of its final decision not later than 2 working days after the in-person screening.

"(5) IN-PERSON SCREENING.—An individual (or the legal guardian or representative of such individual) whose application for long-term care benefits under this title is denied on the basis of information provided through a telephone or written questionnaire, shall be notified of such individual's right to an in-person screening by a nurse or appropriate health care professionals.

"(6) APPEALS.—The Secretary shall establish a mechanism for hearings and appeals in cases in which individuals contest the eligibility findings of the Screening Agency.

"(7) FUNDING LEVEL.—The Screening Agency shall be responsible for determining the estimated funding level that shall be allotted for individuals eligible for home and community-based care, pursuant to standards established under section 2115(e) and regulations of the Secretary.

"(b) LONG-TERM CARE CASE MANAGEMENT AGENCY.—

"(1) ESTABLISHMENT.—The Secretary shall contract with a State or, in any case in which a State declines to contract with the Secretary, a private non-

profit organization, to establish and administer a Long-Term Care Case Management Agency (hereinafter referred to in this title as 'Case Management Agency') for each designated area of a State. Such agency shall demonstrate expertise in the delivery of health and social services to the chronically ill and disabled pursuant to requirements established in this title and such standards as the Secretary may establish by regulation (including standards for training and qualification of personnel, financial responsibility, and governance).

"(2) DUTIES.—A Case Management Agency shall provide case management services for eligible individuals directly or through contracts with home care or home health agencies that meet the requirements of this title and standards prescribed by the Secretary by regulation for providing case management services.

"(3) CARE PLAN.—The Case Management Agency shall develop a care plan for each individual determined to be eligible by a Screening Agency. In developing a care plan for an individual, the Case Management Agency shall design a plan that meets the service needs of the individual, consistent with the resources available to the agency.

"(4) FUNDING.—

"(A) IN GENERAL.—The actual level of funding allotted to an eligible individual by the Case Management Agency to cover services included in the individual's care plan may fall above or below the estimated annualized level allotted to the individual by the Screening Agency based on the detailed assessment and plan of care provided by the Case Management Agency.

"(B) LIMITATION.—The Case Management Agency shall allocate the resources available from the Screening Agency (as described in section 2115(a)) to ensure that the total expenditures for home and community-based care for individuals eligible for services covered under this title residing within the geographic jurisdiction of the agency do not exceed the total amount available monthly to the Case Management Agency, pursuant to this section, for home and community-based services. The Case Management Agency shall establish specific financial controls (including authorizing the amount, scope, and duration of services to be provided to an individual) to carry out this subparagraph.

"(c) REGISTRY.—A Case Management Agency shall maintain a registry of qualified providers of home and com-

munity-based and nursing home care in the State and shall assist individuals in choosing qualified providers to carry out the care plan. An individual eligible for services under this title shall be free to choose from the registry the home care agency, home health agency, or other qualified provider of services to carry out the care plan of such individual. The Case Management Agency shall assist the individual in locating alternative providers if the individual becomes dissatisfied with the provider initially chosen.

"(d) MONITORING.—A State shall, along with the Secretary, monitor the performance of all designated Case Management Agencies and assure the fiscal stability of such agencies. A State shall act as the financial guarantor of each agency.

"SEC. 2103. CONTRIBUTION OF STATE FUNDS.

"(a) ESTIMATE.—The Secretary shall estimate the amount that a State would have spent during each calendar year for individuals eligible for long-term care services under each Federal-State entitlement program in the absence of the program established by this title. Such estimate shall be updated annually based on the projected increases in the cost of carrying out this title.

"(b) CONTRIBUTION.—For residents of a State to be eligible to participate in the program established by this title during a calendar year, the State shall contribute the amount

estimated under subsection (a) to the Secretary to share in the costs of providing services to such State residents under the program established by this title for such calendar year.

"PART B—COVERAGE OF HOME AND COMMUNITY-BASED CARE SERVICES

"SEC. 2111. BENEFITS.

"An individual who meets the eligibility criteria prescribed in section 2112 shall be eligible under the program established by this part for coverage for home and community-based care services that are—

"(1) determined to be necessary by a Case Management Agency;

"(2) described in the care plan of the individual;

"(3) services for which the individual is eligible; and

"(4) consistent with the need for care of the individual, regulations issued by the Secretary, and standards established under this part.

"SEC. 2112. ELIGIBILITY.

"(a) IN GENERAL.—An individual shall be eligible for benefits under this part only if the individual—

"(1)(A) with respect to benefits before January 1 of the fourth year that begins after the date of the enactment of this title, is—

"(i) 65 years of age or older; or

"(ii) eligible for benefits under part A of title XVIII as the result of a disability; and

"(B) has been determined by a Screening Agency through a screening process (conducted in accordance with section 2102) to be—

"(i) completely dependent (does not participate) in at least one age-appropriate activity of daily living or unable to perform two or more age-appropriate activities of daily living without human assistance or supervision; or

"(ii) so cognitively impaired (due to adult onset, acquired chronic organic disease of the brain occurring in clear consciousness, and including those individuals who would meet such criteria except for the presence of a transient delirium in such individuals) as to require constant supervision from another individual because such impaired individual engages in inappropriate behavioral patterns that pose a substantial health and safety hazard to such impaired individual or to others; or

"(2)(A) is under 19 years of age; and

"(B) has been determined by a Screening Agency through a screening process (conducted in accordance with section 2102)—

"(i) to be unable to perform one or more age-appropriate activities of daily living without human assistance or supervision; or

"(ii) to require both a medical device to compensate for the loss of a vital body function that is necessary to avert death or major loss of bodily functional capacity and substantial and ongoing nursing care to avert death or further disability; or

"(3)(A) would be eligible for benefits under title XVIII on the basis of a disability except for the required 24-month waiting period;

"(B) has been determined by a Screening Agency through a screening process (conducted in accordance with section 2102) to be completely dependent (does not participate) in at least one age-appropriate activity of daily living or unable to perform two or more age-appropriate activities of daily living without human assistance or supervision; and

"(C) has a medical prognosis that such individual's life expectancy is 12 months or less.

"(b) APPLICATION.—An individual shall be eligible for benefits under this part only if—

"(1) the individual has filed an application for, and is in need of, benefits covered under this part;

"(2) the legal guardian of the individual has filed an application on behalf of an individual who is in need of benefits covered under this part; or

"(3) the representative of an individual who is cognitively impaired, who has no legal guardian, and who is in need of benefits covered under this part, files an application on behalf of the individual.

"SEC. 2113. RESPITE CARE.

"(a) ELIGIBILITY.—An individual shall be eligible for respite care benefits under this part if—

"(1)(A) the individual meets the requirements established in section 2112;

"(B) the individual is dependent on a daily basis on a primary caregiver and is assisting the individual without monetary compensation in the performance of at least two age-appropriate activities of daily living; and

"(C) without such assistance the individual could not perform such activities of daily living; or

"(2) the individual has dementia or other cognitive impairments, as determined by a Screening Agency.

"(b) DETERMINATION OF NEED.—The determination of the need of an individual for respite care shall be made by the Case Management Agency. An analysis of such need shall be included in the care plan of the individual.

"(c) SERVICES.—Respite care services under this section may include home and community-based services or nursing home services described in section 2121(b).

"(d) PERIOD OF COVERAGE.—Coverage for such services shall be for short periods of time of not to exceed 30 days or 720 hours during a given calendar year.

"(e) REIMBURSEMENT RATES.—Reimbursement rates for respite care services covered under this section shall be the same as rates established elsewhere in this part for home and community-based services and nursing home services.

"SEC. 2114. QUALIFIED SERVICE PROVIDERS.

"(a) IN GENERAL.—Services provided to eligible individuals pursuant to a plan of care under this part shall be provided by qualified service providers.

"(b) TYPES.—A qualified service provider shall include—

"(1) a home care agency certified by the State;

"(2) a home health agency certified by the Secretary;

"(3) an adult day health care center certified by the State; and

"(4) other certified or licensed provider of specific services including a registered professional nurse, qualified social worker, physician, nurse practitioner, physical, occupational or speech therapist, certified dietitian,

and other providers as the Secretary shall designate by regulation that meet standards established by the Secretary.

"(c) APPROVAL REQUIRED FOR REIMBURSEMENT.—No individual or agency shall be eligible for reimbursement for services provided to an individual under this part unless the Case Management Agency approves the provision of services to such individual or agency.

"SEC. 2115. PAYMENT FOR SERVICES.

"(a) CASE MANAGEMENT AGENCIES.—The Secretary shall pay an amount monthly to each Case Management Agency that equals the sum of the amounts allotted by the Screening Agency for eligible individuals in the geographic jurisdiction of such Case Management Agency who have been determined by such Screening Agency to be eligible to receive services covered under this part.

"(b) SERVICE PROVIDERS.—

"(1) DIRECT PAYMENTS.—The Case Management Agency shall make direct payments to certified home care and home health agencies, and other qualified providers of home and community-based services reimbursable under this part, in accordance with such methods as the State may establish pursuant to regulations promulgated by the Secretary.

"(2) FULL PAYMENT FOR SERVICES.—All providers of home and community-based care services under the program established under this part shall accept payment rates established by the Case Management Agency as payment in full for services and shall not pass on additional charges to beneficiaries for services rendered under a plan of care.

"(c) PROVIDERS OF CASE MANAGEMENT SERVICES.—If a Case Management Agency contracts with a home health or home care agency to provide case management services, the Case Management Agency shall make direct payments to such organization in accordance with such methods as the State may establish pursuant to regulations promulgated by the Secretary.

"(d) LIMIT ON PAYMENT FOR HOME HEALTH AND COMMUNITY-BASED SERVICES.—

"(1) INITIAL PERIOD.—During the 3-year period beginning on the date of enactment of this title, the maximum amount of payments that may be made to a Case Management Agency for home and community-based services provided to an individual who resides in the geographic jurisdiction of the agency and who is eligible for services under this part shall be, on an annualized basis, not more than 65 percent of the average amount payable, including the cost of ancillary

services, for the same number of care days in a skilled nursing facility under title XVIII in the area in which the home and community-based care is provided.

"(2) SUBSEQUENT YEARS.—In years subsequent to the period referred to in paragraph (1), the maximum amount referred to in such paragraph shall be established by the Secretary according to such prospective payment methods as the Secretary may establish by regulation to assure that no payment is made for home and community-based services that will exceed the cost of an alternative placement in a nursing facility, less a reasonable estimate of the cost of room and board in such facilities or in the community.

"(e) AMOUNT OF COVERAGE.—

"(1) IN GENERAL.—Subject to subsection (d) and other provisions of this subsection, the amount of coverage allotted to an eligible individual shall be the amount necessary to carry out the service needs of the individual.

"(2) MAXIMUM AVERAGE AMOUNT.—In the case of an individual in a given geographic area, the average amount payable for such individual shall not exceed an amount determined by multiplying—

"(A) the maximum amount prescribed in subsection (d); by

"(B) a measure of the severity of the need for services of the individual.

"(3) SEVERITY OF NEED FOR SERVICES.—For purposes of paragraph (2), the severity of the need for services of an individual shall be estimated by such statistical models and techniques, that shall include a measure of the severity of dependency in activities of daily living, cognitive impairment, living arrangement, age, and such other factors as the Secretary shall specify by regulation, except that all individuals determined to be eligible for services under this part shall be presumed to face a monthly need for services of at least 5 percent of the maximum allotment. In determining eligibility, the Secretary shall not use any measures of the income and assets of the individual. Expenditures authorized by this paragraph shall be made only for the services specified in this part in accordance with a written care plan prepared through case management services provided by the Case Management Agency or a home care or home health agency under contract with the agency to provide case management services.

"(4) CHRONICALLY-ILL INDIVIDUAL.—The amount of coverage allotted in a month to an eligible individual who is a chronically-ill individual, as de-

(relating to military medical programs and CHAMPUS) and title 38 (relating to Veterans' health care) of the United States Code.

SEC. 505. RELATION TO ERISA.

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

Division B—Life Care Long-Term Care Protection Act

SEC. 1001. SHORT TITLE; TABLE OF CONTENTS.

(a) SHORT TITLE.—This division may be cited as the "Lifecare Long-Term Care Protection Act".

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

Sec. 1001. Short title; table of contents.
Sec. 1002. Lifecare long-term care protection program.

"TITLE XXI—LIFECARE LONG-TERM CARE PROTECTION PROGRAM

"Part A—General Provisions

"Sec. 2101. Definitions.
"Sec. 2102. Long-term care agencies.
"Sec. 2103. Contribution of State funds.

"Part B—Coverage of Home and Community-Based Care Services

"Sec. 2111. Benefits.
"Sec. 2112. Eligibility.
"Sec. 2113. Respite care.
"Sec. 2114. Qualified service providers.
"Sec. 2115. Payment for services.
"Sec. 2116. Home and Community-Based Advisory Council.
"Sec. 2117. Quality assurance boards and community advisory boards.
"Sec. 2118. Home and community-based care quality assurance.
"Sec. 2119. Certification.
"Sec. 2120. Reimbursement.

"Part C—Coverage of First 6 Months of Nursing Home Care

"Sec. 2121. Benefits.
"Sec. 2122. Eligibility.
"Sec. 2123. Limitations on payment.
"Sec. 2124. Reimbursement.
"Sec. 2125. Relationship to other entitlement programs.

"Part D—Insurance Coverage for Nursing Home Care That Exceeds 6 Months

"Sec. 2131. Establishment of Federal Long-Term Care Insurance Program.
"Sec. 2132. Eligibility.
"Sec. 2133. Premium rates.
"Sec. 2134. Benefits.
"Sec. 2135. Qualified service providers.
"Sec. 2136. Reimbursement.
"Sec. 2137. Extension of eligibility to individuals of any age.

"Part E—Training and Research

"Sec. 2141. Grants for training for home and community-based care for the elderly.
"Sec. 2142. Grants for home health aides.
"Sec. 2143. Grants for model consumer training programs.
"Sec. 2144. Centers for long-term care planning and technical assistance.

"Part F—Demonstration Projects

"Sec. 2151. Demonstration projects for seriously mentally ill individuals.
"Sec. 2152. Demonstration projects for working age individuals with severe functional limitations.
"Sec. 2153. General authority.".
Sec. 1003. Effective date.

SEC. 1002. LIFECARE LONG-TERM CARE PROTECTION PROGRAM.

The Social Security Act is amended by adding at the end the following new title:

"TITLE XXI—LIFECARE LONG-TERM CARE PROTECTION PROGRAM

"PART A—GENERAL PROVISIONS

"SEC. 2101. DEFINITIONS.

"As used in this title:

"(1) ACTIVITY OF DAILY LIVING.—The term 'activity of daily living' includes:

"(A) BATHING.—Getting water and cleansing the whole body, including turning on the water for a bath, shower, or sponge bath, getting to, in, and out of a tub or shower, and washing and drying oneself;

"(B) DRESSING.—Getting clothes from closets and drawers and then getting dressed, including putting on braces or other devices and fastening buttons, zippers, snaps, or other closures, selecting appropriate attire, and dressing in the proper order;

"(C) TOILETING.—Going to a bathroom for bowel and bladder function, transferring on and off the toilet, cleaning after elimination, and arranging clothes;

"(D) TRANSFERRING.—Moving in and out of bed and in and out of a chair or wheelchair; or

"(E) EATING.—Transferring food from a plate or its equivalent into the body, including cutting food so as to make possible safe ingestion.

"(2) ADULT DAY HEALTH CARE.—The term 'adult day health care' means a community-based group program designed to—

"(A) meet the need for adult day health care for functionally impaired individuals in a structured, comprehensive program; and

"(B) provide a variety of health and social services furnished by an adult day health care center in an ambulatory group care setting during any part of a day, but on a less than 24-hour basis, to an individual described in section 2112.

"(3) ADULT DAY HEALTH CARE CENTER.—

"(A) IN GENERAL.—The term 'adult day health care center' means a public agency or private organization (or a subdivision thereof), with an identifiable administrative unit headed by a Director, that meets such standards for personnel, program, physical characteristics of the facility, recordkeeping, and such other aspects of the function of such center as the Secretary considers necessary or desirable for the health, safety, and effective treatment of patients and establishes by regulation.

"(B) PROFESSIONAL ORGANIZATION STANDARDS.—In promulgating such regulations, the Secretary shall carefully consider certification standards established by the National Council on

Aging and its professional membership unit, the National Institute for Adult Day Care.

"(C) PERSONNEL.—Such standards shall include the participation in the provision of the services of the center of a multidisciplinary group of personnel that includes at least—

"(i) one physician or nurse practitioner, which could be the individual's own physician or nurse practitioner;

"(ii) one registered professional nurse;

"(iii) one social worker;

"(iv) individuals with skills representing physical, recreational, or occupational therapy or speech-language pathology; and

"(v) a dietitian.

"Such personnel may be employed directly by the center or on a consultant basis, as specified by the Secretary by regulation.

"(D) STATE CERTIFICATION.—To be considered an adult health care center under this title, a center shall be certified by a State, pursuant to regulations issued by the Secretary.

"(4) CARE PLAN.—

"(A) IN GENERAL.—The term 'care plan' means a plan that has been developed by a Case

Management Agency, or a home care or home health agency working under contract with the Case Management Agency to provide case management services. Such a care plan shall be based on the results of a comprehensive needs assessment of an eligible individual conducted by a case management team in cooperation with the individual, the family of the individual, or other informal caregivers, and in consultation with such other health professionals as the case management team considers appropriate for the needs of the individual. A care plan developed by a home care or home health agency is subject to review and approval by the Case Management Agency. Any entity performing case management services for individuals determined eligible for services under this title shall not be allowed to self-refer for services included in the care plan of such individual.

"(B) CONTENTS.—The plan shall—

"(i) include a definition of specific outcome goals on which improvement, reduced rate of decline, maintenance, or improved quality of life for the individual is expected; and

"(ii) identify the specific mix of services necessary to meet the outcome goals allotted to the patient and reimbursable under this title as determined by the procedure described in section 2102.

"(5) CASE MANAGEMENT SERVICES.—

"(A) IN GENERAL.—The term 'case management services' means services performed by a case management team that include—

"(i) conducting a comprehensive needs assessment in cooperation with an individual and the family of an individual and in consultation with such other health professionals (including a physical therapist, occupational therapist, nurse practitioner, certified dietitian, or physician) as the case management team considers appropriate for the needs of the individual to assess the physical, social, cognitive, and environmental status of the individual;

"(ii) developing, implementing, and modifying (when necessary) the care plan of an individual;

"(iii) coordinating the services provided under the care plan;

"(iv) monitoring the care plan to ensure the quality, quantity, timeliness, and effectiveness of the services;

"(v) monitoring the progress of an individual toward achievement of the goals specified in the care plan; and

"(vi) reviewing and revising, as necessary, the care plan at least once every three months or earlier in the event that the condition of the individual changes.

"(B) REQUIREMENT.—Individuals providing case management services to children and the disabled under this title shall demonstrate their experience with the special needs of these populations.

"(6) CASE MANAGEMENT TEAM.—The term 'case management team' means a registered professional nurse and a qualified social worker (who is licensed or certified, if applicable, in the State in which the individual is providing services), working in consultation with other health professionals as needed, who are employed by a Case Management Agency or by a certified home health agency, home care agency, or other private nonprofit organization under contract with the agency to provide case management services pursuant to the requirements of this title and standards pre-

scribed by the Secretary by regulation. Such nurse and social worker shall meet standards of education, training, and experience established by the Secretary by regulation to qualify to provide case management services under this title. The case management team for any person determined eligible for services under this title, as defined under section 2112(a)(2)(B)(ii), shall also include a physician.

"(7) COMPREHENSIVE NEEDS ASSESSMENT.—The term 'comprehensive needs assessment' means a comprehensive interdisciplinary assessment of the status and needs of an individual that is conducted by a case management team. The assessment shall address functional status (including activities of daily living), instrumental activities of daily living (such as housekeeping, shopping, transportation, meal preparation, and taking medication), medically defined conditions, drug regimen, nutrition status, mental status, living arrangement, and availability of caregiver support.

"(8) HEAVY CHORE SERVICES.—The term 'heavy chore services' means heavy cleaning and minor home repair. Chore services may not be used to perform activities that are the responsibility of a housing authority or landlord, or both. Heavy chore services shall be provided by personnel not requiring special training but

who work under supervision of the case management agency or other qualified provider. Heavy chore services include those services determined by a case manager to be necessary to protect the health and safety of an individual such as washing floors and walls, woodcutting, changing storm windows, replacing window panes, door and window locks, installing minor home adaptations, snow shoveling, weatherization, and such other needed heavy chore services as are specified by a case manager.

"(9) HOME AND COMMUNITY-BASED CARE SERVICES.—The term 'home and community-based care services' means items and services provided to an individual—

"(A) under a written plan of care for furnishing such items and services to the individual;

"(B) except as provided clauses (iv), (v), and (xii) of subparagraph (C), on a visiting basis in a place of residence of the individual and in other facilities (but not including a nursing facility); and

"(C) that include—

"(i) homemaker services;

"(ii) home health aide services;

"(iii) heavy chore services;

"(iv) adult day health care provided at an adult day health care center;

"(v) respite care;

"(vi) home mobility aids and minor adaptations to the home of the individual that promote independence (such as installation of an emergency alarm system, railings, ramps, and special toilets) that are approved by the case manager and included in the care plan of the individual;

"(vii) nursing care provided by or under the supervision of a registered professional nurse;

"(viii) medical social work services;

"(ix) physical, occupational, or speech therapy or rehabilitative services to preserve and restore functional capability or to prevent functional deterioration;

"(x) transportation to and from health or social services;

"(xi) nutrition and dietary counseling provided by or under the supervision of a qualified dietitian; and

"(xii) any of the items and services referred to in clauses (i) through (xi)—

"(I) that are provided on an outpatient basis, under arrangements made by the case manager, at a hospital or nursing facility, or at a rehabilitation center that meets such standards as may be prescribed in regulation; and

"(II) the furnishing of which cannot readily be made available to the individual in such place of residence, or can be provided more economically or effectively in such hospital, facility, or center.

"(10) HOME CARE AGENCY.—The term 'home care agency' means an agency in any State that has been certified by the State to provide home care services pursuant to regulations of the Secretary. Such services include homemaker services, heavy chore services, and respite services.

"(11) HOME HEALTH AGENCY.—The term 'home health agency' means an agency in any State that has been certified by the Secretary to provide home health services. Such services shall include home health aide services, homemaker services, nursing services, respite services, medical social work services, and occupa-

tional, physical, speech therapy, and nutrition and dietary counseling.

"(12) HOME HEALTH AIDE SERVICES.—

"(A) IN GENERAL.—The term 'home health aide services' means the services provided by a home health aide who meets such educational, training, and any other requirements as the Secretary shall establish by regulation and who is employed by a home health or home care agency or whose services are provided under a contract with, or subcontract on behalf of, a Case Management Agency.

"(B) SERVICES.—Such services shall include—

"(i) providing personal care in following the instructions of the case management team of an individual under the supervision of a registered professional nurse or, if appropriate, a physical, speech, or occupational therapist;

"(ii) assisting the individual with activities of daily living;

"(iii) assisting the individual with the taking of medications ordered by a physician, that are ordinarily self-administered;

"(iv) assisting and reinforcing the individual with necessary self-help skills; and

"(v) reporting to the registered professional nurse supervisor any change in the condition or family situation of the individual.

"(13) HOMEMAKER SERVICES.—

"(A) IN GENERAL.—The term 'homemaker services' means services provided by a homemaker who meets such educational, training, and any other requirements as the Secretary shall establish by regulation and who is employed by a home health or home care agency or who are working under contract with, or subcontract on behalf of, a Case Management Agency.

"(B) SERVICES.—Homemaker services may include—

"(i) organizing the homemaking activity of the household with the active participation of an individual, if possible, and other responsible family members;

"(ii) coordinating efforts of other family members in planning and carrying out the duties necessary for the normal functioning of the household;

"(iii) performing routine housekeeping tasks, planning and preparing meals, doing the marketing and simple errands, and taking care of light laundry;

"(iv) assisting the individual with personal care services including performing activities of daily living; and

"(v) performing such incidental household services as are essential to the care of an individual at home, such as reporting to a registered professional nurse supervisor changes in the condition or family situation of the individual and following a written case plan established by a case management team.

"(14) NURSING FACILITY.—

"(A) IN GENERAL.—The term 'nursing facility' means an institution that meets such requirements as the Secretary shall prescribe by regulation to ensure the safe and efficient provision of nursing home services under this title.

"(B) REQUIREMENTS.—

"(i) REGISTERED PROFESSIONAL NURSE.—All nursing facilities shall maintain at least one registered professional nurse on

duty at all times. The Secretary may provide limited waivers of such requirement if—

"(I) the facility demonstrates to the satisfaction of the Secretary that it has been unable, despite diligent efforts (including offering wages at the community prevailing rate) to recruit and retain appropriate personnel;

"(II) the Secretary determines that a waiver of the requirement will not endanger the health, safety, or well being of residents of the facility;

"(III) the facility meets any other requirements that the Secretary may establish for the approval of such a waiver; and

"(IV) such waiver is not for a period in excess of 6 months, but such may be renewed on a limited basis for additional periods not to exceed 6 months.

"(ii) REGISTERED PROFESSIONAL SOCIAL WORKER.—All nursing facilities shall maintain at least one full-time regis-

and hourly payments, so long as the amount of payments under such methodology do not exceed, in the aggregate, the amount of payments that would otherwise be made under the methodology described in subsection (a).

SEC. 315. APPLICATION TO MEDICARE PROGRAM.

Payment methodologies established under this subtitle in a State shall also be applied to payments under medicare for services furnished in the State.

Subtitle C—Sources of Revenues

SEC. 331. STATE SOURCES OF REVENUES.

(a) IN GENERAL.—Each State shall be responsible for establishing a financing program for the implementation of the State CHC program in the State. Such financing program may include State funding from general revenues, earmarked taxes, sales taxes, subject to section 332, employer and employee health insurance premiums and cost-sharing, and such other measures consistent with this division as the State may provide.

(b) START-UP FUNDS.—In order to assist each State in the development and implementation of the State CHC program, each State is entitled to receive $10,000,000.

(c) ON-GOING ENTITLEMENT.—Each State with a State CHC program approved by the National CHC Board is entitled to funding from the Board in the amounts provided under section 303.

SEC. 332. COST-SHARING.

(a) IN GENERAL.—Except as provided in this section, a State CHC program may permit qualified health plans to charge premiums and cost-sharing for services under this division.

(b) LIMITATION ON COST-SHARING.—

(1) INCOME UNDER POVERTY LINE.—No premiums or other cost-sharing may be imposed with respect to any individual in a family the income of which (as determined in accordance with standards specified by the National CHC Board) in the previous year is less than 200 percent of the income official poverty line (as defined in paragraph (5)).

(2) OTHER SERVICES.—No deductibles or other cost-sharing may be imposed with respect to—

(A) items and services provided to a pregnant woman,

(B) well-baby care, for an individual in a family the income of which (as so determined) in the previous year is less than 150 percent of the income official poverty line.

(3) GENERAL LIMIT ON COST-SHARING.—Subject to paragraph (6), premiums in a calendar year and cost-sharing with respect to expenses incurred in a calendar year for required items and services other than long-term care may not exceed—

(A) a deductible of more than $200 for a family consisting of 1 individual or $500 for family consisting of more than 1 individual,

(B) a coinsurance rate of 20 percent, and

(C) total premiums and cost-sharing for a family consisting of 1 individual of $1,000 or $2,500 for a family consisting of more than 1 individual.

(4) PAYMENT AMOUNT IS PAYMENT IN FULL.—No individual shall be liable for payment of any amounts for basic covered health care services furnished under this division except as permitted in this section.

(5) INCOME OFFICIAL POVERTY LINE DEFINED.—In this section, the term "income official poverty line" means the income official poverty line, as defined by the Office of Management and Budget, and revised annually in accordance with section 673(2) of the Omnibus Budget Reconciliation Act of 1981, applicable to a family of the size involved.

(6) INDEXING.—The dollar amounts specified in paragraph (3) shall be increased, for years after 1994, by the same percentage as the percentage increase in the consumer price index for all urban consumers (U.S. city average) between January 1993 and January of

the previous year. If such dollar amounts are not a multiple of $10, they shall be rounded to the nearest multiple of $10.

(c) COMMUNITY-RATED PREMIUMS.—Premiums charged by a qualified health plan under this division shall be community-rated and shall not reflect the health status of individuals or insured groups.

SEC. 333. TRUST FUND AND ALLOCATIONS.

(a) USE OF TRUST FUND.—

(1) IN GENERAL.—There is hereby created on the books of the Treasury of the United States a trust fund to be known as the "Federal Long-Term Care 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 (as is hereby authorized to be received) and such amounts as may be deposited in, or appropriated to, such fund as provided in this division.

(2) APPROPRIATION.—There are hereby appropriated to the Trust Fund amounts equivalent to 100 percent of the additional revenues received as a result of the provisions of section 333(a) of this Act. The amounts appropriated by the preceding sentence shall be transferred from time to time (not less frequently than monthly) from the general fund in the Treasury to the Trust Fund, such amounts to be determined on the

basis of estimates by the Secretary of the Treasury of the revenues, specified in the preceding sentence, 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 revenues specified in the preceding sentence.

(3) INCORPORATION OF TRUST FUND PROVISIONS.—The provisions of subsections (b) through (i) of section 1841 of the Social Security Act shall apply to the Trust Fund in the same manner as they apply to the Federal Supplemental Medical Insurance Trust Fund, except that any reference to the Secretary of Health and Human Services or the Administrator of the Health Care Financing Administration shall be deemed a reference to National CHC Board.

(b) ALLOCATION TO STATES.—

(1) IN GENERAL.—Payments in each calendar year to each State from the Trust Fund for long-term care benefits in the State shall be in an amount equal to the Federal matching percentage for the State of the product of—

(A) the number of residents of the State in the calendar year who are within each age group (specified under paragraph (3)), and

(B) the Federal per capita allocation for individuals within the age group.

For purposes of this paragraph, the term "Federal matching percentage" for a State means 100 percent minus the ratio of the per capita income of the State to the per capita income of the 50 States (and the District of Columbia).

(2) DETERMINATION OF FEDERAL PER CAPITA ALLOCATION.—

(A) INITIALLY.—The Secretary shall establish initial Federal per capita allocations for individuals within each of the age groups. Such allocations shall be established in a manner so that—

(i) the ratios of the allocations among the different age groups reflects the ratios of the average per capita costs incurred in providing long-term care to the population of individuals within the respective age groups nationwide, and

(ii) the average level of the allocation reflects the level of expenditures for such services under current law.

(B) LIMITATION ON INCREASE IN FEDERAL PER CAPITA ALLOCATION.—After 1994, the amount of each of the Federal per capita alloca-

tion for a calendar year shall be such Federal per capita allocation for the previous calendar year increased by an index (specified by the Secretary) that reflects the year-to-year rate of increase in average, nationwide costs of a representative marketbasket of the items and services composing long-term care.

(3) AGE GROUPS.—For purposes of this subsection, each of the following shall be considered a separate age group of individuals:

(A) Individuals over 64, and under 75, years of age.

(B) Individuals over 74, and under 85, years of age.

(C) Individuals over 84 years of age.

TITLE IV—ADMINISTRATION

SEC. 401. NATIONAL COMPREHENSIVE HEALTH CARE BOARD.

(a) IN GENERAL.—There is hereby established as an independent agency a National CHC Board (in this section referred to as the "National Board").

(b) APPOINTMENT AND TERMS OF MEMBERS.—The National Board shall consist of 7 individuals approved by the President, with the advice and consent of the Senate. Such individuals shall serve for a term of 5 years, except that the terms of individuals initially appointed shall be (as specified

by the President) for such fewer number of years as will provide for the expiration of terms on a staggered basis.

(c) DUTIES.—The National Board is responsible for the overall administration of this division, as well as the development of specific guidelines to permit States to carry out this division.

(d) REPORT.—The National Board shall report to Congress on the status of expenditures under this division, long-range plans and goals for the organization and delivery of personal health services, differences in the health status of the populations of the different States, as well as opportunities for improvements in the program provided under this division.

(e) NATIONAL ADVISORY BOARD.—

(1) The National Board shall provide for appointment of a National Advisory Board to advise the National Board on its activities.

(2) Such Advisory Board shall consist of 15 members who are representatives of employers, unions, health care providers, health care insurers, consumer organizations, State CHC Boards, and public health professionals, as well as the general public. Such members shall serve for terms of 3 years, except that, in the initial appointment, 5 members shall be each appointed for terms of 1-year, 2-years, and 3-years.

(3) Such Advisory Board shall sponsor site visits and studies that are concerned with issues of access to health care services, utilization of health care services, and consumer participation and satisfaction in the provision of health care services.

SEC. 402. STATE COMPREHENSIVE HEALTH CARE PROGRAMS.

(a) IN GENERAL.—Each State shall submit to the National CHC Board a plan for its State CHC program in the State.

(b) REVIEW AND APPROVAL OF PLANS.—The National CHC 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 unless it finds that the plan provides, consistent with the provisions of this division, for—

(1) adequate financing of health services under the plan,

(2) freedom of choice of eligible individuals in the selection among qualified health plans,

(3) effective cost containment measures and payment methodologies consistent with title III,

(4) adequate administration, including the designation of a single State agency responsible for administration of the program and the establishment of a

public advisory board (with board representation of interested parties),

(5) appropriate safeguards and grievance procedures,

(6) responsive quality control mechanisms (including the establishment of a State Commission on Quality),

(7) organization of a State commission to develop programs and schedules to reduce excess hospital beds, and

(8) an organized grievance procedure available to consumers through which complaints about the organization and administration of personal medical care services may be filed and hearings held (at the discretion of the State CHC Board). Programs under paragraph (7) shall provide for appropriate plans to refinance outstanding hospital debt (for hospitals in which beds will be reduced) and to retrain (where necessary) staff displaced by a reduction in excess hospital beds.

(c) OPERATIONAL STATUS.—A State CHC program in a State shall not be considered operational unless it is approved under subsection (b) and it has enrolled at least 90 percent of the eligible individuals in the State under the program.

(d) FAILURE OF APPROVAL.—

(1) If the National CHC Board finds that a State plan submitted under subsection (a) does not meet the requirements for approval under subsection (b) or that a State plan, previously approved, no longer meets such requirements the Board shall provide notice to the State CHC Board of such failure and that unless corrective action is taken within a period of 90 days the sanctions described in paragraph (2) may be applied, effective 90 days after the end of such 90-day period.

(2) The sanctions described in this paragraph are—

(A) that expenses of employers in the State for health-related items may not be deducted from income under section 212 of the Internal Revenue Code of 1986, and

(B) amounts otherwise payable under this division to the State shall be reduced by 10 percent.

SEC. 403. COMMISSIONS ON QUALITY.

(a) NATIONAL COMMISSION ON QUALITY.—

(1) IN GENERAL.—The National CHC Board shall provide for appointment of a National Commission on Quality to establish, evaluate, and update national minimum standards to assure the quality of services provided under this division and to monitor efforts

by State CHC Boards to assure the quality of such services. Members of the Board shall be appointed to serve for fixed (and staggered) terms and in a manner as to provide for representation of the viewpoints of relevant health professions, health institutions and programs, the general public (including representation of various population groups in the public).

(2) NATIONAL MINIMUM STANDARDS.—The national minimum standards under paragraph (1) shall be established for institutional providers of services, physicians and other individual health care personnel, and organized delivery programs. Such standards shall include elements relating to—

(A) adequacy and quality of facilities,

(B) competence of personnel,

(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, and structure of services, and outcome in palliation, improvement of health, stabilization, cure, or rehabilitation).

(3) ANNUAL REPORT.—The National Commission on Quality shall prepare an annual report on quality

assurance under this division. Such report shall include an assessment of the impact of this division on health care quality, access, and beneficiary cost.

(4) EXCHANGE OF INFORMATION.—The National Commission on Quality shall provide for an exchange, at least annually, among State Commissions on Quality of information respecting quality assurance and cost containment.

(b) STATE COMMISSION ON QUALITY.—

(1) IN GENERAL.—Each State CHC Board shall provide for an appointment of a State Commission on Quality to implement national minimum standards in each State. Members of such a Board shall be appointed to serve for fixed (and staggered) terms and in a manner as to provide for representation of the viewpoints of relevant health professions, health institutions and programs, the general public (including representation of various population groups in the public).

(2) MODIFICATION OF STANDARDS.—Each State Commission on Quality may, with the consent of the National Commission on Quality, provide for the application of modified national minimum standards due to special conditions or opportunities in the State.

SEC. 404. NATIONAL ADVISORY COMMISSION ON TECHNOLOGY ASSESSMENT AND CLINICAL EFFECTIVENESS.

(a) ESTABLISHMENT.—The National CHC Board shall establish a National Advisory Commission on Technology Assessment and Clinical Effectiveness (in this section referred to as the "Commission").

(b) DUTIES.—The Commission shall, in close consultation with the Secretary of Health and Human Services, make recommendations related to—

(1) technological development and clinical treatment effectiveness;

(2) outcomes of drugs, devices, and clinical procedures; and

(3) possible inclusion of new drugs and technological procedures as covered health services and discontinuance of payment for inefficient procedures.

SEC. 405. NATIONAL RESOURCES EQUALIZATION FUND.

(a) ESTABLISHMENT.—There is hereby established a National Resources Equalization Fund, to be administered by the National CHC Board.

(b) PURPOSE.—The Fund shall be used by the Board to augment the capability of medically under-developed areas to provide services under this division and to strengthen their abilities to provide local services.

(c) FUNDING.—There are authorized to be appropriated for the Fund for fiscal year 1994, $1,000,000,000, and, for each fiscal year thereafter, amounts equal to 1 percent of the expenditures to be made under this division in that fiscal year.

(d) GRANTS.—The Board shall provide, upon application, for making amounts available in the fund to States and localities.

TITLE V—EFFECTIVE DATES; TRANSITION; RELATION TO OTHER PROGRAMS

SEC. 501. EFFECTIVE DATES.

(a) IN GENERAL.—The comprehensive health care program established under this division shall first apply to health care services furnished during the 3rd calendar year beginning after the date of the enactment of this Act.

(b) EXCEPTION.—However, such program shall not apply with respect to any calendar year unless, before the beginning of the year, the Secretary of Health and Human Services has determined that at least ½ of the number of States have enacted legislation necessary to implement this division in such States.

SEC. 502. TRANSITION.

(a) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated for each of 3 fiscal years beginning after the date of the enactment of this Act such sums as

may be necessary to provide for financial assistance to States in the planning and development of State CHC programs.

(b) FEHBP.—Notwithstanding any other provision of law, no health benefits plan may be offered under chapter 89 of title 5, United States Code, after the effective date of this division unless the plan is a qualified health plan under this division.

SEC. 503. TREATMENT OF MEDICARE AND MEDICAID PROGRAMS.

(a) MEDICARE PROGRAM.—

(1) Except as specifically provided in this division, nothing in this division shall be construed as changing medicare.

(2) To the extent that individuals who are entitled to benefits under medicare are enrolled under a State CHC program under this division, the medicare program shall be primary payor with respect to any duplicative benefits.

(b) MEDICAID PROGRAMS.—Except as specifically provided in this division, the medicaid program shall not apply in any State with a State CHC program approved and in operation under this division.

SEC. 504. TREATMENT OF CERTAIN PROGRAMS.

Nothing in this division shall be construed as making any changes in the programs of health care under title 10

SEC. 202. EXCLUSIONS.

(a) GENERAL EXCLUSIONS.—Basic covered health services do not include items and services for which payment may not be made under medicare, including the following items and services:

(1)(A) Except for items and services described in the succeeding subparagraphs, items and services not reasonable and necessary for the diagnosis or treatment of illness, injury, or condition, or to improve the functioning of a malformed body member.

(B) In the case of preventive health services (including immunizations), services which are not reasonable and necessary for the prevention of illness.

(C) In the case of hospice care, care which is not reasonable and necessary for the palliation or management of terminal illness.

(D) In the case of personal care services, services which are not reasonable and necessary to assure the health and condition of the individual is maintained in the individual's noninstitutinal residence.

(2)(A) Subject to subparagraph (B), items and services not provided within the United States.

(B) Subparagraph (A) shall not apply to—

(i) emergency hospital or physicians' services available in Canada or Mexico if the hospital or physician is closer to the individual's residence

than a hospital or physician in the United States, or

(ii) items and services required by a citizen of the United States while traveling en route between a residence in the United States and Alaska.

(3) Services which constitute personal comfort items.

(4) Items and services, other than preventive health services, for routine physical checkups, eyeglasses, and hearing aids.

(5) Cosmetic surgery, except for prompt repair of accidental injury or for improvement of the functioning of malformed body member.

(6) Services rendered by immediate relatives of the individual or members of the individual's household.

(7) Services, other than preventive health services, in connection with the care, treatment, filling, removal, or replacement of teeth or structures directly supporting teeth, except for inpatient hospital services in connection with the treatment of an underlying medical condition.

(8)(A) Subject to subparagraph (B), treatment of flat feet conditiod the prescription of supportive

devices thereof, the treatment of subluxations of the foot, or routine foot care (including the cutting or removal of corns or calluses, the trimming of nails, and other routine hygienic care).

(B) Subparagraphs (A) shall not apply to services or treatment required to prevent serious handicapping for patients with a diagnosed case of diabetes mellitus.

(b) EXCLUSIONS OF NON-MEDICARE INDIVIDUALS.—Basic covered health services do not include, for individuals who are not entitled to benefits under medicare, the following items and services:

(1) Orthopedic shoes or other supportive devices for the feet.

(2) Professional services of chiropractors.

(3) Inpatient hospital services furnished outside the United States and described in section 1814(f) of the Social Security Act.

(c) ADDITIONAL EXCLUSIONS.—The National CHC Board, after consultation with the National Advisory Board and the Commission on Quality, may stipulate, upon the basis of the cost and effectiveness of providing particular health care items or services, that payment may not be made by a qualified health plan, under this division, or under medicare, for such an item or service.

SEC. 203. PROVIDER STANDARDS.

(a) IN GENERAL.—Except as otherwise provided in this division, the provisions of title XVIII of the Social Security Act with respect to—

(1) definitions of terms and descriptions of health care providers (under section 1861 of such Act), and

(2) conditions of participation for health care providers (under section 1866 of such Act) and the use of State or other agencies in determining compliance with standards (under sections 1863 and 1864 of such Act),

shall apply to basic covered health care services provided under qualified health plans to the same extent as they apply to items and services for which payment may be made under title XVIII of such Act.

(b) ADDITIONAL CONDITIONS FOR PROVISIONS OF CERTAIN SERVICES.—

(1) UNDER THIS DIVISION.—In the case of high-risk, high-cost, elective, or over-utilized items or services, specified by the National CHC Board, for which payment may otherwise be made under this division or medicare, the Board may restrict coverage of such items or services to a provider—

(A) that is certified by an appropriate specialty board in the relevant medical specialty, or

(B) that is adequately equipped and staffed (in accordance with regulations of the Board) to furnish the items or services.

(2) UNDER MEDICARE.—Notwithstanding any provision of title XVIII of the Social Security Act to the contrary, payment may only be made under such title for an item or service for which a restriction is in effect under paragraph (1) if it is provided by a provider who meets the requirements of such paragraph.

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

SEC. 204. STATE APPROVAL OF QUALIFIED HEALTH PLANS.

(a) IN GENERAL.—Each State CHC program shall provide for the review and approval or disapproval of health plans as qualified health plans in the State for purposes of this division.

(b) REQUIREMENTS.—A State may not approve a health plan as a qualified health plan under its *State CHC* program unless the State finds that the plan—

(1) provides for benefits at least equal to the minimum benefits specified in section 202,

(2) provides for enrollment of individuals in a manner consistent with this division,

(3) provides for establishment of budgets and payments for services in a manner consistent with this division,

(4) establishes a responsive grievance procedure for the receipt and resolution of grievances concerning the enrollment of individuals and delivery of services under this division,

(5) provides for benefits in an acceptable quality (as determined by the State),

(6) does not discriminate in its enrollment and provision of benefits on the basis of race, religion, sex, marital status, health status, or other impermissible basis (as specified by the National CHC Board),

(7) provides for economic operation and administration,

(8) provides for minimum retention charges,

(9) provides for simplified procedural requirements, and

(10) meets such other requirements as the National CHC Board may specify to insure against fraud and abuse under this division.

(c) LIMITATIONS ON NON-HMO QUALIFIED HEALTH PLANS.—

(1) IN GENERAL.—A State may limit the number of qualified health plans which may be offered in a State.

(2) EXCEPTION FOR HEALTH MAINTENANCE PLANS.—Paragraph (1) shall not apply to qualified health plans that are qualified health maintenance organizations (as defined in section 1310(d) of the Public Health Service Act) or meet the requirements of subparagraphs (A) through (C) of section 1876(b)(2) of the Social Security Act.

(d) WITHDRAWAL OF APPROVAL.—If a State determines that a health plan, that has been previously approved as a qualified health plan, no longer meets the requirements of a qualified health plan, the State shall withdraw approval of the plan and shall provide a procedure whereby individuals enrolled in the plan may be enrolled in other qualified health plans.

TITLE III—FINANCING

Subtitle A—Budget Process

SEC. 301. NATIONAL HEALTH ESTIMATES.

(a) IN GENERAL.—The National CHC Board shall establish every 2 years a biennial estimate of expenditures and revenues under this division which estimates—

(1) the expenditures to be made in the period covered under the estimate by States and the Federal Government for required benefits under this division (including administrative costs),

(2) the revenues required to meet such expenditures, and

(3) an average per capita level of Federal contribution for each State.

Such estimate shall not include expenditures or revenues attributable to the operation of medicare.

(b) INITIAL NATIONAL ESTIMATE.—

(1) EXPENDITURES.—The level of expenditures in the first year of the program under this division shall be based on the average of State and Federal expenditures for required health care benefits for a base period (identified by the National CHC Board) increased to the first year by the percentage increase in the medical care component of the consumer price index for all urban consumers between the base period and the first year. Such estimate shall treat as expenditures for the base period those expenditures that would have resulted from the delivery of free or discounted care for required services.

(c) LIMITATIONS ON NON-HMO QUALIFIED HEALTH PLANS.—

(1) IN GENERAL.—A State may limit the number of qualified health plans which may be offered in a State.

(2) EXCEPTION FOR HEALTH MAINTENANCE PLANS.—Paragraph (1) shall not apply to qualified health plans that are qualified health maintenance organizations (as defined in section 1310(d) of the Public Health Service Act) or meet the requirements of subparagraphs (A) through (C) of section 1876(b)(2) of the Social Security Act.

(d) WITHDRAWAL OF APPROVAL.—If a State determines that a health plan, that has been previously approved as a qualified health plan, no longer meets the requirements of a qualified health plan, the State shall withdraw approval of the plan and shall provide a procedure whereby individuals enrolled in the plan may be enrolled in other qualified health plans.

TITLE III—FINANCING

Subtitle A—Budget Process

SEC. 301. NATIONAL HEALTH ESTIMATES.

(a) IN GENERAL.—The National CHC Board shall establish every 2 years a biennial estimate of expenditures and revenues under this division which estimates—

(1) the expenditures to be made in the period covered under the estimate by States and the Federal Government for required benefits under this division (including administrative costs),

(2) the revenues required to meet such expenditures, and

(3) an average per capita level of Federal contribution for each State.

Such estimate shall not include expenditures or revenues attributable to the operation of medicare.

(b) INITIAL NATIONAL ESTIMATE.—

(1) EXPENDITURES.—The level of expenditures in the first year of the program under this division shall be based on the average of State and Federal expenditures for required health care benefits for a base period (identified by the National CHC Board) increased to the first year by the percentage increase in the medical care component of the consumer price index for all urban consumers between the base period and the first year. Such estimate shall treat as expenditures for the base period those expenditures that would have resulted from the delivery of free or discounted care for required services.

(2) FEDERAL CONTRIBUTIONS.—The average per capita annual level of Federal contribution for each State in the first year shall be equal to the sum of—

(A) the amount of the annual expenditures of the Federal Government made during the base period (identified under paragraph (2)) on required services (other than under medicare) for residents of the State, computed on an average per capita basis, increased by the percentage increase in the medical care component of the consumer price index for all urban consumers between the base period and the first year, and

(B) ⅓ of the amount of additional expenditures (as estimated by the National CHC Board) required to be made in the State on an annual basis for required services in the first year for which expenditures were not being made during the base period, computed on an average per capita basis.

(c) SUBSEQUENT NATIONAL HEALTH ESTIMATES.—

(1) EXPENDITURES.—The level of expenditures provided under subsequent national health estimates shall be based on the level of expenditures in the previous national health estimate increased or decreased by the percentage increase or decrease, respectively,

during the previous 2 years in the gross national product of the United States.

(2) FEDERAL CONTRIBUTION.—The average per capita annual levels of Federal contribution for each State in each subsequent national health estimate shall be based on the average annual per capita levels of Federal contribution for the State in the previous estimate period increased or decreased by the percentage increase or decrease, respectively, during the previous 2 years in the gross national product of the United States. The National CHC Board may adjust such average annual per capita levels of Federal contribution (A) in order to take into account the changes in required services and changes in the relative per capita expenditures required for services due to change in demography of the population and (B) among the States in order to make equitable adjustments based on changes in the required services and changes in the relative per capita expenditures for required services among the States and in order to take into account each State's past performance in containing costs of such services in the State.

SEC. 302. STATE HEALTH BUDGETS.

(a) IN GENERAL.—Each State CHC Board shall establish every 2 years a biennial State health budget which provides for—

(1) the expenditures to be made under the State CHC program in the period covered under the budget under this division (including administrative costs), and

(2) the revenues to meet such expenditures. Such budget shall not include expenditures or revenues attributable to the operation of medicare.

(b) COORDINATION.—Each State health budget shall be coordinated, in a manner specified by the National CHC Board, with the national health estimate established under section 301(a).

(c) MAINTENANCE OF EFFORT.—

(1) FIRST YEAR.—Each State health budget for the first year shall provide for a contribution by the State of amounts not less than the amounts provided by the State in the base year (identified by the National CHC Board) increased by the percentage increase in the medical care component of the consumer price index for all urban consumers between the base period and first year.

(2) SUBSEQUENT BUDGET PERIODS.—Each State health budget for a subsequent budget period shall provide for a contribution by the State of amounts not less

than the amounts provided by the State in the previous budget period increased or decreased by the percentage increase or decrease, respectively, during the previous 2 years in the gross national product of the United States.

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

SEC. 303. PAYMENTS TO STATES.

(a) IN GENERAL.—Each State with an approved State CHC program is entitled to receive, from amounts in the Treasury not otherwise appropriated, an amount equal to the product of (1) the average number of residents of the State, and (2) the average annual per capita Federal contribution level (computed under section 301), adjusted to take into account differences in the health care consumption pattern of the State, from the national average, resulting from the age and sex composition of the population of the State, compared to the national average for all States. The National CHC Board shall provide for periodic adjustments in payments under this section to take into account the differences between the actual average number of residents of each State (and their age and sex composition) compared to such number (and composition) used under the previous sentence.

(b) USE OF COMPREHENSIVE HEALTH CARE FUNDS.—

(1) IN GENERAL.—All revenues (including deductible and coinsurance payments) provided to finance the program under this division shall be deposited, with respect to each State, into a Comprehensive Health Care Fund for the State. Payments to qualified health plans shall be made from such Funds.

(2) NATIONAL AMOUNTS.—Paragraph (1) shall not apply to such revenues as are required to provide for the National CHC Board and national administrative expenses.

SEC. 304. ESTABLISHMENT OF EXCHANGE PROGRAM.

The National CHC Board shall establish a program under which, if a State furnishes covered health services to residents of another State, the first State would receive credit for payments for the services against the amounts to which the other State is otherwise entitled to receive.

Subtitle B—Payments to Qualified Health Plans and to Providers

SEC. 311. PAYMENTS TO QUALIFIED HEALTH PLANS.

(a) COMPUTATION OF ADJUSTED AVERAGE PER CAPITA COST.—Based on a methodology established by the National CHC Board, each State CHC program shall compute an adjusted average per capita cost for required services

under the program in the State for different classes of individuals. Such adjusted average per capita cost shall reflect the average per capita level of expenditures that the State estimates (based on actual experience or actuarial equivalent, with appropriate adjustments to assure actuarial equivalence) is required to provide for expenditures in the State for services (and related administrative costs) under the State CHC program. Such adjusted average per capita cost shall be computed for individuals based on age and sex and such other factors as will assure actuarial equivalence and otherwise provide for equitable distribution of funds to qualified health plans.

(b) PAYMENT TO PLANS.—Each State CHC program shall provide for payment to qualified health plans, for individuals enrolled under this division, on a monthly basis in an amount equal to the adjusted average per capita cost computed under subsection (a) with respect to such individuals. The program may provide for retroactive adjustment in such payments to take into account any difference between the actual number (or composition) of individuals enrolled under the plan and the number of such individuals estimated to be so enrolled in determining the amount of the advance payment.

SEC. 312. PAYMENTS TO PROVIDERS UNDER QUALIFIED HEALTH PLANS.

(a) IN GENERAL.—Each State CHC program shall provide for the payment of providers by qualified health plans in a manner consistent with this subtitle.

(b) MANDATORY ASSIGNMENT.—Each provider of services or other practitioner that receives funding under this division agrees to accept the payment amount recognized under the State CHC program for services covered under the program as payment in full for such services and may not impose any charges for such services other than those permitted with respect to such services under section 332.

(c) CONTINUUM OF CARE.—The National CHC Board, in order to avoid fragmented care, shall develop financial incentives, in the payment methods provided under this subtitle, to promote a continuum of care.

(d) DIRECT PAYMENT FOR CERTAIN HEALTH PROFESSIONALS.—A State CHC program shall require qualified health plans (other than health maintenance plans) to provide for direct payment to nurse practitioners, nurse midwives, physicians' assistants, and similar health professionals who are authorized to provide health services under State law while not under the direct supervision of a physician.

SEC. 313. PAYMENTS TO INSTITUTIONAL PROVIDERS.

(a) IN GENERAL.—Payment for institutional care, including hospital services and nursing facility services, shall be

made in each State on the basis of a biennial prospective budgeting system, established by the State consistent with its State health budget established under section 302 after negotiations with institutional providers.

(b) WAIVERS.—The National CHC Board may waive the requirement of subsection (a) in the case of a State, but only if the State demonstrates that the payment methodology used will not result in expenditures exceeding those provided under its State health budget.

SEC. 314. PAYMENTS FOR PHYSICIANS' SERVICES.

(a) IN GENERAL.—Except as otherwise provided in this section, payment for physicians' services shall be based on payment schedules established by each State CHC Board. Such schedules—

(1) shall be established after negotiations with organizations representing physicians,

(2) shall be based on a national relative value scale, developed by the National CHC Board taking into account the relative value scale developed under section 1848 of the Social Security Act, and

(3) shall be in amounts consistent with the State health budget adopted under section 302.

(b) ALTERNATIVE PAYMENT MECHANISMS.—Payment for physicians' services may be based on alternative payment methodologies, including capitation methods, annual salary

101ST CONGRESS
2D SESSION

H. R. 4253

To provide for an equitable and universal national health plan administered by the States, and for other purposes.

IN THE HOUSE OF REPRESENTATIVES

MARCH 13, 1990

Ms. OAKAR (for herself, Mr. STOKES, Mr. RAHALL, Mr. FAUNTROY, and Mr. HAYES of Illinois) introduced the following bill; which was referred jointly to the Committees on Ways and Means and Energy and Commerce

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A BILL

To provide for an equitable and universal national health plan administered by the States, and for other purposes.

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 "Comprehensive Health Care for All Americans Act" and also may be cited as the "Claude Pepper Comprehensive Health Care Act".

SEC. 2. HONORING CLAUDE PEPPER.

The comprehensive health care program provided under this Act is enacted in honor of Senator Claude Pepper and

his 50 years of public service efforts to provide comprehensive health care and long-term care for Americans of all ages.

SEC. 3. DIVISION OF ACT.

This Act is divided into 5 divisions as follows:

DIVISION A—Comprehensive Health Care Act

DIVISION B—Life Care Long-Term Care Protection

DIVISION C—Grants to States for Establishment and Implementation of State Health Objectives Plans

DIVISION D—Independence for Older Americans

DIVISION E—Authorization of Additional Funds for Research for AIDS, Hypertension, Sickle Cell Anemia, Infant Mortality, and Breast Cancer

Division A—Comprehensive Health Care Act

SEC. 100. SHORT TITLE; TABLE OF CONTENTS.

(a) SHORT TITLE.—This division may be cited as the "Comprehensive Health Care Act".

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

Sec. 1. Short title; table of contents.
Sec. 2. General definitions.

TITLE I—UNIVERSAL ELIGIBILITY AND ENROLLMENT

Sec. 101. Universal eligibility.
Sec. 102. Enrollment.
Sec. 103. Choice of qualified health plan.
Sec. 104. Issuance of Comprehensive Health Care card.

TITLE II—BENEFITS AND PROVIDERS

Sec. 201. Basic covered health services.

Sec. 202. Exclusions.
Sec. 203. Provider standards.
Sec. 204. State approval of qualified health plans.

TITLE III—FINANCING

SUBTITLE A—BUDGET PROCESS

Sec. 301. National health budget.
Sec. 302. State health budgets.
Sec. 303. Payments to States.
Sec. 304. Establishment of exchange program.

SUBTITLE B—PAYMENTS TO QUALIFIED HEALTH PLANS AND TO PROVIDERS

Sec. 311. Payments to qualified health plans.
Sec. 312. Payments to providers.
Sec. 313. Payments to institutional providers.
Sec. 314. Payments for physicians' services.
Sec. 315. Application to medicare program.

SUBTITLE C—SOURCES OF REVENUES

Sec. 331. State sources of revenues.
Sec. 332. Cost-sharing.
Sec. 333. Trust fund and allocations.

TITLE IV—ADMINISTRATION

Sec. 401. National Comprehensive Health Care Board.
Sec. 402. State comprehensive health care programs.
Sec. 403. Commissions on Quality.
Sec. 404. National Advisory Commission on Technology Assessment and Clinical Effectiveness.
Sec. 405. National Resources Equalization Fund.

TITLE V—EFFECTIVE DATES; TRANSITION; RELATION TO OTHER PROGRAMS

Sec. 501. Effective dates.
Sec. 502. Transition.
Sec. 503. Treatment of medicare and medicaid programs.
Sec. 504. Treatment of certain programs.
Sec. 505. Treatment of ERISA.

SEC. 2. GENERAL DEFINITIONS.

In this division:

(1) The term "basic covered health services" means those basic covered health services specified in section 201.

(2) The term "medicare" means the program of health insurance established under title XVIII of the Social Security Act.

(3) The term "medicaid" means the program of medical assistance of States approved under title XIX of the Social Security Act.

(4) The term "National CHC Board" means the National Comprehensive Health Care Board.

(5) The term "qualified health plan" means a health plan (whether offered by an insurer, health maintenance organization, or other entity) approved by a State under section 204.

(6) The term "State CHC Board" means a State Comprehensive Health Care Board.

(7) The term "State CHC program" means a State comprehensive health care program approved under section 402.

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

(9) Except as otherwise provided, the definitions contained in section 1861 of the Social Security Act shall apply in this division.

TITLE I—UNIVERSAL ELIGIBILITY AND ENROLLMENT

SEC. 101. UNIVERSAL ELIGIBILITY.

(a) IN GENERAL.—Each 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 (c)) is eligible to enroll with a qualified health plan for coverage for health benefit under this division under the State CHC program in the State in which the individual maintains a primary residence.

(b) TREATMENT OF CERTAIN NONIMMIGRANTS.—

(1) IN GENERAL.—The National CHC Board may make eligible to enroll for coverage for health benefits under paragraph (1), the Board shall consider reciprocity in health care benefits offered to United States provide.

(2) CONSIDERATION.—In providing for eligibility under paragraph (1), the Board shall consider recipro--city in health care benefits offered to United States citizens who are nonimmigrants to other foreign states, and such other factors as the Board deems appropriate.

(3) FINANCIAL ASSISTANCE.—Notwithstanding any other provision of this division, in the case of aliens made eligible under this subsection, the National Board shall provide such financial assistance to States

as to assure that States are not required to contribute to the costs of health care benefits provided to such aliens.

(c) LAWFUL RESIDENT ALIEN DEFINED.—In this section, the term "lawful resident alien" means an alien lawfully admitted for permanent residence and any other alien lawfully residing permanently in the United States under color of law, including an alien with lawful temporary resident status under section 210, 210A, or 245A of the Immigration and Nationality Act.

SEC. 102. ENROLLMENT IN QUALIFIED HEALTH PLANS.

(a) ENROLLMENT PROCESS.—

(1) IN GENERAL.—Each State CHC program shall specify an understandable and readily available process for the enrollment of eligible individuals residing in the State in qualified health plans. Such enrollments may occur at places of employment, offices of the State CHC program, and other locations.

(2) DEFAULT ENROLLMENT.—In the case of an eligible individual who otherwise is not enrolled in a qualified health plan under any State CHC program, the State shall provide a process for enrollment of the individual at the time and place at which the individual first is provided (after the effective date of benefits under this division) basic covered health services.

(3) ISSUANCE OF CHC CARD.—Upon enrollment in a qualified health plan, each eligible individual shall be issued a Comprehensive Health Care card, which indicates the qualified health plan in which the individual is enrolled.

(b) TREATMENT OF MARRIED INDIVIDUALS.—A State may not require married individuals to enroll in the same qualified health plan.

(c) TREATMENT OF MINOR DEPENDENTS.—In the case of an unmarried individual under 18 years of age, enrollment in a qualified health plan shall be effected, in a manner specified under each State CHC program in accordance with guidelines of the National CHC Board, by a parent or guardian of the child. Except in such cases as the Board may provide, such enrollment shall be in the qualified health plan in which the enrolling parent or guardian is enrolled.

(d) TREATMENT OF MEDICARE-ELIGIBLE INDIVIDUALS.—Individuals entitled to benefits under medicare shall be enrolled in a qualified health plan in the same manner as other eligible individuals, but such enrollment shall only apply to benefits under such a plan that are not otherwise provided under medicare.

TITLE II—BENEFITS AND PROVIDERS

SEC. 201. BASIC COVERED HEALTH SERVICES.

(a) IN GENERAL.—Subject to section 202, the basic covered health services provided under this division by each qualified health plan are as follows:

(1) HOSPITAL CARE.—Subject to subsection (b)(2) (relating to special limitation on mental health care), inpatient and outpatient hospital care.

(2) PHYSICIANS SERVICES AND OTHER PROFESSIONAL MEDICAL SERVICES.—Subject to subsection (b)(2) (relating to special limitation on mental health care), physicians' services and professional services of nurse practitioners, nurse midwives, social workers, physicians' assistants, and similar health professionals who are authorized to provide health services under State law while not under the direct supervision of a physician.

(3) TESTS.—Diagnostic and screening tests.

(4) PRE-NATAL AND WELL-BABY CARE.—Pre-natal and well-baby care (for infants under 1 year of age).

(5) MENTAL HEALTH SERVICES.—Subject to subsection (b)(2), diagnosis, evaluation, treatment, and crisis intervention for a mental illness.

(6) DRUG AND ALCOHOL ABUSE TREATMENT PROGRAMS.—Subject to subsection (b)(3), inpatient and outpatient drug and alcohol abuse treatment services provided under a treatment program approved by the State and through provider organizations that meet State qualification standards, including—

(A) for acute care—

(i) intervention,

(ii) assessment, diagnosis, and referral (by State-certified alcohol and drug professionals),

(iii) medical detoxification according to individual need,

(iv) minimum 14-day primary treatment program and post-detoxification,

(v) aftercare treatment,

(vi) outpatient treatment, and

(vii) day treatment; and

(B) for long-term care—

(i) long-term halfway house care,

(ii) three-quarter way house care,

(iii) primary youth treatment,

(iv) detoxification and long-term treatment for pregnant, addicted women to reha-

bilitate mother and prevent addicted infant births,

(v) relapse prevention programs in non-traditional settings, and

(vi) outpatient counseling and group therapy.

(7) HOSPICE CARE.—Hospice care for individuals certified to be terminally ill, including case-management services, provided by a hospice program approved under medicare or approved by the State.

(8) POST-HOSPITAL SKILLED NURSING FACILITY SERVICES.—Subject to the limitations on nursing facility services and personal care services in subparagraph (B) and (C) of paragraph (9), post-hospital skilled nursing services and home health services.

(9) LONG-TERM CARE.—

(A) IN GENERAL.—Subject to the succeeding provisions of this paragraph, nursing facility services and personal care services for individuals determined (in a manner specified under the State CHC program, in accordance with guidelines of the National CHC Board) to be impaired in 2 or more activities of daily living (as defined by the National CHC Board) or to have a severe cogni-

tive impairment creating a comparable need for such services.

(B) BENEFICIARY LIMITATION.—

(i) INITIAL PHASE.—During an initial phase (of at least 2 years, but not more than 5 years, duration, beginning on the effective date of benefits under this division) to be specified by the National CHC Board, benefits under this paragraph are limited to individuals entitled to benefits under part A of title XVIII of the Social Security Act, except that, in determining entitlement to such benefits, any references to required periods of disability in section 226(b) of such Act shall be reduced by 18 months.

(ii) TRANSITION TO ENTIRE POPULATION.—

(I) INFANTS.—After the initial phase, the benefits under this paragraph shall be made available to eligible individuals under 1 year or age.

(II) OTHERS.—In a manner and time specified by the National CHC Board, the benefits under this paragraph shall also be made available to all

eligible individuals without regard to medicare entitlement or age.

(C) LIMITATION ON AMOUNT.—

(i) INITIAL PHASE.—During the initial phase referred to in subparagraph (B)(i), benefits under this paragraph with respect to any individual are limited to 90 days in any calendar year. Days of receipt of such benefits under paragraph (8) shall not be counted against the limitation specified in this clause.

(ii) TRANSITION TO ELIMINATE LIMITATION ON AMOUNT.—In a manner and time specified by the National CHC Board, the benefits under this paragraph shall be increased to cover all days in a year.

(D) INCLUSION OF CASE MANAGEMENT.—Benefits under subparagraph (A) include benefits for case management services, including assessment of care needs, prior authorization and arrangement for services, and continuing review of care needs.

(10) PREVENTIVE HEALTH SERVICES.—As defined by the National CHC Board:

(A) Basic immunizations.

(B) Pre-natal and post-natal care.

(C) Well-child care (including periodic physical examinations, hearing and vision screening and developmental screening and examinations) for individuals under 23 years of age.

(D) Annual screening mammography and periodic colorectal examinations and examinations for prostat cancer.

(E) Annual pap smears.

(F) Such other health services as are designed to prevent, or to minimize the effect of, illness, disease, or medical condition as specified by the National CHC Board.

(11) OTHER MEDICAL AND HEALTH SERVICES.—Other medical and health services specified by the National CHC Board, including the following:

(A) Services and supplies incidental to the provision of physicians' services.

(B) Hospital services incidental to physicians' services rendered to outpatients.

(C) Appropriate medical services relating to treatment of infection with the etiologic agent for acquired immune deficiency syndrome (AIDS) or treatment for (or prevention of) opportunistic diseases relating to AIDS.

(D) Diagnostic services furnished to outpatients of hospitals.

(E) Outpatient physical therapy services, outpatient speech pathology services, and outpatient occupational therapy services.

(F) Health clinic services, including rural health clinic services.

(G) Home dialysis supplies and equipment.

(H) Diagnostic x-ray tests, diagnostic laboratory tests, and other diagnostic tests.

(I) X–ray (and related) therapy.

(J) Durable medical equipment used in the patient's home.

(K) Ambulance service, to the extent provided in regulation.

(L) Prosthetic devices (other than dental) which replace all or part of an internal body organ (including lens after cataract surgery), including replacements of such devices.

(M) Leg, arm, back, and neck braces, and artificial legs, arms, and eyes, including necessary replacements.

(N) Opthalmological examinations.

(O) Upon a determination of a certified audiologist or physician that a hearing problem

exists and is caused by a condition which can be corrected by use of a hearing aid—

(i) audiometric examination,

(ii) hearing aid evaluation test, and

(iii) a hearing aid specified by prescription as a result of the hearing aid evaluation test (including binaural hearing aids in exceptional cases prescribed by a physician).

(P) Health care and health promotion services designed to prevent or minimize the effect of illness, disease, or medical condition, as the National CHC Board may, in its discretion, specify.

(b) LIMITATIONS ON AMOUNT, DURATION, AND SCOPE.—

(1) NO LIMITS IN GENERAL.—Except as provided in this subsection, a qualified health plan may not limit the amount, duration, or scope of services for benefits required under subsection (a) beyond those specified in the State plan.

(2) LIMITATION ON MENTAL HEALTH SERVICES.—A qualified health plan is not required under subsection (a) to provide—

(A) inpatient mental health services for an individual unless the individual requires continuing professional care and the individual's mental con-

dition is determined to be amenable to modification through treatment in an inpatient setting; or

(B)(i) more than 45 days of inpatient mental health services with respect to any individual for a calendar year, or (ii) more than 20 outpatient mental health visits with respect to any individual for a calendar year.

(3) STATE LIMITATIONS ON SUBSTANCE ABUSE TREATMENT PROGRAMS.—A State CHC program may limit the amount, duration, or scope of substance treatment services required to be provided by a qualified health plan under subsection (a)(6).

(c) ADDITIONAL BENEFITS.—Nothing in this section shall be construed as limiting the health care benefits that a State or qualified health plan may provide.

(d) NO DUPLICATE PRIVATE INSURANCE.—No private insurance may be sold which provides for benefits that duplicates basic covered health services described in subsection (a).

(e) STATE-FINANCING OF SUPPLEMENTAL BENEFITS.—There is no Federal financing available under this Act for benefits other than basic covered health services described in subsection (a).

Division D—Independence for Older Americans

SEC. 3001. SHORT TITLE.

This division may be cited as the "Independence for Older Americans Act".

SEC. 3002. FINDINGS.

The Congress finds that—

(1) by the year 2020 the number of Americans aged 65 and over will increase to over 50,000,000; by the year 2040 will more than double from present levels to 67,000,000 and those 85 and older will more than quadruple to 13,000,000;

(2) more than 1 of every 5 persons 65 years of age or older will be hospitalized during the next year;

(3) one of every 4 Americans over age 65 has some degree of activity limitation in performing daily tasks such as walking, buying groceries, and doing housework; and many more older Americans face numerous psychological, social, economic and environmental obstacles to living independently;

(4) death rates among older people from acute conditions have decreased dramatically from the year 1900, while chronic conditions which inhibit independence are now the prevalent health problem for older

Americans and will increase greatly during the next century;

(5) the diseases and conditions of aging that result in dependency are widespread, including 4,000,000 victims of Alzheimer's disease, 50,000,000 older Americans suffering from arthritis and related disorders, and 5,000,000 victims of incontinence;

(6) older people require a large proportion of the Nation's health care resources and face a higher average out-of-pocket medical cost burden than younger people; approximately one-third of the Nation's health care costs, an estimated $180,000,000,000 in 1989, will be spent on people over age 65; the average per capita out-of-pocket cost of persons 65 years of age or older is expected to equal 18.5 percent of income by 1991;

(7) Americans of all ages desire an independent, healthy existence for older individuals;

(8) advances in biomedical, psychological, and social research offer promise of major breakthroughs in diseases and conditions that rob the elderly of their independence;

(9) independence for older Americans is an achievable goal for our Nation's research and health care systems.

TITLE I—TASK FORCE ON INDEPENDENCE FOR OLDER AMERICANS

SEC. 3101. ESTABLISHMENT.

(a) COMPOSITION.—There is established in the Department of Health and Human Services (hereinafter referred to as the "Department") the Task Force on Independence for Older Americans (hereinafter referred to as the "Task Force"). The Task Force shall be composed of—

(1) the Assistant Secretary for Health;

(2) the Surgeon General of the United States;

(3) the Assistant Secretary for Planning and Evaluation;

(4) the Director of the National Institute on Aging, as well as the Directors of other components of the National Institutes of Health as may be appointed by the Secretary of Health and Human Services (hereinafter referred to as the "Secretary");

(5) the Commissioner of the Administration on Aging;

(6) the Commissioner of the Food and Drug Administration;

(7) the Chief Medical Director of the Department of Veterans Affairs;

(8) such additional members as the Secretary considers appropriate.

(b) CHAIRMAN.—The Secretary shall select a Chairman for the Task Force from among its members.

(c) QUORUM.—A majority of the members of the Task Force shall constitute a quorum, but a lesser number may hold hearings.

(d) MEETINGS.—The Task Force shall meet periodically at the call of the Chairman, but not less than twice each year.

(e) APPOINTMENT OF EXECUTIVE SECRETARY; ADMINISTRATIVE STAFF AND SUPPORT.—The Secretary shall appoint an Executive Secretary for the Task Force and shall provide the Task Force with such administrative staff and support as may be necessary to enable the Task Force to carry out its functions.

SEC. 3102. DUTIES.

The Task Force shall—

(1) coordinate research conducted by or through the Department and other Federal agencies on conditions and diseases leading to dependence among the elderly;

(2) establish a mechanism for the sharing of information among all officers and employees of the agencies participating on the Task Force;

(3) identify the most promising areas of research concerning diseases, behavioral and social conditions leading to dependence among the elderly;

(4) establish mechanisms to use the results of research concerning the conditions and diseases leading to dependence among the elderly in the development of policies, programs, and means to improve the quality of life for older Americans; and

(5) review and evaluate public and private spending on such research.

SEC. 3103. REPORTS TO CONGRESS.

Within 1 year after the effective date and annually thereafter, the Task Force shall transmit to the Congress, and make available to the public, a report on—

(1) progress made by research sponsored by the Federal Government on the conditions and diseases leading to dependence among the elderly;

(2) new directions in research on such conditions and diseases which the Task Force considers potentially important; and

(3) recommendations for resource allocations.

SEC. 3104. AUTHORIZATION OF APPROPRIATIONS.

To carry out this title, there are authorized to be appropriated $100,000 for each of the fiscal years 1991 through 1993.

TITLE II—GERIATRIC RESEARCH AND TRAINING CENTERS

SEC. 3201. ESTABLISHMENT.

Section 445A of the Public Health Service Act is amended to read as follows:

"SEC. 445A. COMPREHENSIVE INDEPENDENCE RESEARCH, TRAINING, AND DEMONSTRATION CENTERS.

"(a) The Director of the National Institute on Aging shall enter into cooperative agreements with, and make grants to, public and private nonprofit entities for the development of comprehensive centers of excellence for geriatric research and training of researchers and for the demonstration and dissemination of the applications of such research.

"(b) Each center developed or expanded under this section shall—

"(1) utilize the facilities of a single institution, or be formed from a consortium of cooperating institutions, meeting such research and training qualifications as may be prescribed by the Director;

"(2) be a comprehensive center including research, training, demonstration and dissemination activities related to enhancing the independence of older Americans;

"(3) be affiliated with one or more nursing homes; and

"(4) conduct—

"(A) research into the aging processes and into the diagnosis, treatment, and rehabilitation of diseases, disorders, and complications related to aging, particularly those which reduce the ability of the elderly to live independently;

"(B) programs to develop individuals capable of conducting research concerning aging and concerning such diseases, disorders, and complications;

"(C) development and demonstration of applications of research findings to increase the independence of older Americans;

"(D) development and demonstration of training programs for older Americans and their families to prolong independence;

"(E) training of health care professionals in acute and chronic care methods which promote independence; and

"(F) research and demonstration of public education and prevention programs to improve the health and independence of older Americans.

"(c) To carry out this section, there are authorized to be appropriated $32,500,000 in fiscal year 1991, $40,000,000 in fiscal year 1992, and $50,000,000 in fiscal year 1993.".

TITLE III—AVAILABILITY OF INFORMATION TO HEALTH PROFESSIONALS, OLDER AMERICANS, AND THE GENERAL PUBLIC

SEC. 3301. NATIONAL INDEPENDENCE FOR OLDER AMERICANS INFORMATION PROGRAM.

The Secretary, acting through the Director of the National Institute on Aging, shall prepare a comprehensive plan for a National Independence for Older Americans Information Program. The plan shall contain provisions to implement the provisions of this title.

SEC. 3302. INFORMATION CLEARINGHOUSE.

(a) The Secretary, acting through the Director of the National Institute on Aging, shall establish a clearinghouse to make available information on the latest developments to improve the health and independence of older Americans available to Federal agencies, States, health care professionals, and the general public. A computer-based data system shall be established to aid in the accomplishment of these responsibilities.

(b) The clearinghouse shall support programs to develop model curricula for the training of health professionals and other methods to speed the transfer of medical research de-

velopments designed to improve the health and independence of older Americans to health care providers.

(c) The Secretary shall establish a toll-free telephone communications system to provide health care professionals and the general public with information and advice designed to increase and maintain the independence of older Americans.

(d) The Secretary may enter into contracts or cooperative agreements with, and make grants to, public and private nonprofit entities to carry out this section.

SEC. 3304. PUBLIC INFORMATION CAMPAIGNS.

(a) The Secretary, acting through the Director of the National Institute on Aging, shall make grants to nonprofit and to public entities concerned with the health and independence of older Americans, and may enter into contracts with public and private entities, for the development and delivery of public service announcements and paid advertising messages about the importance of health and nutrition, and screening techniques, such as pap smears and mammograms, in avoiding and preventing illnesses and conditions which inhibit the independence of older Americans. Such information shall also inform the general public on the availability of treatments for conditions such as immobility, incontinence, and memory loss which reduce the need for the dependent care of older Americans.

(b) The Secretary shall determine the form and manner of such agreements necessary to carry out this section.

SEC. 3305. AUTHORIZATION OF APPROPRIATIONS

To carry out this title, there are authorized to be appropriated $20,000,000 in fiscal year 1991 and such sums as necessary in fiscal year 1992 and 1993.

TITLE IV—PREVENTION OF AND RECOVERY FROM CHRONIC ILLNESS

SEC. 3401. COMPREHENSIVE GERIATRIC ASSESSMENT.

(a) The National Institute on Aging, in cooperation with the Health Care Financing Administration, shall support research to determine (1) the most effective techniques of geriatric assessment; (2) the most effective method of targeting comprehensive geriatric assessment to appropriate populations of older persons to determine their health care needs; and (3) the most effective means of providing for such needs to maximize health and independence.

(b) The report shall include an evaluation of the feasibility and cost of a geriatric assessment to be done at admission or enrollment in all institutional or community-based health services for older persons. Such an assessment shall include, but not be limited to, evaluating factors such as physical and mental health, nutrition, prescription medications and the average amount of physical activity performed by said persons.

(c) The National Institute on Aging and the Health Care Financing Administration shall report to Congress on the results of this research and recommended guidelines on or before March 1, 1994.

SEC. 3402. FRAILTY AND IMMOBILITY PREVENTION AND REHABILITATION.

(a) The Secretary, acting through the Director of the National Institute on Aging, shall develop (1) model techniques to aid in the prevention and rehabilitation of older persons from frailty and other mobility problems; and (2) model curricula for the health professions for training in the use of such techniques.

(b) The National Institute on Aging may establish up to 5 demonstration programs at Comprehensive Independence Research Training and Demonstration Centers to prevent the loss of mobility and to help frail older persons regain independence, using existing and experimental techniques. Physiological, behavioral, and environmental factors shall be considered in this investigation.

(c) The Secretary, acting through the Director of the National Institute on Aging, shall conduct research to the extent which falls are associated with loss of confidence to function independently and increase the need for long-term care.

SEC. 3403. RECOVERY FROM CHRONIC ILLNESS.

(a) The Secretary, acting through the Director of the National Institute on Aging, shall develop (1) model techniques to aid in the recovery and rehabilitation of older persons from chronic and debilitating illness, especially those residing in nursing homes; and (2) model curricula for the health professions for training in the use of such techniques.

(b) The Secretary shall report to Congress on or before March 1, 1992, on the results of model development for frailty and rehabilitation, including the design of programs for the recovery of nursing home patients.

SEC. 3404. AUTHORIZATION OF APPROPRIATIONS.

To carry out this title, there are authorized to be appropriated $3,000,000 in fiscal year 1991, and $5,000,000 for each fiscal year 1992 through 1995.

TITLE V—RESEARCH ON HEALTH, RETIREMENT, AND INDEPENDENCE

SEC. 3501. HEALTH CARE DATA.

(a) The Secretary, acting through the Director of the National Institute on Aging, shall commence a 10-year health and retirement history survey. Said survey shall include information on health functioning and expenditures; longevity; labor force and retirement; women in the labor force; housing and living arrangements; and financial status of older Americans.

(b) The Secretary, acting through the Director of the National Institute on Aging, shall establish an advisory panel on data collection to review existing government surveys and census data to coordinate information on the health and retirement status of older Americans. Said panel shall include, but not be limited to, representatives from the Bureau of the Census; the Department of Labor; the Federal Reserve Board; the National Center for Health Statistics; the Social Security Administration; and the Health Care Financing Administration.

SEC. 3502. HEALTH PROMOTION AND DISEASE PREVENTION DATA.

(a) The National Center for Health Statistics shall include persons age 75 and over in the National Health and Nutrition Examination Survey.

(b) The Director of the National Center for Health Statistics shall develop questions related to health promotion and disease prevention appropriate for older persons to be included in the National Health Interview Survey and the National Health and Nutrition Examination Survey.

(c) The Director of the National Center for Health Statistics shall develop questions related to the health promotion and disease prevention practices of health care providers with special relevance to older persons to be included in the National Ambulatory Medical Care Survey.

SEC. 3503. INVESTIGATOR-INITIATED RESEARCH GRANTS.

(a) The National Institute on Aging shall request proposals from individual and team investigators on behavioral, social, and environmental mechanisms for promoting the health and independence of older Americans.

(b) Such investigation shall include, but not be limited to, social support of older persons, environmental factors, and psychological implications of aging.

SEC. 3504. AUTHORIZATION OF APPROPRIATIONS.

To carry out this title, there are authorized to be appropriated $5,000,000 in fiscal year 1991, $7,200,000 in fiscal year 1992, $7,500,000 in fiscal year 1993, and such sums as necessary in subsequent fiscal years.

TITLE VI—AUTHORIZATION OF APPROPRIATIONS FOR NIH

SEC. 3601. AUTHORIZATION.

The National Institutes of Health are authorized to be appropriated $1,000,000,000 in fiscal year 1991, to be added to the National Institute on Aging and other institutes in proportion to their current spending levels on aging research.

Division E—Authorization of Additional Funds for Research for AIDS, Hypertension, Sickle Cell Anemia, Infant Mortality, and Breast Cancer

SEC. 4001. ADDITIONAL AUTHORIZATION OF APPROPRIATIONS.

In addition to the sums authorized to be appropriated for under titles III, IV, and XXIII of the Public Health Service Act for each of fiscal years 1991 through 1995, there are authorized to be appropriated—

(1) such amounts as may be necessary to provide for $1,200,000,000 for research relating to acquired immune deficiency syndrome (AIDS),

(2) such amounts as may be necessary to provide for $200,000,000 for research relating to hypertension,

(3) such amounts as may be necessary to provide for $75,000,000 for research relating to sickle cell anemia,

(4) such amounts as may be necessary to provide for $300,000,000 for research relating to infant mortality, and

(5) to the National Cancer Institute $25,000,000 for research into prevention and cure of breast cancer (other than research which involves treatment or clinical trials).

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101ST CONGRESS
2D SESSION

H. R. 4280

To amend the Social Security Act to provide for a program of health insurance for children under 23 years of age and for mothers to be financed through a general payroll tax.

IN THE HOUSE OF REPRESENTATIVES

MARCH 15, 1990

Mr. STARK introduced the following bill; which was referred to the Committee on Ways and Means

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A BILL

To amend the Social Security Act to provide for a program of health insurance for children under 23 years of age and for mothers to be financed through a general payroll tax.

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 "Health Insurance for Children and Mothers Act of 1990".

SEC. 2. HEALTH INSURANCE FOR CHILDREN AND MOTHERS.

(a) IN GENERAL.—The Social Security Act is amended by adding at the end the following new title:

"TITLE XXI—HEALTH INSURANCE FOR CHILDREN AND MOTHERS

"SEC. 2100. ESTABLISHMENT OF PROGRAM OF HEALTH INSURANCE FOR CHILDREN AND MOTHERS.

"There is hereby established a program of health insurance for children under 23 years of age and mothers, to be financed by payroll taxes.

"PART A—ELIGIBILITY

"SEC. 2101. GENERAL ELIGIBILITY.

"(a) CHILDREN.—

"(1) IN GENERAL.—Every individual who—

"(A) is a child (as defined in paragraph (2)),

"(B) is a resident of the United States, and

"(C) is a citizen or national of the United States or a permanent resident alien (as defined in subsection (d)),

is, upon registration under section 2102, entitled to benefits under this title as a child.

"(2) CHILD DEFINED.—In this title, the term 'child' means an individual from birth until the end of the month in which the individual attains 23 years of age.

"(b) MOTHERS.—

"(1) IN GENERAL.—Every woman who—

"(A) is a pregnant woman (as defined in paragraph (2)),

"(B) is a resident of the United States, and

"(C) is a citizen or national of the United States or a permanent resident alien (as defined in subsection (d)),

is entitled to benefits under this title as a pregnant woman.

"(2) PREGNANT WOMAN DEFINED.—In this title, the term 'pregnant woman' means a woman during the period—

"(A) beginning on the date she receives the examination or test which forms the basis for the certification of pregnancy under section 2102(b)(1), and

"(B) ending on the last day of the month in which the 60-day period (beginning on the date of termination of the pregnancy) ends.

"(c) PREGNANT CHILDREN.—In the case of an individual who is entitled under this section to benefits under this title as a child and as a pregnant woman, the individual is entitled to benefits as both.

"(d) PERMANENT RESIDENT ALIEN DEFINED.—In this section, the term 'permanent resident alien' means an alien lawfully admitted for permanent residence or or otherwise

permanently residing in the United States under color of law, and includes an alien granted asylum under section 208 of the Immigration and Nationality Act or lawfully admitted as a temporary resident under section 210, 210A, or 245A of such Act.)

"SEC. 2102. REGISTRATION; CERTIFICATION OF PREGNANCY.

"(a) REGISTRATION OF CHILDREN.—

"(1) IN GENERAL.—The Secretary shall establish a process for the registration of children at the time of birth in the United States or at the time of immigration into the United States or other acquisition of lawful permanent resident status in the United States.

"(2) TRANSITIONAL REGISTRATION.—The Secretary also shall establish a process for the registration of children born before the effective date of benefits under this title.

"(3) EFFECT OF FAILURE TO REGISTER.—The failure of a child to be registered under this subsection shall not be considered to deny the child's entitlement to benefits under this title, but merely to delay payment with respect to such benefits under this title.

"(b) CERTIFICATION OF PREGNANCY AND REGISTRATION OF PREGNANT WOMEN.—

"(1) CERTIFICATION OF PREGNANCY.—A certification of pregnancy for purposes of this title—

"(A) may be made by a physician (or such other qualified health professionals as the Secretary may designate) on the basis of such tests or procedures as the Secretary may specify,

"(B) shall be stated on such form as the Secretary shall specify, and

"(C) shall be filed with the Secretary in a manner specified by the Secretary.

"(2) REGISTRATION.—The Secretary shall establish a process for the registration of pregnant women in connection with the filing of a certification of pregnancy under paragraph (1)(C).

"SEC. 2103. COVERAGE PERIOD.

"(a) IN GENERAL.—No payments may be made under this part with respect to the expenses of an individual unless such expenses were incurred by such individual during a period which, with respect to the individual, is a coverage period under this section.

"(b) CHILDREN.—With respect to an individual entitled to benefits under this title as a child, the coverage period shall begin on the first date (on or after the effective date of benefits under this title) on which the individual meets the requirements for such entitlement under section 2101(a) and shall end on the day before the first month in which the individual no longer meets such requirements.

"(c) PREGNANT WOMEN.—With respect to an individual entitled to benefits under this title as a pregnant woman, the coverage period shall begin on the first date (on or after the effective date of benefits under this title) on which the individual meets the requirements for such entitlement under section 2101(b) and shall end on the day before the first month in which the individual no longer meets such requirements.

"PART B—BENEFITS

"SEC. 2111. SCOPE OF BENEFITS FOR CHILDREN.

"(a) IN GENERAL.—Except as provided in the succeeding provisions of this section, the benefits provided to an individual by the program established by this part shall consist of the same benefits that are available under title XVIII to individuals entitled to benefits under part A of that title and enrolled under part B of that title.

"(b) WELL CHILD SERVICES.—

"(1) IN GENERAL.—In addition to the benefits described in subsection (a), in the case of an individual entitled to benefits under this title as a child, the benefits under this title shall include entitlement to have payment made (in the same manner as for physicians' services under part B of title XVIII) for the following, without the application of deductibles, coinsurance, or

copayments, subject to the periodicity schedule established with respect to the services under paragraph (2):

"(A) Newborn and well-baby care, including normal newborn care and pediatrician services for high-risk deliveries.

"(B) Well-child care, including routine office visits, routine immunizations (including the vaccine itself), routine laboratory tests, and preventive dental care.

"(2) PERIODICITY SCHEDULE.—The Secretary, in consultation with the American Academy of Pediatrics, shall establish a schedule of periodicity which reflects the general, appropriate frequency with which services listed in paragraph (1) should be provided to healthy children.

"SEC. 2112. SCOPE OF BENEFITS FOR PREGNANT WOMEN.

"(a) IN GENERAL.—In the case of an individual entitled to benefits under this title as a pregnant woman, the benefits under this title shall consist of entitlement to have payment made for the following, without the application of deductibles, coinsurance, or copayments, subject to the periodicity schedule established with respect to the services under subsection (b) and prior authorization of certain services under subsection (c):

"(1) Prenatal care, including care for all complications of pregnancy.

"(2) Inpatient labor and delivery services.

"(3) Postnatal care.

"(4) Postnatal family planning services.

"(b) PERIODICITY SCHEDULE.—The Secretary, in consultation with the American College of Obstetrics and Gynecology, shall establish a schedule of periodicity which reflects the general, appropriate frequency with which services listed in subsection (a) should be provided to pregnant women without complications of pregnancy.

"(c) PRIOR AUTHORIZATION REQUIRED FOR CERTAIN SERVICES.—

"(1) IN GENERAL.—Except in the case of items and services specified under paragraph (2), benefits are not available with respect to an item or service under subsection (a) unless the provision of the item or service has been approved by a utilization and quality control peer review organization before the provision of the item or service.

"(2) EXCEPTION FOR ROUTINE OR COMMON ITEMS AND SERVICES.—Paragraph (1) shall not apply to items and services which the Secretary has specified on a list as being either—

"(A) related to normal pregnancy, or

"(B) related to a highly prevalent complication of pregnancy,

or in the case of emergency services.

"SEC. 2123. EXCLUSIONS.

"(a) IN GENERAL.—Except as provided in subsections (b) and (c), section 1862 shall apply to expenses incurred for items and services provided under this title the same manner as such section applies to items and services provided under title XVIII.

"(b) BENEFITS EXCEPTION.—

"(1) CHILDRENS' SERVICES.—In applying section 1862(a) with respect to services described in section 2121(b)(1) (relating to well-child services), payment shall not be denied under paragraph (1), (7), or (12) of such section 1862(a) if the services are provided in accordance with the periodicity schedule described in section 2121(b)(2).

"(2) SERVICES FOR PREGNANT WOMEN.—In applying section 1862(a) with respect to services described in section 2122(a) (other than paragraph (2) thereof), payment shall not be denied under paragraph (1) or (7) of such section 1862(a) if the services are provided in accordance with the periodicity schedule described in section 2122(b).

"(c) COORDINATION OF PAYMENTS.—

"(1) PRIMARY TO GROUP HEALTH PLANS.—Section 1862(b)(1) (relating to requirements of group health plans) shall not apply under this title.

"(2) SECONDARY TO MEDICARE.—Payment shall not be made under this title with respect to benefits to the extent that payment for such benefits may be made under title XVIII.

"PART C—PAYMENT FOR BENEFITS AND FINANCING

"SEC. 2131. PAYMENTS FOR BENEFITS.

"(a) IN GENERAL.—Except as otherwise provided in this section—

"(1) payment of benefits under this title with respect to benefits shall be made in the same amounts and on the same basis as payment may be made with respect to such benefits under title XVIII, and

"(2) the provisions of sections 1814, 1833, 1842, 1848, and 1886 shall apply to payment of benefits under this title in the same manner as they apply to benefits under title XVIII.

"(b) NO COST-SHARING FOR CERTAIN SERVICES.—No deductibles, coinsurance, copayments, or other cost-sharing shall be imposed with respect to—

"(1) well-child care services described in section 2111(b)(1), and

"(2) items and services for which an individual is entitled under this title as a pregnant woman.

"(c) ADJUSTMENT OF PAYMENTS.—

"(1) ESTABLISHMENT OF NEW DRGS AND WEIGHTS.—In making payment under this title with respect to inpatient hospital services, the Secretary shall make such adjustments in the diagnosis-related groups and weighting factors with respect to discharges within such groups, otherwise established under section 1886(d)(4) as may be necessary—

"(A) to reflect the types of discharges occurring under this title which are not occurring under title XVIII, and

"(B) to provide for a weighting factor, for cesearian section deliveries, which is 95 percent of the weighting factor that otherwise would be established.

"(2) PAYMENT FOR OBSTETRICAL SERVICES.—

"(A) GLOBAL FEE.—In making payment under this title with respect to the group of obstetrical services typical of treatment throughout a course of pregnancy, the Secretary shall establish, as a schedule under section 1848, a global fee with respect to such group of services.

"(B) BONUS FOR EARLY PRESENTATION.—The fee schedule amount with respect to obstetrical services under this title shall be increased by 5 percent in the case of services furnished to women who have presented for prenatal care during the first trimester.

"(C) DISINCENTIVE FOR CESEARIAN SECTIONS.—The fee schedule amount otherwise established with respect to a cesearian section shall be 95 percent of the fee schedule amount otherwise established.

"(c) CONDITIONS OF AND LIMITATIONS ON PAYMENTS.—The provisions of sections 1814 and 1835 shall apply to payment for services under this title in the same manner as they apply to payment for services under parts A and B, respectively, of title XVIII.

"(d) USE OF TRUST FUND.—In carrying out this section, any reference in title XVIII to a trust fund shall be treated as a reference to the Children and Mothers Health Insurance Trust Fund established under section 2132.

"SEC. 2132. CHILDREN AND MOTHERS HEALTH INSURANCE TRUST FUND.

"(a) ESTABLISHMENT.—(1) There is hereby created on the books of the Treasury of the United States a trust fund to be known as the 'Children and Mothers Health Insurance 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 as provided in section 201(i)(1) and amounts appropriated under paragraph (2).

"(2) There are hereby appropriated to the Trust Fund amounts equivalent to 100 percent of—

"(A) the taxes imposed by sections 3101(c) or 3111(c) of the Internal Revenue Code of 1986,

"(B) the taxes imposed by section 1401(c) of such Code, and

"(C) the taxes imposed by sections 3201(c), 3211(a)(3), and 3221(e) of such Code.

The amounts appropriated by the preceding sentence shall be transferred from time to time 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 taxes specified in such sentence.

"(b) INCORPORATION OF PROVISIONS.—

"(1) IN GENERAL.—Subject to paragraph (2), the provisions of subsections (b) through (j) of section 1817 shall apply to the Trust Fund in the same manner as

they apply to the Federal Hospital Insurance Trust Fund.

"(2) EXCEPTIONS.—In applying paragraph (1)—

"(A) the Board of Trustees and Managing Trustee of the Trust Fund shall be composed of the members of the Board of Trustees and the Managing Trustee, respectively, of the Federal Hospital Insurance Trust Fund; and

"(B) any reference in section 1817 to the Federal Hospital Insurance Trust Fund, to title XVIII (or part A thereof), or to section 3102(b) of the Internal Revenue Code of 1986 is deemed a reference to the Trust Fund under this section, this title, and to section 3102(c) of such Code, respectively.

"PART D—GENERAL PROVISIONS

"SEC. 2151. INCORPORATION OF CERTAIN MEDICARE PROVISIONS.

"(a) USE OF CARRIERS AND INTERMEDIARIES.—The Secretary shall provide for the administration of this title through the use of fiscal intermediaries and carriers in the same manner as title XVIII is carried out through the use of such fiscal intermediaries and carriers.

"(b) DEFINITIONS.—Except as otherwise provided in this title, the definitions contained in section 1861 shall apply

for purposes of this title in the same manner as they apply for purposes of title XVIII.

"(c) CERTIFICATION, PROVIDER QUALIFICATION, ETC.—The provisions of sections 1863 through 1875, sections 1878 through 1880, section 1883, section 1885, and sections 1887 through 1892 shall apply to this title in the same manner as they apply to title XVIII.

"(d) HEALTH MAINTENANCE ORGANIZATIONS AND COMPETITIVE MEDICAL PLANS.—

"(1) IN GENERAL.—Except as provided in this subsection, section 1876 shall apply to individuals entitled to benefits under this title in the same manner as such section applies to individuals entitled to benefits under part A, and enrolled under part B, of title XVIII.

"(2) LIMITATION TO REASONABLE COST REIMBURSEMENT CONTRACTS FOR PREGNANT WOMEN.—

"(A) IN GENERAL.—The provisions of section 1876 relating only to risk-sharing contracts (and not to reasonable cost reimbursement contracts) shall not apply to individuals entitled to benefits under this title only as pregnant women.

"(B) REPORT.—Not later than January 1, 1992, the Secretary shall submit to the Congress a report concerning recommendations on

how the provisions of section 1876 relating to risk-sharing contracts may be adapted to apply to benefits provided under this title to pregnant women.

"(3) APPLICATION.—In applying section 1876 under this section—

"(A) the provisions of such section relating only to individuals enrolled under part B of title XVIII shall not apply;

"(B) any reference to a Trust Fund established under title XVIII and to benefits under such title is deemed a reference to the Children and Mothers Health Insurance Trust Fund and to benefits under this title;

"(C) the adjusted average per capita cost and the adjusted community rate shall be determined on the basis of benefits under this title; and

"(D) subsection (f) shall not apply.

"SEC. 2152. INCORPORATION OF PEER REVIEW PROVISIONS AND FRAUD AND ABUSE PROVISIONS.

"The provisions of sections 1121 through 1126, sections 1128 through 1128B, section 1134, section 1138, and part B of title XI shall apply to this title in the same manner as they apply to title XVIII.".

(b) CONFORMING AMENDMENTS.—

(1) Section 201(g)(1)(A) of the Social Security Act (42 U.S.C. 401(g)(1)(A)) is amended by striking "and the Federal Supplementary Medical Insurance Trust Fund" and inserting ", Federal Supplementary Medical Insurance Trust Fund, and the Children and Mothers Health Insurance Trust Fund".

(2) Section 201(i)(1) of such Act (42 U.S.C. 401(i)(1)) is amended by striking "and the Federal Supplementary Medical Insurance Trust Fund" and inserting ", Federal Supplementary Medical Insurance Trust Fund, and the Children and Mothers Health Insurance Trust Fund".

(c) EFFECTIVE DATE.—The amendments made by this section shall take effect on the date of the enactment of this Act, except that no benefits shall be available under title XXI of the Social Security Act for items or services furnished before January 1, 1992.

SEC. 3. INCREASE IN EMPLOYMENT TAXES TO FUND HEALTH INSURANCE FOR CHILDREN AND PREGNANT WOMEN.

(a) GENERAL RULE.—

(1) EMPLOYEE TAX.—Section 3101 of the Internal Revenue Code of 1986 (relating to rate of tax on employees) 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) ADDITIONAL TAX TO FUND HEALTH INSURANCE FOR CHILDREN AND PREGNANT WOMEN.—In addition to the taxes imposed by the preceding subsections, there is hereby imposed on the income of every individual a tax equal to 1.45 percent of the wages (as defined in section 3121(a)) received by the individual with respect to employment (as defined in section 3121(b)."

(2) EMPLOYER TAX.—Section 3111 of such Code is amended by redesignating subsection (c) as subsection (d) and by inserting after subsection (b) the following new subsection.

"(c) ADDITIONAL TAX TO FUND HEALTH INSURANCE FOR CHILDREN AND PREGNANT WOMEN.—In addition to the taxes imposed by the preceding subsections, there is hereby imposed on every employer an excise tax, with respect to having individuals in his employ, equal to 1.45 percent of the wages (as defined in section 3121(a)) paid by the employer with respect to employment (as defined in section 3121(b))."

(3) SELF-EMPLOYMENT TAX.—Section 1401 of such Code is amended by redesignating subsections (c) and (d) as subsections (d) and (e), respectively, and by

inserting after subsection (c) the following new subsection:

"(c) ADDITIONAL TAX TO FUND HEALTH INSURANCE FOR CHILDREN AND PREGNANT WOMEN.—In addition to the taxes imposed by the preceding subsections, there is hereby imposed for each taxable year, on the self-employment income of every individual, a tax equal to 2.9 percent of the self-employment income for such taxable year."

(4) RAILROAD RETIREMENT TAXES.—

(A) Section 3201 of such Code is amended by redesignating subsection (c) as subsection (d) and by inserting after subsection (b) the following new subsection:

"(c) ADDITIONAL TAX TO FUND HEALTH INSURANCE FOR CHILDREN AND PREGNANT WOMEN.—In addition to other taxes, there is hereby imposed on the income of each employee a tax equal to 1.45 percent of the compensation received during any calendar year by such employee for services rendered by such employee."

(B) Subsection (a) of section 3211 of such Code is amended by redesignating paragraph (3) as paragraph (4) and by inserting after paragraph (2) the following new paragraph:

"(3) ADDITIONAL TAX TO FUND HEALTH INSURANCE FOR CHILDREN AND PREGNANT WOMEN.—In

addition to other taxes, there is hereby imposed on the income of each employee representative a tax equal to 2.9 percent of the compensation received during any calendar year by such employee representative for services rendered by such employee representative."

(C) Section 3221 of such Code is amended by redesignating subsection (e) as subsection (f) and by inserting after subsection (d) the following new subsection:

"(e) ADDITIONAL TAX TO FUND HEALTH INSURANCE FOR CHILDREN AND PREGNANT WOMEN.—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 1.45 percent of the compensation paid during any calendar year by such employer for services rendered to such employer."

(b) CONFORMING AMENDMENTS.—

(1) Subsection (u) of section 3121 of such Code is amended by adding at the end thereof the following new paragraph:

"(4) APPLICATION OF TAX FOR HEALTH INSURANCE FOR CHILDREN AND PREGNANT WOMEN.—The provisions of paragraphs (1) and (2) of this subsection shall also apply for purposes of the taxes imposed by sections 3101(c) and 3111(c); except that subparagraphs (B)(i), (C), and (D) of paragraph (2) shall not apply for purposes of such taxes."

(2) Subsection (a) of section 201 of the Social Security Act is amended—

(A) by striking "sections 3101(b) and 3111(b)" each place it appears in paragraph (3) and inserting "sections 3101(b) and (c) and 3111(b) and (c),", and

(B) by striking "section 1401(b)" each place it appears in paragraph (4) and inserting "subsections (b) and (c) of section 1401".

(3) Section 218 of the Social Security Act is amended by adding at the end thereof the following new subsection:

"Certain Taxes Not Covered

"(g) For purposes of this section, section 3101 of the Internal Revenue Code of 1986 shall be applied as if it did not contain subsection (c) thereof and section 2111 of such Code shall be applied as if it did not contain subsection (c) thereof."

(4)(A) Subsection (d) of section 3201 of such Code (as redesignated by this section) is amended by striking "subsections (a) and (b)" and inserting "subsections (a), (b), and (c)".

(B) Paragraph (4) of section 3211(a) of such Code (as redesignated by this section) is amended by striking "paragraphs (1) and (2)" and inserting "paragraphs (1), (2), and (3)".

(C) Subsection (f) of section 3221 of such Code (as redesignated by this section) is amended by striking "subsections (a) and (b)" and inserting "subsections (a), (b), and (e)".

(D) Clause (i) of section 3231(e)(2)(B) of such Code is amended by striking "TIER 1 TAXES" in the heading and inserting "TIER 1 TAXES AND TAXES TO FUND HEALTH INSURANCE FOR CHILDREN AND PREGNANT WOMEN".

(E) Subparagraph (A) of section 3231(e)(4) of such Code is amended by striking "sections 3201(a), 3211(a)(1), and 3221(a)" and inserting "sections 3201(a) and (c), 3211(a)(1) and (a)(3), and 3221(a) and (e)".

(F) Subsection (a) of section 15 of the Railroad Retirement Act of 1974 is amended by adding at the end thereof the following new sentence: "For purposes of this section, the Railroad Retirement Tax Act shall be applied as if it did not contain sections 3201(c), 3211(a)(3), and 3221(e)."

(c) EFFECTIVE DATES.—

(1) The amendments made by this section (other than by subsection (a)(3)) shall apply to remuneration paid after December 31, 1991.

(2) The amendment made by subsection (a)(3) shall apply to taxable years beginning after December 31, 1991.

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