DEPARTMENT OF HEALTH & HUMAN SERVICES

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Chris -
From CHIR this morning
They received today 4-6;
tomorrow (Thurs) 8-12 + 2 to ?;
+ then Friday 8-12. Kennedy will
offer amend. en bloc each day. No
titles close until final passage.
Call for more. -ICP

Package for Labor

Chris -
- En bloc amendment each day.
Won't ever close title so they can
continue offering amendments to
Titles.

SUMMARY OF CHAIRMAN'S AMENDMENT

Includes technical and clarifying amendments and changes reflecting requests of members of the Committee. These include:

1. Legal aliens. Clarifies that the definition of eligible aliens includes all those legally authorized to work in the U.S.

2. Pap smears. Clarifies that pap smears and pelvic examinations are covered every two years after three consecutive negative examinations.

3. Clarify provisions of mental health benefit.

4. Clarify requirement to disclose promptly incorrect test results applies only to life-threatening conditions.

5. Clarify and standardize general anti-discrimination requirements.

6. Prohibit states from requiring plans to discriminate against out-of-state providers.

7. Allow contiguous states to coordinate their operations.

8. Allow states to establish alternative capitalization and solvency requirements for community-rated health plans, if consistent with Federal standards.

9. Require state coordination of services for special needs children.

10. Require direct billing for ancillary health services.

11. Clarify rules on collection of large out-of-pocket expenses.

12. Eliminate Advisory Council on Breakthrough drugs and substitute medical technology impact program.

13. Require reports on coverage of dental care and in-vitro fertilization.

14. Modify definition of essential community providers to include certain urban and rural hospitals and rural health clinics.

AMENDMENT NO. ____ Calendar No. ____

Purpose: To make technical and miscellaneous changes to title I of the bill.

IN THE SENATE OF THE UNITED STATES—103d Cong., 2d Sess.

S.____

To ensure individual and family security through health care coverage for all Americans in a manner that contains the rate of growth in health care costs and promotes responsible health insurance practices, to promote choice in health care, and to ensure and protect the health care of all Americans.

Referred to the Committee on _____
and ordered to be printed

Ordered to lie on the table and to be printed

AMENDMENTS intended to be proposed by Mr. KENNEDY

Viz:

Strike "Indians" each place that such term appears and insert "American Indians".

In section 1001(c)(1), strike subparagraph (B) and insert the following new subparagraph:

"(B) a citizen of another country legally residing in the United States (as defined in section 1901(1));".

Subsection (a) of section 1005, is amended to read as follows:

(a) CERTAIN ALIENS INELIGIBLE FOR BENEFITS.—An alien who is not an eligible individual or otherwise not made eligible under this Act for benefits is not eligible to obtain the comprehensive benefit package through enrollment in a health plan under this Act.

Add at the end of section 1005, the following new subsection:

(d) CONSTRUCTION.—The National Health Board shall adopt procedures that assure that each person who is eligible for enrollment in an applicable health plan is able to enroll in such a plan.

In section 1114(a)(2), after "clinician visit" insert "(including preventive counseling and health advice)".

In subsections (a)(2), (f)(2), (g)(2), and (h)(2) of section 1114, strike subparagraph (A) and insert the following new subparagraph:

> *(A) Annual papanicolaou smears and pelvic exams, for females who are at risk for cervical cancer, unless three consecutive annual pap smears have been negative and it has been determined that the female is not at risk for sexually transmitted diseases, in which case pap smears and pelvic exams are covered every 3 years.*

In section 1115(d)(2)(A), strike "or residential".

In section 1115(d)(2)(C), add after the period the following: "On or after such date, such annual aggregate limit shall not apply.".

In section 1115(e)(2)(B)(i), strike the last sentence and insert "After such number is reduced to 15, no residential treatment may be covered, except as provided in clause (ii). On or after such date, such annual aggregate limit shall not apply.".

In section 1115(e)(2)(B)(ii), insert "mental health" after "residential".

In section 1115(e)(2)(B)(ii), strike "Secretary." and insert "National Health Board.".

In section 1115(f)(1)(A), insert "a mental health consumer-run service center" after "hospitalization program,".

In section 1115(f)(2)(A), strike ", or as an alternative to,".

In section 1115(f)(2)(B), strike "mental illness and".

In section 1115(g)(2)(B), strike "mental illness and"

Strike subsection (h) of section 1115 and insert the following new subsection:

(h) MANAGEMENT OF CARE FOR MENTAL ILLNESS AND SUBSTANCE ABUSE.—

(1) PROVISION OF TREATMENT.—Quality managed care techniques shall be utilized by health plans to ensure that all necessary care is provided in the most appropriate, cost effective setting, and that unnecessary care is not provided.

(2) QUALITY MANAGED CARE.—The term "quality managed care" refers to the administration of benefits through the methods of central intake, preauthorization, and utilization review. Health plans may contract with specialized behavioral care entities to administer benefits if such entities are certified by the State as proficient in the use of quality managed care techniques that facilitate the provision of clinically appropriate, cost-effective, and confidential treatment, providing continuity of care between and among treatment providers.

(3) TREATMENT DECISIONS.—

(A) Treatment placement decisions shall be based primarily on medical necessity, with inpatient treatment regarded as the placement of last resort. Criteria used for placement shall be based on uniform assessment tools recognized by treatment and other professional organizations in the fields of mental illness and substance abuse or approved for use by the National Health Board and shall be publicly available.

(B) All treatment assessment and placement decisions or review of such decisions shall be made by personnel—

(i) with certification, licensure, or other credentials recognized in the fields of mental health and substance abuse treatment;

(ii) with no financial stake in the outcome of such decisions; and

(iii) in the same mental health or substance abuse provider category as the treating provider.

(4) RULE OF CONSTRUCTION.—Nothing in this section shall be construed as prohibiting health plans from providing mental health and substance abuse treatment through fee-for-service arrangements.

In section 1115(i), add the following new paragraphs:

(3) FULL IMPLEMENTATION OF PLAN.—Subject to paragraph (2)(F). the State shall assure that public or philanthropic resources are available to implement each child's plan, including residential treatment in excess of the limit set forth in subsection (e) if clinically appropriate.

(4) RULE OF CONSTRUCTION.—Nothing in this subsection shall be construed as prohibiting a child or a child's legal guardian from freely choosing the child's health care provider.

In section 1127, strike "classes" each place such term appears and insert "programs"

In section 1127(a), after "programs" (as added under the previous amendment) insert "including community-based programs"

In section 1127(a), insert after the period the following: "Health care providers may refer plan members to health education pro-

grams that best meet their needs based on an assessment of individual risks and learning styles.".

In section 1127(b), insert after the period the following: "Health plans shall inform health providers about the availability of such health education programs annually, either at the time of paying the first claim to that provider, or in the case of a network plan, at the time of contracting with the provider.".

In section 1130(a) and (b), strike "and services" each place that such term appears.

In section 1130(b), strike "is routine ear examinations and diagnosis for defects in hearing as part of a physician visit and".

In section 1133(7)(A), strike "$1,500" and insert "$2,500".

In the table in section 1135, in the 13th item, strike "Clinician" and insert "Family planning services described in 1116(1), and clinician".

Strike section 1163 and insert the following new section:

SEC. 1163. DUTY TO DISCLOSE INCORRECT TEST RESULTS.

(a) IN GENERAL.—Any facility, including hospitals, clinics, and clinical laboratories, which provide health care items and services covered under this Act shall promptly notify the patient (or family if patient is incapacitated) and the provider who ordered the test, of the existence of life threatening errors in the results of the tests performed.

(b) PENALTIES.—The Secretary shall establish by regulation the penalties for failure to promptly notify the patient or family and provider who ordered the test.

In section 1201(3), strike "and all such fees shall be used exclusively for medical board activities".

In section 1202(c)(1), strike "may not discriminate" and all that follows through the end thereof and insert "comply with the antidiscrimination requirements of section 1915.".

In section 1202(c), strike paragraph (2).

In section 1203(a)(1), insert after the period the following: "A State may not limit the ability of any plan to contract with a provider of health services located outside of the geographic boundaries

of a health care coverage area or the State, so long as the provider is authorized under State law to provide such services.".

In section 1203(b)(2)(A), strike "1502" and insert "1915".

In section 1203(b)(2)(A), strike "as a community-rated health plan"..

In section 1203(c), strike "community-rated".

In section 1203, insert after subsection (c), the following new subsection and redesignate the remaining subsections and all cross references thereto accordingly:

(d) COORDINATION IN MULTI-STATE AREAS.—One or more States may coordinate their operations in contiguous health care coverage areas. Such coordination may include, the following activities, adoption of joint operating rules, contracting with health plans, enforcement activities, and establishment of fee schedules for health providers.

In section 1203(e)(2)(B), insert "disability" after "levels,".

Add at the end of section 1204, the following new subsection:

(d) ALTERNATIVE CAPITAL STANDARDS FOR COMMUNITY- AND PROVIDER-BASED HEALTH PLANS.—

(1) IN GENERAL.—States shall consider alternative capitalization and solvency requirements for community- and provider-based health plans as defined in paragraph (2), in accordance with section 1651 and consistent with assuring the fiscal integrity and financial solvency of such plans.

(2) ELIGIBLE PLANS.—Plans eligible for special consideration by States must be public or not-for-profit entities that are owned, or in which a majority share of the plan's investment is held by—

(A) health care providers who practice in the plan;

(B) individuals who live in the area, or not-for-profit organizations located in the area serviced by the plan;

(C) a combination of individuals and organizations described in subparagraphs (A) and (B); or

(D) organizations located outside the service area which provide for control over local operations by individuals described in subparagraphs (A) or (B).

In section 1206(a)(2)(B), strike "6127(d)" and insert "1207".

In section 1206(c), insert "under this section" after "responsibilities of the State".

In section 1207(c)(4), strike "1259" and insert "1687".

In section 1208(a), insert "adequate training and" after "provide".

In section 1208(c)(4) strike "assistance" and insert "information to enrollees about existing grievance procedures and coordination with other entities to assist".

In section 1208(c), after "report to the Secretary" insert "and the State".

In section 1208(c), add at the end thereof the following new sentence:
"Nothing in this section shall replace grievance procedures established or otherwise required under this Act.".

Add at the end of part 1 of subtitle C of title I, the following new section:

SEC. 1210. COORDINATED HEALTH CARE SERVICES FOR CHILDREN.

(a) DESIGNATION OF STATE AGENCY.—The State shall designate an agency (hereafter referred to in this as the "lead agency") to coordinate the delivery of medical and social services to children with special health care needs. The lead agency shall:

(1) Serve as an information resource for children with special health care needs and their families and health providers, providing technical assistance regarding available specialty and support services and referral networks for these children and their families.

(2) Coordinate activities with all other State agencies which provide services to children with special health care needs and their families, and establish mechanisms to identify and maximize resources available for these children and families.

(3) Provide assistance to the State in fulfilling functions under section 1203 in certifying and monitoring the performance of health plans in delivering appropriate services to children in a timely and efficient manner.

(4) Make recommendations to States, plans, and providers to identify what services are lacking for children with special health care needs.

(b) PROVISION OF ACTIVITIES.—The lead agency shall provide the activities under subsection (a) for all children with special health care needs or children under foster care who are referred by a qualified health plan, other health or social service provider, or publicly funded programs where children receive services.

In section 1223(c)(4), strike "race, sex, national origin, religion".

In section 1232(a), insert the following new paragraph (4) and redesignate the remaining paragraphs accordingly:

(4) DIRECT ENROLLMENT AND OTHER MECHANISMS.— States shall allow individuals to enroll directly in health plans of

their choice and through mechanisms other than those described in (3), consistent with subsection (f) (regarding enrollment priorities for oversubscribed plans) and other provisions of this part.

In section 1232(a)(5)(A) (as so redesignated), strike "6000" and insert "6000(a)(3)".

In section 1233, insert before the period the following: "consistent with standards developed by the Board".

At the end of section 1234, add the following new subsection:
(c) RULE OF CONSTRUCTION.—Nothing in this section shall be construed to prevent a health plan from providing for a different basis or level of payment than the fee schedule established under this section as part of a contractual agreement with participating providers under the plan.

In section 1236(a), strike the subsection heading.

In section 1236, strike subsection (b).

In section 1255(g), insert "by the Secretary" after penalties.

In section 1255(f), insert "timely" before "resolution".

In section 1256(c), insert "by the Secretary" after penalties.

In section 1262(a), strike "plan enrollment" and insert "plans, enrollment activities, the determination of enrollment".

In section 1271(b)(1)(A), strike "periodic" and insert "annual".

In section 1301(b), insert "an agency of the State or" before "independent agency".

In section 1302(b)(1)(A), "throughout the health care coverage area" after "individuals".

At the end of section 1302(b), add the following new paragraph:

(3) MEMBERS ENROLLED IN COMMUNITY-RATED PLANS.—Board members shall be enrolled in a community-rated plan offered by the cooperative as a condition of membership on the Board.

In section 1302(c)(1), strike "the governor of".

In section 1302(c)(1), ", labor" after "consumer".

In section 1302(c)(1), strike "to the governor".

In section 1302(c)(2)(D), strike "substantial" and insert "significant."

In section 1302(d)(2), strike "substantial" and insert "significant."

Strike section 1303.

In section 1401(d)(4), insert "part-time," before "seasonal".

In section 1404(b)(2), strike "insurance clearinghouse" and insert "contracting entity described in section 1232"

In section 1421(a), strike "COOPERATIVES" and insert "PLANS".

In section 1425(g), insert "reasonably" before "compensate".

Strike the heading of part 1 of subtitle F of title I and insert the following:

PART 1—STATE-CERTIFIED HEALTH PLANS

In section 1502, strike subsection (e) and insert the following new subsection:

(e) ANTIDISCRIMINATION.—

(1) IN GENERAL.—No health plan may discriminate on the basis of—

(A) the method through which a family seeks enrollment under the plan (including enrollment through the

State-designated enrollment process described in section 1232(a)); or

(B) the provider's status as a member of a health care profession for the purposes of selecting among providers of health services for membership in a provider network, provided that the State authorities members of that profession to render the services in question and that such services are covered in the comprehensive benefits package described in subtitle B.

(2) RULE OF CONSTRUCTION.—Nothing in paragraph (1)(B) shall be construed as requiring any health plan to:

(A) include in a network any individual provider;

(B) establish any defined ratio of different categories of health professionals;

(C) reimburse different categories of health professionals on a similar basis; or

(D) regulate the utilization review or internal quality standards of the health plan.

In section 1502, strike subsection (j).

In section 1504(d), insert before the period the following: "or for the purposes of determining a plan or area's compliance with per-capita premium targets provided for under subtitle A of Title VI of this Act".

At the end of section 1505(b), add the following new paragraph:

(3) MATERIALS IN APPROPRIATE LANGUAGES.—In the case of a health care coverage area that includes a significant number or proportion of residents with limited English proficiency, the State shall provide all such materials in the native languages of such residents, as appropriate.

In section 1505(b)(1), strike "community-rated".

In section 1505(b)(1), strike "community -rate".

Strike subsection (e) of section 1603 and insert the following:

(e) INFORMATION STANDARDS.—The Board shall develop and implement standards for—

(1) the uniform reporting of plan information as required under sections 1206 and 1505; and

(2) the national health information system as required under section 5101 regarding quality standards.

In section 1506(a), strike "consistent with" and insert "in accordance with."

In section 1506(b)(1), strike "ombudsman" and insert "consumer advocate."

In section 1507(c)(3), insert "the continued care is" before "medically indicated".

In section 1507(c)(4)(a)(iii), insert "consistent with subtitle C of title 5 of this Act" after "mechanism".

In section 1507(e)(1), strike "paragraph (2)" and insert "paragraphs (2) and (3)".

In section 1507(e), insert after paragraph (1) the following new paragraph and redesignate the remaining paragraph accordingly:

(2) RULE OF CONSTRUCTION.—Nothing in the paragraph (1) shall be construed to prevent a health plan from providing for a different basis or level of payment than the fee schedule established under section 1234 as part of a contractual agreement with participating providers under the plan.

In section 1507(f)(2), add after the period the following: "An individual or entity who furnishes ancillary health services may not present or cause to be presented, a claim, bill, or demand for payment to any person other than the enrollee receiving such services, or to the health plan of the enrollee.".

Strike section 1510 and insert the following new section:

SEC. 1510. REQUIREMENT RELATED TO COST SHARING OBLIGATIONS.

An enrollee that incurs cost sharing expenses in a month in excess of $250, may request that a health plan establish a payment plan so that the enrollee is not required to pay more than $250 in any one month. For individuals who have submitted and been approved for a reduction in cost sharing under section 1282(c), community-rated plans must accept such requests and may not charge any interest or finance charges on out of pocket expenses financed under this section.

In the heading for section 1513(a), strike "CONSUMER".

In section 1513(a), insert "providers and" after "disclose to".

In section 1602(b), strike "and individuals with disabilities" and insert ", individuals with disabilities, and individuals in rural and urban undeserved areas".

In section 1611(a)(2), strike "parts 2 and 3 of".

In section 1611(c)(2), strike "section 1202, and in particular, subsection (c) of such section" and insert "sections 1202 and 1915, and in particular, the requirements of such sections".

In section 1642, insert "additional" before "adjustment".

In subpart G of part 1 of subtitle G of title I, add the following new section to the end thereof:

SEC. 1661. DISTRIBUTION OF COMPARATIVE INFORMATION.

The Board shall specify a period of time prior to open enrollment during which states must distribute to community-rate eligible individuals enrollment materials and comparative information on health plans.

In section 1671(c)(3), strike "and" at the end thereof.

In section 1671(c)(3), strike (including cooperatives and clearinghouse mechanisms." and insert "(including the financial activities of cooperatives and State-designated contracting entities); and".

Add at the end of section 1671(c), the following new paragraph:

"(4) assuring enforcement of the antidiscrimination provisions of this Act.".

Strike section 1672, and insert the following new section:

SEC. 1672. MEDICAL TECHNOLOGY IMPACT STUDY.

(a) ASSESSMENT OF THE COLLECTIVE IMPACT OF MEDICAL TECHNOLOGIES.—

(1) IN GENERAL.—The Administrator shall establish within the Agency for Health Care Policy and Research an interdisciplinary program for the assessment of the impact of medical technologies.

(2) PURPOSE.—The purpose of the program is to assess the impact of old, new, and emerging medical technologies on health care costs, social costs, and patient outcomes.

(3) DEFINITIONS.—For purposes of this section—

(A) the term "medical technologies" means drugs, biologics (including vaccines), medical devices, drug delivery systems, and surgical services, and other procedures for preventing, diagnosing, and treating disease;

(B) the term "medical technology industry" means the biotechnology, pharmaceutical, and medical device industries, and such other industries that invent, develop, or market medical technologies;

(C) the term "patient outcomes" may include—

(i) changes in clinical outcomes, including stabilization of patients with progressive diseases resulting from the use of safe and effective medical technology in prevention, diagnosis, or treatment;

(ii) changes in morbidity, mortality, and health service use;

(iii) changes in quality of life, including ability to perform activities of daily living, ability to return to

work, relief from discomfort or pain, alleviation of fatigue, and changes in mental functioning and well-being; and

(iv) other outcomes that are determined by the advisory committee to be relevant to assessing the impact of medical technology;

(D) the term "economic costs" may include, based on available data—

(i) financial costs to the health care system of diagnosing and treating disease, including the costs of nontreatment and palliative care;

(ii) financial costs to employers resulting from worker illness, including the costs of productivity losses and worker absenteeism;

(iii) financial costs to families resulting from illness of a family member, including costs associated with loss of income, hiring of caretakers, and long term and hospice care;

(iv) financial costs to government of illness, including reductions in income tax revenues attributable to worker illness and increases in transfer payments, including unemployment, disability, welfare, and survivor benefit payments, made to individuals and families on account of illness; and

(v) other costs that are determined by the advisory committee to be relevant to assessing the impact of medical technology; and

(E) the term "economics benefits" may include, based on available data—

(i) reductions in the economic costs of disease;

(ii) increases in employment attributable to the medical technology industry;

(iii) increases in Federal and State tax revenues attributable to the medical technology industry and its employees;

(iv) improvements in the balance of trade attributable to the medical technology industry; and

(v) other benefits that are determined by the advisory committee to be relevant to assessing the impact of medical technology.

(b) PREPARATION OF REPORTS.—

(1) IN GENERAL.—The Administrator shall prepare a report to the Congress and the Secretary as described in paragraph (4) not later than three years after the date of enactment of this section, and reports as described in paragraph (5) every two years thereafter.

(2) CONSULTATION.—The reports required by paragraph (1) shall be prepared in consultation with—

(A) the advisory committee established pursuant to subsection (c); and

(B) the President of the Institute of Medicine.

(3) PEER REVIEW.—The Administrator shall establish an appropriate peer review process for the reports required by paragraph (1). Such process shall provide for an opportunity for review and comment by representatives of the medical technology industry, consumer and patient groups, physicians and other health care providers, and other groups determined by the advisory committee to have a legitimate interest in the reports. No report shall be submitted to the Congress or the Secretary until it has undergone peer review.

(4) INITIAL REPORT REQUIREMENTS.—

(A) BASELINE REPORT.—The first report issued under paragraph (1) shall be known as the baseline report.

(B) IDENTIFICATION OF DISEASES.—The baseline report shall identify up to fifteen diseases (or conditions) selected according to the criteria outlined in paragraph (6).

(C) REQUIREMENTS.—For each disease or condition, the baseline report shall—

(i) determine the economic costs of the disease;

(ii) identify the medical technologies used to prevent, diagnose, and treat the disease;

(iii) evaluate the extent to which utilization of medical technologies has improved patient outcomes;

(iv) determine whether such utilization resulted in a net increase or reduction in the economic costs of the disease;

(v) determine the economic benefits associated with such medical technologies;

(vi) evaluate which medical technologies effectively and efficiently improve patient outcomes and which do not; and

(vii) evaluate the impacts of each medical technology on patient outcomes, resource utilization, and economic costs and benefits.

(D) COSTS AND BENEFITS.—Based on the findings and conclusions determined pursuant to subparagraph (C), the reports shall provide information on aggregate costs and benefits (including improved patient outcomes) of medical technologies for up to fifteen diseases (or conditions) considered to be high priority according to the criteria in paragraph (6).

(E) METHODOLOGY REVISION.—The baseline report may also contain revisions in the methodology for topic section, data to be collected, composition and functions of the advisory committee, and other recommendations to the Congress concerning the best means to evaluate the impact of medical technology.

(5) SUBSEQUENT REPORT REQUIREMENTS.—Reports issued after the baseline report shall identify changes occurring in the factors described in paragraph (4)(C) since the baseline year that are attributable to advances in, or changes in utilization of, medical technology.

(6) SELECTING CONDITIONS FOR STUDY.—The Administrator, in consultation with the advisory committee, shall determine the specific method by which priorities shall be assigned to the diseases or conditions studied in the baseline and subsequent reports. The diseases or conditions studied in such reports shall be those considered to be high priority according to the following criteria:

(A) Aggregate economic costs to the United States.

(B) Overall importance to public health.

(C) Potential for improvements in patient outcomes.

(D) Significant changes expected in management of the condition.

(E) Other criteria identified by the advisory committee.

(7) RESPONSE BY SECRETARY.—

(A) DISSEMINATION.—Upon receipt of each report of the Administrator, the Secretary shall make the Administrator's report publicly available.

(B) REPORT BY SECRETARY.—Not later than 180 days after receiving the Administrator's report, the Secretary shall prepare a report that—

(i) evaluates the Administrator's report and identifies any Federal policies that may constitute impediments to the appropriate use of medical technology in clinical practice;

(ii) identifies whether the Secretary has the authority under existing law to remove the impediments to appropriate use of medical technology (and, if the Secretary has such authority, the Secretary shall take prompt action to remove the impediments); and

(iii) identifies whether there is any existing authority which allows the Secretary to respond appropriately to the technology assessments made in the Administrator's report (and, if there is no such authority, the Secretary shall provide a description of the legislative changes necessary to provide the authority).

(C) PUBLICATION.—The report of the Secretary shall be published in the Federal Register and, following an appropriate period for the receipt of public comments, the Secretary shall undertake to remedy any impediments identified therein.

(D) IMPEDIMENTS.—For the purposes of this subsection, impediments to the appropriate use of medical technology in clinical practice may include—

(i) inadequate dissemination of information to medical practitioners about the best clinical practices;

(ii) payment policies that discourage best clinical practices or perpetuate suboptimal clinical practices; and

(iii) such other policies, or lack thereof, that inhibit patient access to effective and appropriate prevention, diagnosis and treatment.

(8) GRANTS AND CONTRACTS.—The Administrator may enter into such cooperative agreements, grants or contracts with appropriate entities to conduct assessments of health care technologies and for related activities as may be necessary carry out this subsection.

(c) ADVISORY COMMITTEE.—

(1) IN GENERAL.—The Administrator shall establish an advisory committee to assist the Agency in preparing the reports required by subsection (b). Except as provided in paragraph (3), no member of the advisory committee shall be an employee of the Federal Government.

(2) MEMBERSHIP.—

(A) The membership of the advisory committee shall include two individuals appointed by the President of the Institute of Medicine and two individuals from each of the following categories:

(i) Experts in medical technology assessment.

(ii) Experts in objective measures of improved patient outcomes, such as clinical outcomes, morbidity, mortality, and health service use.

(iii) Experts in subjective measures of improved patient outcomes, such as quality of life.

(iv) Experts in quantifying the economic benefits of the medical technology industry, the economic costs of disease to the health care system.

(v) Experts in health statistics and epidemiology.

(vi) Physicians and other health care providers.

(vii) Officers or employees of health plans and other health care payers.

(viii) Experts in the ethical implications of health care.

(ix) Consumers and members of patient advocacy groups.

(x) Health professional organizations.

(xi) Officers or employees of biotechnology companies.

(xii) Officers or employees of medical device companies.

(xiii) Officers or employees of pharmaceutical companies.

(3) EX OFFICIO MEMBERS.—The following individuals or their designees shall serve as ex officio members of the advisory committee:

(A) The Director of the National Institutes of Health.

(B) The Commissioner of Food and Drugs.

(C) The Director of the Centers for Disease Control and Prevention.

(D) The Administrator of the Health Care Financing Administration.

(E) The Under Secretary of Commerce for Technology.

(F) The Director of the Congressional Office of Technology Assessment.

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

In subpart A of part 2 of subtitle G of title I, add the following new sections:

SEC. 1673. ADVISORY OPINIONS.

(a) IN GENERAL.—Community- and provider-based plans shall be eligible to receive advisory opinions from appropriate Federal entities concerning whether their arrangement complies with Federal self-referral and anti-trust laws.

(b) REGULATIONS.—The Secretary shall issue regulations setting forth the procedures for obtaining advisory opinions described in subsection (a).

(c) TIMING OF OPINIONS.—Advisory opinions shall be issued not later than 90 days after receipt of a request for such opinions from a plan.

(d) FEES.—Applicants shall pay a fee, the amount of which to be determined by the Secretary, to cover the costs of providing the opinion.

SEC. 1674. REPORTS.

(a) DENTAL CARE.—The Secretary shall undertake a study to determine the costs of providing preventative and restorative dental care to adults with cognitive and developmental disabilities and shall determine the best oral health care practice and the cost or savings of providing such care prior to 2001. The Secretary shall report to the National Health Board and the Congress not later than September 1, 1995 concerning such study.

(b) IN VITRO FERTILIZATION.—The Secretary shall undertake a study to determine the costs of providing coverage for in vitro fertilization in the comprehensive benefits package. The Secretary shall report to the National Health Board and the Congress not later than September 1, 1995 concerning such study.

In section 1681(a)(3), insert after "Health Service Act," the following: "nonprofit hospitals with a minimum of 200 beds, located in urban areas where (A) the cumulative total of its services provided to individuals who are entitled to benefits under title XVIII of the Social Security Act or under a State plan under title XIX of such Act equals a minimum of 65 percent and (B) a minimum of 20 percent of its services are provided to individuals eligible for assistance under such title XIX, a Medicare dependent small rural hospital under section 1886(d)(8)(iii) of such Act, except that in administering this paragraph with respect to such section the Secretary shall replace '60 percent' in subclause (IV) with '70 percent'.

In section 1681(a)(5), by striking "and" at the end thereof.

In section 1681(a)(6), by striking the period and inserting "; and".

By adding at the end of section 1681(a), the following new paragraph:

"(7) public and private, nonprofit rural health clinics as defined under section 1861(aa)(2) of the Social Security Act.".

In section 1681(a)(4), strike "designated" and all that follows through "1115" and insert "receiving funds under title V of XIX of the Public Health Service Act".

In section 1682(c), insert "clinical social worker" after "pharmacist,".

In section 1683(b)(1)(A)(II), strike "; and" and insert a semicolon.

In section 1683(b)(1)(B)(I), strike "; or" and insert a semicolon.

At the end of section 1683(b)(1), add the following new subparagraph:

"(C) is a rural health clinic as defined in section 1861(aa)(2) of the Social Security Act.".

In section 1687(a)(1), strike "6127(d)" and insert "1207".

In section 1687(a), strike paragraph (2) and insert the following new paragraph:

"(2) employers maintaining qualified programs receive a rebate annually, based on the average worksite health promotion discount in the health care coverage area, weighted by the enrollment of employees of all employers offering certified wellness programs in the area.".

At the end of section 1687(b), add the following new paragraph:

(3) Ensure that any wellness discount offered by health plans are not taken into account in the Board's determination of plan and area compliance with the per-capita premium targets described in subtitle A of title VI of this Act.

In section 1695, insert "(a) IN GENERAL.—" before "A health".

In section 1695, strike "pursuant to section" and all that follows through the period and insert "to investigate the issues involved in a collective bargaining dispute between the entity and the labor organization."

Add at the end of section 1695, the following new subsection:

(b) TIME FOR REQUEST.—Such request may be made no earlier than 60 days after notice of the existence of a contract dispute has been provided to—

(1) the Federal Mediation and Conciliation Service In accordance with clause (A) or (B) of the last sentence of section 8(d) of the Labor Management Relations Act (29 U.S.C. 158(d)); or

(2) where the health care entity is otherwise exempt from coverage under such Act, any comparable State or territorial agency established to mediate and conciliate disputes to which notice is required to be given under applicable State law.

In section 1696, strike subsection (a) and insert the following new subsection:

(a) IN GENERAL.—Except as provided in subsection (b), the Director shall appoint a Health Care Board of Inquiry not later than 10 days after receipt of a request under section 1695. Each such Board shall be composed of such number of individuals as the Director may deem desirable. No member appointed under this section shall have any interest or involvement in the health care institutions or the employee organizations involved in the dispute.

Section 1697 is amended to read as follows:

SEC. 1697. PUBLIC FACTFINDING.

A Health Care Board of Inquiry appointed under this section shall investigate the issues involved in the dispute and make a written report thereon to the parties and to the Director within 30 days after the establishment of such a Board. The written report shall contain the findings of fact together with the Board's recommendations for settling the dispute, with the objective of achieving a prompt, peaceful and just settlement of the dispute. The Board shall arrange for publication of such report within the community served by the health care entity involved.

Add at the end of part 3 of subtitle H of title I the following new sections:

SEC. 1698. COMPENSATION OF MEMBERS OF BOARDS OF INQUIRY.

(a) EMPLOYEES IF FEDERAL GOVERNMENT.—Members of any board established under this part who are otherwise employed by the Federal Government shall serve without compensation but shall be reimbursed for travel, subsistence, and other necessary expenses incurred by such members in carrying out its duties under this section.

(b) OTHER MEMBERS.—Members of any board established under this section who are not subject to subsection (a) shall receive compensation at a rate prescribed by the Director but not to exceed the daily rate prescribed for GS-128 of the General Schedule under section 5332 of Title 5, United States Code, including travel for each day they are engaged in the performance of their duties under this section and shall be entitled to reimbursement for travel, subsist-

ence, and other necessary expenses incurred by them in carrying out their duties under this part.

SEC. 1699. MAINTENANCE OF STATUS QUO.

After the establishment of a board under section 1696, and for 15 days after any such board has issued its report, no change in the status quo in effect prior to the expiration of the contract in the case of negotiations for a contract renewal, or in effect prior to the time the parties began their bargaining in the case of an initial beginning negotiation, except by agreement, shall be made by the parties to the controversy.

In section 1702(h)(5), strike "may" and insert "shall".

Insert the following new section 1706 and redesignated the remaining sections and cross references thereto accordingly:

SEC. 1706. EVASION OF OBLIGATIONS.

It shall be unlawful for any employer or other person to discharge, fine, suspend, expel, discipline, discriminate or otherwise take adverse action against any employee if a purpose of such action is to Interfere with the employee's attainment of status as a qualifying employee, as a full time employee, or as a part-time employee, or if a purpose of such action is to evade or avoid any obligation under this Act.

In section 1901(b)(2), insert the following new subparagraph after subparagraph (C) and redesignate the remaining subparagraph and all references thereto accordingly:

> *(D) PART-TIME EMPLOYEE.—For purposes of this Act, the term "part-time employee" means, with respect to an employer, an employee who is employed on a part-time basis (as specified in subparagraph (A)) by the employer.*

In section 1901(b)(2)(E) (as redesignated), insert "or (D)" after "subparagraph (C)".

In section 1901(b)(2)(E) (as redesignated), insert "or part-time" after "on a full-time".

In section 1901(b)(2)(E) (as redesignated), insert "or part-time" after "be a full-time".

In section 1901(b)(2)(E) (as redesignated), strike "the employment" and insert "employment".

In section 1901(b)(2)(E) (as redesignated), strike "time employment" and insert "or part-time employment in that industry".

Paragraph (1) of section 1902 is amended to read as follows:

(1) CITIZEN OF ANOTHER COUNTRY LEGALLY RESIDING IN THE UNITED STATES.—The term "citizen of another country legally residing in the United States" means any of the following:

(A) An alien lawfully admitted for permanent residence (within the meaning of section 101(a)(20) of the Immigration and Nationality Act).

(B) An alien eligible for work authorization granted by the Immigration and Naturalization Service.

(C) An alien permanently residing in the United States under color of law, including (but not limited to) any of the following:

(i) An alien who is admitted as a refugee under section 207 of the Immigration and Nationality Act.

(ii) An alien who is granted asylum under section 208 of such Act.

(iii) An alien whose deportation is withheld under section 243(h) of such Act.

(iv) An alien who is admitted for temporary residence under section 210, 210A, or 245A of such Act, and the spouse or children of such alien.

(v) An alien who has been paroled into the United States under section 212(d)(5) of such Act for an indefinite period or who has been granted extended voluntary departure, temporary protected status, or deferred enforced departure.

(vi) An alien who is the spouse or unmarried child under 21 years of age of a citizen of the United States, or the parent of such a citizen if the citizen is over 21 years of age, and with respect to whom an application for adjustment to lawful permanent residence is pending.

(vii) An alien within such other classification of aliens permanently residing under color of law for purposes of this Act only as the National Health Board may establish by regulation. Such regulation shall include categories of such aliens who are included in regulations as in effect on the date of the enactment of this Act under title XIX of the Social Security Act and other categories within a public health priority.

In section 1902, strike paragraph (41).

Add at the end of part 2 of subtitle I of title I, the following new section:

SEC. 1915. ANTIDISCRIMINATION.

(a) IN GENERAL.—Neither the National Health Board nor any State, health plan, consumer purchasing cooperative, large group sponsor, employer, or other entity subject to this Act shall directly or through contractual arrangements—

(1) deny or limit access to or the availability of health care services, or otherwise discriminate in connection with the provision of health care services; or

(2) limit, segregate or classify an individual in any way which would deprive or tend to deprive such individual of health care services, or otherwise adversely affect his or her access to health care services;

on the basis of race, national origin, sex, language, income, age, sexual orientation, disability, health status, or anticipated need for health services.

(b) DEFINITION.—As used in this section, the term "in connection with the provision of health care services" includes—

(1) establishing the boundaries for health care coverage areas under section 1202 and for premium areas under section 1414, enrolling persons in a health care plan or marketing a health care plan, and selecting providers or setting the terms or conditions under which providers participate in a health care plan or provider network; and

(2) determining the scope of services provided by a health care plan, and providing such services and determining the site or location of health care facilities;

on the basis of race, national origin, sex, language, income, age, sexual orientation, disability, health status, or anticipated need for health services.

(c) REGULATIONS.—Not later than 1 year after the date of enactment of this Act, the Secretary of Health and Human Services shall issue regulations to carry out this section.

(d) EFFECT ON OTHER LAWS. Nothing in this Act shall be construed to limit the scope of, or the availability of relief under, any other Federal or State law prohibiting discrimination or providing relief therefore.

(e) BENEFITS.—Nothing in this Act shall be construed to require or prohibit the provision of benefits to an employee for the benefit of his or her same-sex partner.

(f) OUTREACH UNAFFECTED.—Nothing in this section shall be construed to prevent a person from engaging in activities to encourage the enrollment of community rated individuals residing in underserved areas.

United States Senate

Committee on Labor and Human Resources

Senator Edward M. Kennedy, Chair

Amendments

to the

Health Security Act

Title I

May 18, 1994

Table of Contents - Health Security Act Amendments Packet

Hatch Amendment
Title I
[Advisory Council on Breakthrough Drugs]

Strike Sec. 1672, Advisory Council on Breakthrough Drugs [pp. 105-106]

Hatch Amendments en bloc
Title I
[Abortion in the Benefits Package]

At the end of Section 1141(b) [p. 32] add a new subsection as follows:

"(10) Abortion, except where--

(A) a woman suffers from a physical disorder, illness, or injury that would, as certified by a physician, place the woman in danger of death if the fetus were carried to term; or

(B) the pregnancy is the result of rape or incest.

This paragraph shall not be construed to remove or diminish coverage of any reproductive health service, family planning service, or service for pregnant women otherwise provided for under this Act, except abortion."

At the end of Section 1151(b) [p. 32] add a new subsection as follows:

"(c) NO AUTHORITY TO ALTER ABORTION EXCLUSION.-- Notwithstanding any other provision of this Act, the National Health Board may not expand the comprehensive benefits package to include any abortion that is excluded under section 1141(b)(10)."

Senator Coats' Amendments to the Chairman's Mark of The Health Security Act

Title I and Title VI Amendments

1. Two amendments pertaining to abortion (Sec. 1141)
2. One amendment pertaining to Medical Savings Accounts
3. Five amendments pertaining to the standard benefits package (Sections 1114, 1115, 1135, and Parts 1-5 of Subtitle I of Title I)
4. One amendment pertaining to the FEHBP (Sec. 1321)
5. One amendment pertaining to balanced billing (Sec. 1507)
6. One amendment pertaining to direct billing (Sec. 1507)
7. Five amendments pertaining to taxes (Sec. 1914)
8. One amendment pertaining to community rating
9. Three amendments pertaining to a patient's choice of doctor and to preserve the patient-doctor relationship (Sec. 1141 / 1154)
10. One amendment pertaining to the religious conviction clause (Sec. 1162)
11. One amendment pertaining to sexual orientation (Sections 1202, 1236, 1303, and 1502)
12. Two amendments pertaining to the employer mandate (Sec. 6141)

8 a.m. Tuesday, May 17, 1994

AMENDMENT NO. ____ Calendar No. ____

Purpose: To exclude abortions from the comprehensive benefit package except in certain circumstances.

IN THE SENATE OF THE UNITED STATES—103d Cong., 2d Sess.

S.____

To ensure individual and family security through health care coverage for all Americans in a manner that contains the rate of growth in health care costs and promotes responsible health insurance practices, to promote choice in health care, and to ensure and protect the health care of all Americans.

Referred to the Committee on _____
and ordered to be printed

Ordered to lie on the table and to be printed

AMENDMENTS intended to be proposed by Mr. COATS

Viz:

Add at the end of section 1141(b), the following:

(10) Abortions, except where—

(A) a woman suffers from a physical disorder, illness, or injury that would, as certified by a physician, place the woman in danger of death if the fetus were carried to term; or

(B) the pregnancy is the result of rape or incest.

May 17, 1994

MEMORANDUM

To: LABOR COMMITTEE MEMBERS AND STAFF

From: Minority Health Staff/Sen. Kassebaum

Subject: INTENDED AMENDMENTS FOR TOMORROW'S HEALTH REFORM MARKUP SESSION

Listed below are amendments intended to be offered by Senator Kassebaum at tomorrow's initial markup session of the health reform legislation.

Additional amendments will be filed as the markup process continues. These will be filed the day prior to the day on which Senator Kassebaum intends to offer them.

** Strike Subtitles C, D, E, and F of Title I (relating to state responsibilities, purchasing cooperatives, large group sponsors, and health plans)

** Senator Kassebaum also serves notice that she may offer a partial substitute amendment during consideration of this bill to replace and revise the functions of these subtitles.

** Amendment relating to benefits package construction

** Amendment relating to removal of the employer and individual mandates

** Amendment relating to the FEHBP buy-in option

** Amendment relating to the state single-payer option

** Amendment relating to retiree health benefit entitlement

** Amendment relating to essential community providers

** Amendment relating to FDA and distribution of prescription samples

AMENDMENT NO. ____ Calendar No. ____

Purpose: To strike provisions in the bill relating to State responsibilities, consumer purchasing cooperatives, large group sponsors, and health plans.

IN THE SENATE OF THE UNITED STATES—103d Cong., 2d Sess.

S.____

To ensure individual and family security through health care coverage for all Americans in a manner that contains the rate of growth in health care costs and promotes responsible health insurance practices, to promote choice in health care, and to ensure and protect the health care of all Americans.

Referred to the Committee on _____
and ordered to be printed

Ordered to lie on the table and to be printed

AMENDMENT intended to be proposed by Mrs. Kassebaum

Viz:

In title I of the bill, strike subtitles C, D, E, and F and modify all references thereto accordingly.

AMENDMENT NO. ____ Calendar No. ____

Purpose: To revise the benefits provisions of the bill

IN THE SENATE OF THE UNITED STATES—103d Cong., 2d Sess.

S.____

To ensure individual and family security through health care coverage for all Americans in a manner that contains the rate of growth in health care costs and promotes responsible health insurance practices, to promote choice in health care, and to ensure and protect the health care of all Americans.

Referred to the Committee on _____
and ordered to be printed

Ordered to lie on the table and to be printed

AMENDMENT intended to be proposed by Mrs. KASSEBAUM

Viz:

Strike subtitle B of title I and insert the following new subtitle:

Subtitle B—Benefits

SEC. 1301. OFFERING OF BENEFIT PACKAGES.

(a) BENEFIT PACKAGES.—Each qualified health plan shall provide the standard package which shall consist of the categories of benefits specified under subsection (b), subject to the applicable cost sharing requirement specified under subsection (c)(1) for such a package.

ance, and out-of-pocket limits on cost sharing established for such package pursuant to part II.

(2) LIMITATION.—In establishing cost sharing requirements under part II, the Commission shall establish a limit on the total amount of cost-sharing that may be incurred by a family within a class of family enrollment in a year.

(d) CRITERIA FOR DETERMINATION OF MEDICAL NECESSITY AND APPROPRIATENESS.—

(1) IN GENERAL.—A health plan shall provide for coverage of the categories of benefits described in subsection (b) only for treatments and diagnostic procedures when the health plan finds that such treatments and procedures are medically necessary or appropriate. In the case of dispute concerning a determination of medical necessity or appropriateness and subject to the succeeding provisions of this subsection, for purposes of this title, a treatment (as defined in subparagraph (6)(A)) or diagnostic procedure shall be considered to be "medically necessary or appropriate" if the following criteria are met:

(A) TREATMENT OR DIAGNOSIS OF MEDICAL CONDITION.—

(C) EFFECTIVE AND SAFE.—The evidence must demonstrate that the treatment or diagnostic procedure can reasonably be expected to produce the intended health result or provide intended information and is safe and the treatment or diagnostic procedure provides a clinically meaningful benefit with respect to safety and effectiveness in comparison to other available alternatives or the patients current health status.

(2) RELATIONSHIP TO FDA REVIEW.—

(A) APPROVED DRUGS, BIOLOGICALS, AND MEDICAL DEVICES.—

(i) DRUGS.—A drug that has been found to be safe and effective under section 505 of the Federal Food, Drug, and Cosmetic Act is deemed to meet the requirements of paragraphs (1)(B) and (1)(C) (relating to not investigational and safety and effectiveness.)

(ii) BIOLOGICALS.—A biological that has been found to be safe and effective under section 351 of the Public Health Service Act is deemed to meet the requirements of paragraphs (1)(B) and (1)(C)

treatments (as defined in subparagraph (B)) may be considered to be medically necessary or appropriate only if the treatment is part of an approved research trial (as defined in subparagraph (D)).

(B) INVESTIGATIONAL TREATMENT DEFINED.—In subparagraph (A), the term "investigational treatment" means a treatment for which there is not sufficient evidence to determine the health outcome of the treatment compared with the best available alternative treatment (or with no treatment if there is no alternative treatment).

(C) ROUTINE MEDICAL COSTS DEFINED.—In subparagraph (A), the term "routine medical costs" means the cost of health services required to provide treatment according to the design of the trial, except those costs normally paid for by other funding sources (as defined by the Secretary). Such costs do not include the cost of the investigational agent, devices or procedures themselves, the costs of any nonhealth services that might be required for a person to receive the treatment, or the costs of managing the research.

(B) DISCLOSURE.—Each community-rated health plan shall disclose to its enrollees, in a manner specified by the State, its coverage decisions and must submit information on such decisions to the State.

(5) ARBITRATION EVIDENCE.—The evidence that may be used in making coverage decisions under any arbitration process which may apply as a result of this Act includes—

(A) published peer-reviewed literature;

(B) opinions of medical specialty groups and other medical experts; and

(C) evidence of general acceptance by the medical community.

(6) TREATMENT AND HEALTH OUTCOME DEFINED.—As used in this subsection:

(A) IN GENERAL.—The term "treatment" means any health care intervention undertaken, with respect to a specific indication, to improve, maintain, or stabilize a health outcome or to prevent or mitigate an adverse change in a health outcome.

(B) HEALTH OUTCOME.—The term "health outcome" means an outcome that affects the length and quality of an enrollee's life.

(B) may not specify the categories of health care providers who are authorized to deliver categories of benefits;

(C) with respect to the categories of benefits, may not specify (in this Act or by regulations) particular procedures or treatments, or classes thereof;

(D) with respect to section 1301(b)(9), shall, after consultation with the Federal Aviation Administration. provide for maximum flexibility to air ambulance services, consistent with basic public safety requirements, in order to avoid an adverse change in health outcomes (within the meaning of section 1301(d)(1)(A)) for persons using such services; and

(E) with respect to categories of benefits. may specify (in this Act or through regulations) particular procedures or treatments that shall not be covered in a standard benefit package.

(2) SPECIFICATION OF COST SHARING.—A specification of the precise deductibles, copayments, coinsurance, and out-of-pocket limits on cost sharing that are to apply to the standard package and the catastrophic package under section 1301(c). Such specification—

third proposal in accordance with the procedure described in the preceding sentence. If such third proposal is not approved by the Congress, the members of the Commission shall vacate their positions, and new members shall be appointed under section 1313 to fill such vacancies. Such new members shall submit to the Congress not more than three proposals conforming to the requirements of subsection (a) in accordance with the procedure described in this subsection.

(c) PROPOSED MODIFICATIONS.—

(1) IN GENERAL.—Not earlier than January 1 of the year that occurs 1 year after a legislative proposal described in subsection (a) or (b) is enacted, and not more frequently than annually, the Commission may submit to the Congress a proposal for legislation containing recommended modifications to such enactment. Such a proposal shall be treated as an initial proposal under subsection (a) for purposes of consideration in the Congress under section 1314 and implementation under section 1315. Subsection (a)(4) shall not apply to such a proposal.

(2) SUBMISSION OF PROPOSAL IF DEFICIT.—If the Commission receives a report concerning a deficit for a year under a pay-as-you-go requirement which may apply as a result of the enactment of this

(D) a reduction in the applicable dollar limit determined under section 91(b)(2) of the Internal Revenue Code of 1986, based on family income.

SEC. 1313. OPERATION OF THE COMMISSION.

(a) MEMBERSHIP.—

(1) IN GENERAL.—The Commission shall be composed of 5 members appointed by the President.

(2) CONSULTATION.—In selecting individuals for nominations for appointments for the Commission, the President should consult with—

(A) the Speaker of the House of Representatives concerning the appointment of 1 member;

(B) the Majority Leader of the Senate concerning the appointment of 1 member;

(C) the Minority Leader of the House of Representatives concerning the appointment of 1 member; and

(D) the Minority Leader of the Senate concerning the appointment of 1 member.

(3) CHAIRPERSON.—The President shall designate 1 individual described in paragraph (1) who shall serve as Chairperson of the Commission.

(2) PAY AND TRAVEL EXPENSES.—

(A) IN GENERAL.—Each member, other than the chairperson of the Commission, shall be paid at a rate equal to the daily equivalent of the minimum annual rate of basic pay payable for level IV of the Executive Schedule under section 5315 of title 5, United States Code, for each day (including travel time) during which the member is engaged in the actual performance of duties vested in the Commission.

(B) CHAIRPERSON.—The chairperson of the Commission shall be paid for each day referred to in subparagraph (A) at a rate equal to the daily equivalent of the minimum annual rate of basic pay payable for level III of the Executive Schedule under section 5314 of title 5, United States Code.

(C) TRAVEL EXPENSES.—Members shall receive travel expenses, including per diem in lieu of subsistence, in accordance with sections 5702 and 5703 of title 5, United States Code.

(3) DIRECTOR OF STAFF.—

(i) IN GENERAL.—Upon request of the Director, the head of any Federal department or agency may detail any of the personnel of that department or agency to the Commission to assist the Commission in carrying out its duties under this Act.

(ii) AGREEMENT WITH COMPTROLLER GENERAL.—The Comptroller General of the United States shall provide assistance, including the detailing of employees, to the Commission in accordance with an agreement entered into with the Commission.

(5) OTHER AUTHORITY.—

(A) CONTRACT SERVICES.—The Commission may procure by contract, to the extent funds are available, the temporary or intermittent services of experts or consultants pursuant to section 3109 of title 5, United States Code.

(B) LEASES AND PROPERTY.—The Commission may lease space and acquire personal property to the extent funds are available.

SEC. 1314. CONGRESSIONAL CONSIDERATION OF COMMISSION PROPOSALS.

(a) CONSIDERATION.—A legislative proposal submitted to the Congress by the Commission (except in the case

recommendations of the Benefits Commission as submitted by the Commission on _____", the blank space being filled in with the appropriate date: and

(2) the title of which is as follows: "Joint Resolution approving the recommendation of the Benefits Commission".

(d) INTRODUCTION AND REFERRAL.—On the day on which a recommendation of the Commission is transmitted to the House of Representatives and the Senate, an approval resolution with respect to such recommendation shall be introduced (by request) in the House of Representatives by the majority leader of the House, for himself or herself and the minority leader of the House, or by Members of the House designated by the majority leader and minority leader of the House; and shall be introduced (by request) in the Senate by the majority leader of the Senate, for himself or herself and the minority leader of the Senate, or by Members of the Senate designated by the majority leader and minority leader of the Senate. If either House is not in session on the day on which such recommendation is transmitted, the approval resolution with respect to such recommendation shall be introduced in the House, as provided in the preceding sentence, on the first day thereafter on which the House is in session.

it was referred, or after such committee or committees have been discharged from further consideration of the approval resolution. If prior to the passage by one House of an approval resolution of that House, that House receives the same approval resolution from the other House then—

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

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

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

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

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

(h) FLOOR CONSIDERATION IN THE SENATE.—

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

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

(3) DEBATE OF MOTIONS AND APPEALS.—Debate in the Senate on any debatable motion or appeal in connection with an approval resolution shall be limited to not more than 1 hour, to be equally divided between, and controlled by, the mover and the manager of the approval resolution, except that in the event the manager of the approval resolution is in favor of any such motion or appeal, the time in opposition thereto, shall be controlled by the Minority Leader or his designee. Such leaders, or either of them, may, from time under their control on the

AMENDMENT NO. ____ Calendar No. ____

Purpose: To eliminate the employer and individual mandates.

IN THE SENATE OF THE UNITED STATES—103d Cong., 2d Sess.

S.____

To ensure individual and family security through health care coverage for all Americans in a manner that contains the rate of growth in health care costs and promotes responsible health insurance practices, to promote choice in health care, and to ensure and protect the health care of all Americans.

Referred to the Committee on _____
and ordered to be printed

Ordered to lie on the table and to be printed

AMENDMENTS intended to be proposed by Mrs. KASSEBAUM

Viz:

Strike sections 1011 through 1014 and redesignate subsequent sections and any cross references thereto, accordingly.

Strike subpart A of part 4 of subtitle C of title I, and modify all references thereto accordingly.

Strike subtitle H of title I, and modify all references thereto accordingly.

AMENDMENT NO. ____ Calendar No. ____

Purpose: To strike the FEHBP buy-in option.

IN THE SENATE OF THE UNITED STATES—103d Cong., 2d Sess.

S.____

To ensure individual and family security through health care coverage for all Americans in a manner that contains the rate of growth in health care costs and promotes responsible health insurance practices, to promote choice in health care, and to ensure and protect the health care of all Americans.

Referred to the Committee on _____
and ordered to be printed

Ordered to lie on the table and to be printed

AMENDMENT intended to be proposed by Mrs. Kassebaum

Viz:

1 In title I of the bill, strike part 3 of subtitle D.

AMENDMENT NO. ____ Calendar No. ____

Purpose: To strike provisions relating to the State single-payer option.

IN THE SENATE OF THE UNITED STATES—103d Cong., 2d Sess.

S.____

To ensure individual and family security through health care coverage for all Americans in a manner that contains the rate of growth in health care costs and promotes responsible health insurance practices, to promote choice in health care, and to ensure and protect the health care of all Americans.

Referred to the Committee on _____
and ordered to be printed

Ordered to lie on the table and to be printed

AMENDMENT intended to be proposed by Mrs. Kassebaum

Viz:

Strike section 1014.

In title I of the bill, strike part 2 of subtitle C, and modify all references thereto accordingly.

Strike subsection (b) of section 1701.

Strike subsection (b) of section 1706.

AMENDMENT NO. ____ Calendar No. ____

Purpose: To strike provisions relating to new retiree health entitlement.

IN THE SENATE OF THE UNITED STATES—103d Cong., 2d Sess.

S.____

To ensure individual and family security through health care coverage for all Americans in a manner that contains the rate of growth in health care costs and promotes responsible health insurance practices, to promote choice in health care, and to ensure and protect the health care of all Americans.

Referred to the Committee on _____
and ordered to be printed

Ordered to lie on the table and to be printed

AMENDMENT intended to be proposed by Mrs. Kassebaum

Viz:

Strike section 1710 and insert in lieu thereof the following:

SEC. 1710. DEFICIT REDUCTION.

Notwithstanding any other provision of law, any savings generated from the elimination of new retiree health entitlement provisions shall be deposited into the Deficit Reduction Trust Fund.

AMENDMENT NO. ____ Calendar No. ____

Purpose: To add certain providers to categories of providers automatically certified as essential community providers.

IN THE SENATE OF THE UNITED STATES—103d Cong., 2d Sess.

S. 1779

To ensure individual and family security through health care coverage for all Americans in a manner that contains the rate of growth in health care costs and promotes responsible health insurance practices, to promote choice in health care, and to ensure and protect the health care of all Americans.

Referred to the Committee on _____
and ordered to be printed

Ordered to lie on the table and to be printed

AMENDMENT intended to be proposed by Mrs. KASSEBAUM

Viz:

Section 1682(a) is amended—

(1) by striking "and" at the end of paragraph (5);

(2) by striking the period at the end of paragraph (6) and inserting a semicolon; and

(3) by inserting after paragraph (6) the following new paragraphs:

"(7) hospitals which would qualify for medicare disproportionate share adjustments under section

AMENDMENT NO. ____ Calendar No. ____

Purpose: To amend the Federal Food, Drug, and Cosmetic Act to prohibit the distribution of samples of prescription drugs.

IN THE SENATE OF THE UNITED STATES—103d Cong., 2d Sess.

S.

To ensure individual and family security through health care coverage for all Americans in a manner that contains the rate of growth in health care costs and promotes responsible health insurance practices, to promote choice in health care, and to ensure and protect the health care of all Americans.

Referred to the Committee on _____
and ordered to be printed

Ordered to lie on the table and to be printed

AMENDMENT intended to be proposed by Mrs. KASSEBAUM

Viz:

At the appropriate place in the bill, insert the following new subpart:

Subpart ____—Prescription Drugs

SEC.____01. SHORT TITLE AND REFERENCE.

(A) SHORT TITLE.—This subpart may be cited as the "Prescription Drug Marketing Reform Act of 1994 ".

(b) REFERENCE.—Whenever in this subpart an amendment or repeal is expressed in terms of an amend-

(5) by redesignating paragraph (3) as paragraph (4) and by adding after paragraph (2) the following:

"(3) Nothing in paragraphs (1) and (2) precludes distribution of a drug subject to subsection (b) at no cost or nominal cost pursuant to a program established by the manufacturer or distributor of such drug to provide it to specific identified patients who, for financial reasons, would not otherwise be able to use such drug. The Secretary shall promulgate regulations to specify the documentation and record keeping required for such a program.", and

(6) by repealing subsection (d) and redesignating subsections (e), (f), and (g) as subsections (d), (e), and (f), respectively.

SEC. ___08. ENFORCEMENT.

(a) PROHIBITED ACT.—Section 301(t) (21 U.S.C. 331(t)) is amended to read as follows:

"(t) The importation of a drug in violation of section 801(d)(1), the distribution, sale, purchase, or trade of a drug or drug sample or the offer to distribute, sell, purchase, or trade a drug or drug sample in violation of section 503(c), the distribution, sale, purchase, or trade of a coupon or the offer to distribute, sell, purchase, or trade such a coupon in violation of section 503(c)(2), or the dis-

the expiration of such days, from providing a drug or a coupon for a drug to patients who would not otherwise be able financially to use such drug.

AMENDMENT NO. ____ Calendar No. ____

Purpose: To modify certain anti-discrimination provisions, and for other purposes.

IN THE SENATE OF THE UNITED STATES—103d Cong., 2d Sess.

S. 1779

To ensure individual and family security through health care coverage for all Americans in a manner that contains the rate of growth in health care costs and promotes responsible health insurance practices, to promote choice in health care, and to ensure and protect the health care of all Americans.

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AMENDMENT intended to be proposed by Mr. THURMOND

Viz:

1 Section 1682(c) add the term "chiropractor," after "pharmacist,".

Proposed Amendments of Senator Gregg to Title I
of the Chairman's Mark of the Health Security Act
(submitted May 17, 1994)

1. Strike Sections 1002 and 1701

2. Strike Section 1003 and replace (1) with:

"Nothing in this Act shall be construed as prohibiting the following:
"(1) An individual from obtaining health care from any health care provider of his or her choice."

3. Add a new subsection (5) to Section 1003, as follows:

"(5) An individual from maintaining his or her existing health insurance policy without any change."

4. Strike Section 1012 (a)

5. Strike Sec. 1222(3)(B)

6. Strike all of Subtitle B-Benefits, Parts 1-4 (Secs. 1101-1141), and replace with Secs.1101-1109 of H.R. 3955

7. In Sec. 1112(c)(2)(A), strike the semicolon and add: "or allied health care professional;"

8. In Sec. 1115(g), strike the period and add "or involves such other counseling or training by other mental health personal as may be appropriate in the treatment regime."

9. At the end of Sec. 1116, add a new subsection (4), as follows:

"Nothing in this Act shall be construed to conflict with any constitutionally permissible regulation of abortion by a State or a subdivision of a State."

10. In Sec. 1132(a)(1), strike "shall have a deductible of $250 per inpatient hospital admission, and"; and in Sec. 1132(a)(2)(A) replace "$2500" with "$1500".

11. In Sec. 1133(7)(A) replace "$2500" with "$1500".

12. In Sec. 1134(b)(1), strike "shall have a deductible of $250 per inpatient hospital admission, and"

13. Strike Sec. 1141(a)(2)

14. Strike Sec. 1154.

34. Strike Secs. 1612(b)(2)(A) & (B), Sec. 1622, and Sec. 1623.

35. Strike Secs. 1641(b)(2)(D),(E), and (F)

36. Strike Sections 1651-52, and replace with:

"HHS shall request that the National Association of Insurance Commissioners or other such appropriate professional organization develop model capital standards for community rated plans and stands for guaranty funds."

37. Strike Sec. 1671(a)

38. Strike Sec. 1914

39. At the end of Section 1001(b), insert the following:

"The Health Security Card shall contain a printed warning that misuse of the card, or other prohibited or fraudulent acts under the Health Security Act, can subject individual American citizens to civil and criminal penalties, including a doubling of their premiums if they fail to enroll in a health plan, as well as fines of up to $10,000 and jail terms of up to 5 years per violation."

40. At the end of Section 1001(b), insert the following:

"The Health Security Card shall display the toll free number established under Section 1208(c)."

41. Strike Section 1911, and replace with:

"Any activity undertaken by the Secretary of Health and Human Services, the Secretary of Labor, or the National Health Board that will legally bind or affect the rights or obligations of any person or entity regulated by the Act (such as, but not limited to, the developing, issuing, promulgating, establishing, specifying, or determining of regulations, rules, guidelines, definitions, standards, requirements or methodologies) as called for under this Act, shall be accomplished through notice and comment rulemaking proceedings, in accordance with the Administrative Procedure Act."

42. Strike Section 1154.

43. At the end of Section 1231, Assuring Family Choice of Health Plans, insert new subsection (c), which states as follows:

"A participating State shall ensure that individuals that are eligible to enroll in large group sponsor health plans

52. Replace Section 1507(f)(2) with:

"Nothing in this Act shall be interpreted to: (1) require or force an individual to receive health care solely through his or her health plan; or (2) prohibit any individual from privately contracting with any provider and paying for the treatment or service on a cash basis or any other basis as agreed to between the individual and provider."

53. Insert a new Subtitle C, Part 7, as follows:

"Part 7 - State Option to Establish Own System

"Notwithstanding any other provision of this Act, a State may elect to establish its own health care system for its citizens. If a State elects to establish its own system: (1) the State shall not be governed by any provision of this Act; (2) the State's citizens shall not be entitled to any of the benefits established by this Act; and (3) none of the fees, assessments, taxes or other charges that otherwise would imposed on the State's citizens and employers by this Act shall be levied or collected."

54. At the end of Section 1503(a), insert the following new sentence:

"However, each health plan shall be allowed to vary its premiums based on behavioral factors that are inherently costly and risky, such as smoking (and other such activities the plan deems appropriate.)"

POSSIBLE SIMON AMENDMENTS

Title I

1. One amendment pertaining to purchasing cooperatives. (Sec. 1004).

2. One amendment pertaining to detainees (Sec. 1502).

3. One amendment pertaining to the National Health Board (Sec. 1603).

4. Two amendments pertaining to state-single payer (Sec. 1615).

5. One amendment pertaining to the OPM Insurance Program (Sec. 1710).

6. Amendment pertaining to citizens who live outside the U.S., receiving coverage.

AMENDMENT NO. ____ Calendar No. ____

Purpose: To permit certain individuals to enroll in health plans offered by religious cooperatives.

IN THE SENATE OF THE UNITED STATES—103d Cong., 2d Sess.

S. 1779

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AMENDMENT intended to be proposed by Mr. SIMON

Viz:

In section 1004(b), insert the following new paragraph after paragraph (3):

(4) MEMBERS OF RELIGIOUS COOPERATIVES.—For those individuals who are eligible to enroll, and who elect to enroll, in a plan offered by a religious cooperative under section 1331, that the plan shall be the applicable health plan.

(3) The entity must—

(A) carry out the tenets and principles of faith of a church, convention, association of churches, or an affiliated group of churches with which it is affiliated,

(B) be operated, supervised, controlled, or principally supported by a church, convention, association of churches, or an affiliated group of churches, and

(C) share common religious bonds and convictions with that church, convention, association of churches, or affiliated group of churches.

(4) The entity must have offered its members health benefits as of September 1, 1993.

(5) As of both September 1, 1993, and January 1, 1996, the entity must provide health benefits to more than 5,000 individuals in the United States.

(6) The entity must bear the risk of insuring its own members and must be subject to regulation by the State insurance commissioner in each State in which it sells coverage.

(7) The entity must offer its members, in addition to health insurance coverage, at least the follow-

(C) Individuals who are described in section 1004(b) (relating to veterans, military personnel, and Indians) and who elect an applicable health plan described in such section.

(d) RESPONSIBILITIES AND AUTHORITIES OF RELIGIOUS COOPERATIVES.—A religious cooperative shall undertake all the duties and retain all the privileges specified in part 2, as determined appropriate by the Secretary.

AMENDMENT NO. ____ Calendar No. ____

Purpose: To clarify reimbursement under health plans with respect to prisoners.

IN THE SENATE OF THE UNITED STATES—103d Cong., 2d Sess.

S. 1779

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AMENDMENT intended to be proposed by Mr. SIMON

Viz:

Strike subsection (i) of section 1502 and insert the following:

(i) RELATION TO PRISONERS.—A health plan is not required to provide any reimbursement to any detention facility for services performed in that facility for prisoners in the facility.

AMENDMENT NO. ____ Calendar No. ____

Purpose: To increase the authority of the National Health Board to administer and enforce the cost containment provisions.

IN THE SENATE OF THE UNITED STATES—103d Cong., 2d Sess.

S. 1779

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AMENDMENT intended to be proposed by Mr. SIMON

Viz:

Subsection (b) of section 1603 is amended to read as follows:

(b) ADMINISTRATION OF COST CONTAINMENT PROVISIONS.—

(1) IN GENERAL.—The Board shall oversee the cost containment requirements of subtitle A of title VI and certify compliance with such requirements.

od to be used by the Board to accomplish such containment in cases of noncompliance.

(ii) CONGRESSIONAL CONSIDERATION.—

(I) IN GENERAL.—Subject to subclause (II), the provisions of 6006(d) shall apply to recommendations under clause (i) in the same manner as such provisions apply to recommendations under section 6006(c)(3).

(II) SPECIAL RULES.—In applying subclause (I) the following shall be substituted for the matter after the resolving clause described in section 6006(d)(2)(B): "That Congress disapproves the recommendations of the National Health Board concerning cost containment in participating States, as submitted by the Board on _____."; and the following shall be substituted for the title described in section 6006(d)(2)(C): "Joint resolution disapproving rec-

AMENDMENT NO. ____ Calendar No. ____

Purpose: To provide financial incentives to a State to develop a single-payer system through per-capita grants.

IN THE SENATE OF THE UNITED STATES—103d Cong., 2d Sess.

S. 1779

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AMENDMENT intended to be proposed by Mr. SIMON

Viz:

Section 1615 is amended by adding at the end the following new subsection:

(c) PER-CAPITA GRANTS.—

(1) IN GENERAL.—The Secretary shall make available a 1-year per-capita grant to each of 2 States selected by the Secretary from applications submitted by States establishing a universal health care system pursuant to part 2 of subtitle C of this title.

AMENDMENT NO. ____ Calendar No. ____

Purpose: To provide financial incentives to a State to develop a single-payer system through grants for start-up support.

IN THE SENATE OF THE UNITED STATES—103d Cong., 2d Sess.

S. 1779

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AMENDMENT intended to be proposed by Mr. SIMON

Viz:

Paragraph (1) of section 1615(b) is amended to read as follows:

(1) IN GENERAL.—The Secretary shall make available to States, upon their enacting enabling legislation to become participating States, grants to assist in the establishment of consumer purchasing cooperatives or State single-payer systems.

AMENDMENT NO. ____ Calendar No. ____

Purpose: To provide participation in OPM insurance program through employee election.

IN THE SENATE OF THE UNITED STATES—103d Cong., 2d Sess.

S. 1779

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AMENDMENT intended to be proposed by Mr. SIMON

Viz:

Section 1710 is amended to read as follows:

SEC. 1710. PARTICIPATION IN OPM INSURANCE PROGRAM.

After the FEHBP termination date referred to in subtitle C of title VIII, an employee who performs services outside the United States for an American employer (as defined in section 3121(h) of the Internal Revenue Code of 1986) that is a community-rated employer, may elect to participate in the health insurance program established

AMENDMENT NO. ____ Calendar No. ____

Purpose: To ensure that coverage provided under the Health Security Act extend to United States citizens that live outside the United States.

IN THE SENATE OF THE UNITED STATES—103d Cong., 2d Sess.

S. 1779

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AMENDMENT intended to be proposed by Mr. SIMON

Viz: [Unless otherwise indicated, section references in this amendment are to the Chairman's mark of the Health Security Act]

Section 1902(a)(2) is amended by striking subparagraph (C).

Subparagraph (D) of section 1902(a)(2) is amended to read as follows:

(C) EXCLUSION OF CERTAIN FOREIGN EMPLOYMENT.—The term "employee" does not in-

At the end of subtitle G of title I, add the following new section:

SEC. 1710. PARTICIPATION IN OPM INSURANCE PROGRAM.

After the FEHBP termination date referred to in subtitle C of title VIII, an American employer (as defined in section 3121(h) of the Internal Revenue Code of 1986) that is a [community-rated] employer, may elect to participate in the health insurance program established by the Office of Personnel Management under such subtitle with respect to the employees of such employer who perform services outside the United States.

At the end of section 6121(c), add the following new paragraph:

(7) CERTAIN EMPLOYEES RESIDING ABROAD.—

(A) IN GENERAL.—The Office of Personnel Management shall determine the appropriate employer and employee premium payment amounts with respect to employees described in subparagraph (B) who elect to participate in the health insurance program established by the Office of Personnel Management under subtitle C of title VIII.

(B) EMPLOYEE.—An employee described in this subparagraph is an employee who is a

[The following page and line numbers refer to S1757]

On page 1246, between lines 6 and 7, insert the following new subsection:

"(d) OTHER EMPLOYEES RESIDING ABROAD.—After the FEHBP termination date, an employee who is a citizen or resident of the United States and who is performing services outside the United States for an American employer (as defined in section 3121(h) of the Internal Revenue Code of 1986) that is a [community-rated] employer, shall be eligible for health insurance under a program which the Office of Personnel Management shall by regulation establish.

AMENDMENT NO. ____ Calendar No. ____

Purpose: To make technical and miscellaneous amendments.

IN THE SENATE OF THE UNITED STATES—103d Cong., 2d Sess.

S.____

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AMENDMENTS intended to be proposed by Mr. WELLSTONE

Viz:

In subsections (e)(2)(B), (f)(2)(B), (g)(2)(B), and (h)(2)(B), of section 1114, strike "females" and insert "females and males".

In section 1231(b)(2)(B), by inserting "primary or" before "non-primary".

In section 1232(d)(2), insert after the first sentence the following new sentence: "Cause shall include the fail-

AMENDMENT NO. ____ Calendar No. ____

Purpose: To make certain revisions with respect to mental health and substance abuse.

IN THE SENATE OF THE UNITED STATES—103d Cong., 2d Sess.

S.____

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AMENDMENTS intended to be proposed by _____

Viz:

In the 10th item in the table in section 1135, insert "(except psychotherapy) after "treatment".

After the 10th item in the table in section 1135, insert the following new item in the appropriate form: "Outpatient psychotherapy, $10 per visit, 50 percent of applicable payment rate".