

*The American Health Security Act, S. 703
Introduced by Senator Sanders (I-VT) on March 25, 2009*

Summary of Provisions

Title I – ESTABLISHMENT OF A STATE-BASED AMERICAN HEALTH SECURITY PROGRAM; UNIVERSAL ENTITLEMENT; ENROLLMENT

Universal Entitlement

States must establish a state health security program to provide health care benefits to individuals on or after January 1, 2011 in order to be eligible to receive payment from the federal government. All individuals who reside in the United States and are citizens, nationals, or lawful resident aliens are entitled to benefits for health care services through the state health security program. The American Health Security Standards Board (“Board”) may make certain classes of aliens eligible for benefits as well.

Enrollment

Each state health security program will provide a mechanism to enroll individuals entitled or eligible for benefits and must make enrollment applications available at a variety of locations accessible to a broad cross-section of individuals eligible to enroll. Health security cards will be used for identification and processing of claims for benefits either through the state health security program or employers.

Portability of Benefits

To ensure continuous access to benefits for health care services, states can not impose a minimum period of residence or waiting periods in excess of three months before residents are eligible for benefits. States must provide continuation of payment for covered health care services to individuals who have terminated residence and established residence in another state for the duration of any waiting period imposed in the state of new residence. States also must provide payment for services to individuals who are temporarily absent from the state and they may form reciprocal arrangements with adjacent states to ensure coverage of enrollees residing in the border region.

Relationship to Existing Federal Health Benefits

Benefits will no longer be available through Medicare, Medicaid, the State Children's Health Insurance Program, the Federal Employees Health Benefits Program, or the Civilian Health and Medical Program of the Uniformed Services after December 31, 2010.

Title II – COMPREHENSIVE BENEFITS, INCLUDING PREVENTIVE BENEFITS AND BENEFITS FOR LONG-TERM CARE

Comprehensive Benefits

Individuals enrolled for benefits under a state health security program are entitled to have payment made for the following items and services if medically necessary or appropriate for the maintenance of health or for the diagnosis, treatment, or rehabilitation of a health condition:

1) hospital services; 2) professional services; 3) community-based primary health services; 4) preventive services; 5) long-term, acute and chronic care services; 6) prescription drugs, biologicals, insulin, medical foods; 7) dental services; 8) mental health and substance abuse treatment services; 9) diagnostic tests; 10) other items including outpatient therapy, durable medical equipment, home dialysis, ambulance, prosthetic devices, and 11) additional items and services as the American Health Security Standards Board may specify.

No person may impose a charge for covered services for which benefits are provided. Each state health security program will prohibit the sale of health insurance if payment under the insurance duplicates payment under the program. However, employers may continue to provide additional supplemental benefits to employees or their dependents, or to former employees or their dependents.

Home and Community-Based Long-Term Care

Limitations are established for aggregate expenditures for home and community-based long-term care services with the intended goal of providing cost-effective services in the most appropriate and least restrictive setting. Special organized system of care service delivery requirements are outlined for mental health and substance abuse treatment services provided to at-risk children.

Limitations and Exclusions

The American Health Security Standards Board is authorized to determine coverage of experimental services, the application of practice guidelines, limitations on eyeglasses, contact lenses, hearing aids and durable medical equipment, and the exclusion from covered services of cosmetic procedures and personal comfort items.

Certification

State health security programs are authorized to require periodic professional certifications as a condition of payment and to require that payment for certain services be tied to a plan of care or treatment.

Title III – PROVIDER PARTICIPATION

Provider Participation Standards

Provider participation agreements, at a minimum, must include a prohibition of discrimination based on race, national origin, income, religion, age, sex or sexual orientation, disability, handicapping condition or illness (subject to the provider's skills and scope of practice).

Qualifications for Providers and for Comprehensive Health Service Organizations

Institutional and individual providers, including Comprehensive Health Service Organizations, will be subject to national minimum standards established by the Board. These standards will include performance standards, minimum training requirements, continuity of care, patient satisfaction with waiting time and access, and adequacy of facilities. The American Health Security Standards Board also will be required to, at least annually, exchange information regarding cost containment and quality assurance. The Comprehensive Health Service Organizations, which will get a capitation payment in exchange for furnishing or arranging a full range of health services and urgent care, also will be subject to a minimum set of standards or

requirements, including such things as consumer representation on Boards of Directors and incorporation of the physician self-referral (“Stark law” limitations).

Title IV – ADMINISTRATION

Subtitle A – General Administrative Provisions

American Health Security Standards Board

The American Health Security Standards Board, composed of the Secretary of Health and Human Services (Secretary) and six individuals appointed by the President by January 1, 2010, will develop federal policies, procedures, guidelines, and requirements for state security health programs. These requirements shall address eligibility, enrollment, benefits, provider participation standards, national and state funding levels, methods for determining payment amounts, the determination of medical necessity, assisting state health security programs with planning for capital expenditures and service delivery, planning for health professional education funding, allocating funds, and encouraging states to develop regional planning mechanisms. The Board will establish uniform reporting requirements and standards to ensure an adequate national database regarding health services practitioners, services and finances of state health security programs, approved plans, providers, and the costs of facilities and practitioners providing services. Standards must include, to the extent feasible, health outcome measures. Beginning January 1 of the second year, the Board will submit an annual report to Congress.

American Health Security Advisory Council

The Board must create an American Health Security Advisory Council (“Council”) to advise the Board on its activities and include the Chair of the Board and twenty appointed members who are representative of state health security programs, public health professionals, providers of health services, and consumer representatives. Specifically, the Council will advise the Board on matters of general policy, the formulation of regulations, and the performance of the Board’s duties and will submit an annual report and recommendations to the Board on the performance of its functions. The Board is required to submit the Council’s report to Congress along with its own report addressing any recommendations of the Council that have not been followed. The Board also must consult with a variety of stakeholders in the formulation of guidelines, regulations, policy initiatives, and information gathering to assure the broadest and most informed input.

State Health Security Programs

Each state will submit to the Board a plan for a state health security program. States may join together to form regional health security programs. The Board will review these plans and determine whether they meet certain requirements for approval. Requirements include:

- 1) payment for required health services for eligible individuals;
- 2) adequate administration;
- 3) establishment of a state health security budget;
- 4) establishment of payment methodologies;
- 5) assurances that individuals have the freedom to choose practitioners;
- 6) a procedure for carrying out long-term regional management and planning functions to ensure participation of consumers and prioritization of the most acute shortages of health personnel;
- 7) the licensure and regulation of all health providers and facilities, establishment of a quality review system, establishment of an independent ombudsman for consumers to register complaints;

8) publication of an annual report on the state health security program; 9) provision of a fraud and abuse prevention and control unit; and 10) payment prohibition for physician self-referrals.

States must form state Health Security Advisory Councils composed of at least 11 individuals who represent the state health security program, public health professionals, providers of health services, and consumer representatives. The state Council must review and submit comments to the Governor concerning the implementation of the state health security program and the state will provide assistance and technical support.

Subtitle B – Control Over Fraud and Abuse

State Health Care Fraud and Abuse Control Units

Each state must establish and maintain a health care fraud and abuse control unit that meets certain requirements and conducts investigations, reviews complaints and collects overpayments. The unit must employ auditors, attorneys, investigators, and other personnel and provide resources to promote the effective and efficient conduct of its activities. Federal sanctions under the Social Security Act, including civil monetary penalties and criminal penalties, apply to cases of fraud and abuse within state health security programs.

Title V – QUALITY ASSESSMENT

American Health Security Quality Council

The American Health Security Quality Council (“Quality Council”) will be established no later than January 1, 2010 and be composed of 10 members appointed by the President, one of which will serve as Chair. Council members must be health professionals and serve a term of five years, with a few exceptions.

Methodologies, Guidelines, and Standards

The Quality Council will review and evaluate each practice guideline established by the Agency for Healthcare Research and Quality and determine whether each guideline should be recognized for purposes of determining payments under a state health security program. Services provided in accordance with national practice guidelines will be deemed appropriate and will be covered (as medically necessary and appropriate services) under a state’s health security program. The Quality Council also will be responsible for the review and evaluation of each standard of quality, performance measure, and medical review criterion (developed by the Agency for Healthcare Research and Quality) and determining whether they are appropriate for assessing or reviewing the quality of services provided by state health security programs, health care institutions, or health care providers. The Quality Council will develop minimum competence criteria to qualify entities to conduct ongoing and continuous external quality review for state quality review programs which shall be reported and coordinated to ensure national consistency in quality standards. The Quality Council also must report annually to the American Health Security Standards Board on its activities and findings from outcomes research and development of practice guidelines that may affect the Board’s determination of coverage of services.

The Quality Council must adopt methodologies for profiling the patterns of practice of health care professionals and for identifying outliers which suggest deficiencies in the quality of health care services being provided. It will develop guidelines for certain medical procedures

designated by the American Health Security Standards Board to be performed only at tertiary care centers, or Centers of Excellence, consistent with a high probability of the desired patient outcome. Reimbursement for designated procedures may only be provided if performed at a center that meets such standards. The Quality Council will develop standards for education and sanctions for outliers to assure the quality of health care services. It also must develop criteria for referral of providers to the state licensing board if education proves ineffective in correcting provider practice behavior. Methodologies must be disseminated to the state for profiling patterns of practice and identifying outliers, for identifying Centers of Excellence and denying reimbursement for procedures not performed at a center that meets standards, and for education and sanctioning poor performers.

State Quality Review Programs

In order to meet the requirement that states establish a quality review systems as a condition of approval for the state's health security program plan, each state quality review program must establish one or more qualified entities to conduct quality reviews of persons providing covered services under the program. A state may apply standards other than the federal standards established by the American Health Security Quality Council so long as the state demonstrates to the satisfaction of the Council (on an annual basis) that the standards applied have been as efficacious in promoting and achieving improved quality of care as the application of the federal standards.

Elimination of Utilization Review Programs; Transition

The state program of quality review established supersedes existing federal requirements for utilization review programs, including requirements for random case-by-case reviews and programs requiring pre-certification of medical procedures on a case-by-case basis. Before January 1, 2013, the American Health Security Standards Board and states may use existing utilization review standards and mechanisms as necessary to transition to pattern of practice-based reviews.

Title VI – HEALTH SECURITY BUDGET; PAYMENTS; COST CONTAINMENT MEASURES

Subtitle A – Budgeting and Payments to States

National Health Security Budget

The American Health Security Standards Board, by September 1 before the beginning of each year, must establish a national health security budget that specifies the total expenditures by the state and federal government for covered health care services. The budget must be divided into four components, including: quality assessment activities; health professional education expenditures; administrative costs; and operating and other expenditures.

Computation of Individual and State Capitation Amounts

A method for computing the capitation amount for each eligible individual residing in the state and for the state capitation amount must be developed, including appropriate adjustments factors for risk group classifications. State adjustment factors to adjust differences between the state and the national level in social, labor, environmental, or geography also must be developed. Such adjustment factors must be applied in a manner that is budget neutral.

State Health Security Budgets

Each state health security program must establish a proposed and final state health security budget within specified timeframes. Limits are placed on the total expenditures specified in each state health security budget.

Federal Payments to States

Each state with an approved state health security program is entitled to a monthly state capitation amount and federal contribution percentage. Payments made may only be used to carry out the state health security program.

Account for Health Professional Education Expenditures

Each state health security program must include a separate account for health professional education expenditures. The distribution of such funds must be consistent with national and program goals and also take into account the potentially higher costs of placing health professional students in clinical education programs that reside in health professional shortage areas.

Subtitle B – Payments by States to Providers

Payments

State health security programs shall make payments for operating expenses directly to institutions or facilities for institutional and facility-based care under an annual global budget. The state shall develop standards for creation of annual prospective global budget for an institution or facility through a negotiated process between relevant interests groups and the institution or facility. The providers of health care services covered by the payment guidelines for global budgets include: institutional and facility-based care; community-based primary health services; comprehensive health service organizations. Payments for prescription drugs and approved devices and equipment also will be covered under the global budget. State health security programs shall make payments to independent health care practitioners based on a fee for each billable covered service.

The American Health Security Standards Board also may establish special payment rules or provide adjustments in capitation amounts to promote the provision of services in medically underserved areas. The Board also shall encourage state health security programs to implement alternative payment methodologies that incorporate global fees for related services or for a basic group of services to improve health care quality and efficiency.

Subtitle C – Mandatory Assignment and Administrative Provisions

Mandatory Assignment and Administrative Provisions

Payments for benefits by the state health security programs will constitute payment in full for those benefits. Sanctions may be imposed by the state and the American Health Security Standards Board on entities that bill or accept additional payment for those benefits in violation of the mandatory assignment and no balance billing requirements. Procedures are established for timely payment of provider claims and an appeals process for handling grievances pertaining to provider payments.

**Title VII – PROMOTION OF PRIMARY HEALTH CARE; DEVELOPMENT OF
HEALTH SERVICE CAPACITY; PROGRAMS TO ASSIST THE MEDICALLY
UNDERSERVED**

Subtitle A – Promotion and Expansion of Primary Care Professional Training

Role of Board

The American Health Security Standards Board shall be responsible for expanding the number of primary care practitioners in the United States by coordinating health professional education policies in order to achieve specific national goals.

Primary Care Professional Output Goals

The national goals for building primary care capacity are: 1) regarding graduate medical education, within five years of enactment of this Act, at least 50 percent of the residents in medical residency education programs are primary care residents; 2) to assure an adequate supply of mid-level primary care practitioners, the Board shall specify a number of mid-level primary care practitioners employed in the health care system as of January 1, 2013; and 3) to assure an adequate supply dental care practitioners, the Board shall specify a number of dentists employed in the health care system as of January 1, 2013. The Board must create a method of applying the national goals to program goals for each medical residency education program or to medical residency education consortia. To enforce compliance, the Board must develop a formula for reducing payments to state health security programs that fail to meet the goals established for each individual educational program.

For increasing the number mid-level primary care practitioners, the Board must: 1) advise the Public Health Service on allocations of funding under titles VII and VIII of the Public Health Service Act (the federal health professions education programs), the National Health Service Corps, and other programs in order to increase the supply of midlevel primary care practitioners; and 2) commission a study of the potential benefits and disadvantages of expanding the scope of practice authorized under state laws for any class of mid-level primary care practitioners.

Advisory Committee on Health Professional Education

To advise the Board on carrying out of its duties, the Board shall establish an Advisory Committee on Health Professional Education concerning graduate medical education policies, primary care disciplines, and health care policy. The Advisory Committee members will serve five year terms and include individuals who are representative of medical schools, other health professional schools, residency programs, primary care practitioners, teaching hospitals, professional associations, public health organizations, state health security programs, and consumers.

Grants for Health Professions Education

The Board is authorized to make transfers from the American Health Security Trust Fund to the Public Health Service to support the National Health Service Corps, health professions education and nursing education, including education of clinical nurse practitioners, certified registered nurse anesthetists, certified nurse midwives, and physician assistants. The Board is required to make specific monetary transfers increasing in value annually from \$320,461,632.00 in 2010 to

\$1,154,510,336.00 in 2015 and then set by formula for 2016 and beyond from the Trust Fund to the National Health Service Corps.

Subtitle B – Direct Health Care Delivery

Set-Aside for Public Health

The Board will make transfers from the American Health Security Trust to the Public Health Service for the following purposes: 1) payments to states under the maternal and child health block grants under Title V of the Social Security Act; 2) prevention and treatment of tuberculosis under Section 317 of the Public Health Service Act; 3) prevention and treatment of sexually transmitted diseases under Section 318 of the Public Health Service Act; 4) preventive health block grants under Part A of title XIX of the Public Health Service Act; 5) grants to states for community mental health services under Subpart I of Part B of Title XIX of the Public Health Service Act; 6) grants to states for prevention and treatment of substance abuse under Subpart II of Part B of Title XIX of the Public Health Service Act; 7) Grants for HIV health care services under Parts A, B, and C of Title XXVI of the Public Health Service Act; and 8) public health formula grants for carrying out core public health functions to monitor and protect the health of communities from communicable diseases and exposure to toxic environmental pollutants, occupational hazards, harmful products, and poor health outcomes. Core public functions include data collection, analysis, and assessment of public health data, vital statistics, and personal health data to assess community health status and outcomes reporting. Each state receiving funds for these purposes must submit annual reports to the Secretary on the health status of the population and on several measurable objectives for improving the health of the public in the state.

The Board also shall transfer funds from the American Health Security Trust for community health centers authorized under Section 330 of the Public Health Service Act. This funding is to be used to build up capacity for the provision of primary health care services in community health centers. The Board is required to make specific monetary transfers increasing in value annually from \$2,988,821,592.00 in 2010 to \$8,332,924,155.00 in 2015 and the set by formula for 2016 and beyond from the Trust Fund to the Public Health Service.

The Board is also authorized to make grants for public and nonprofit entities to plan and develop primary care centers which will serve medically underserved populations with funds from the American Health Security Trust.

Subtitle C – Primary Care and Outcomes Research

Primary Care and Outcomes Research

To support primary care and outcomes research, the Office of Primary Care and Prevention Research (Office) is established in the Office of the Director of National Institutes of Health (“NIH”). The Office will identify promising research projects on primary care and prevention focusing on children and adults, encourage the coordination and collaboration among research entities, recommend a research agenda, promote allocation of sufficient resources to conduct the research, and prepare appropriate reports describing and evaluating activities undertaken and expenditures made. The research will be funded by the American Health Security Trust Fund. Appropriate funds will be transferred to the Agency for Health Care Policy and Research and

have been authorized for fiscal years 2010, 2011 and 2012. Thereafter, the Office Director will ensure that the NIH allocates sufficient funds for Office projects.

Primary care and prevention research is defined as “research on improvement of the practice of family medicine, general internal medicine, and general pediatrics.” The term also includes “research relating to obstetrics and gynecology, dentistry, or mental health or substance abuse treatment when provided by a primary care physician or other primary care practitioner, and primary care provided by multidisciplinary teams.” Particular emphasis will be placed on the following areas: clinical patient care with special focus on pediatric clinical care and diagnosis; diagnostic effectiveness; primary care education; health and family planning services; medical effectiveness outcomes of primary care procedures and interventions; and the use of multidisciplinary teams of health care practitioners. A data system will be established for the collection, storage, analysis, retrieval and dissemination of information related to the research that is conducted or supported under the Office. To disseminate the information captured through the data system, a program will be established to encourage the use of information on activities related to primary care and prevention research.

Subtitle D – School-Related Health Services

School-Related Health Services

The Secretary is authorized to make grants to state health agencies or to local community partnerships to develop and operate school health service sites. Funds have been appropriated for 2012 through 2016 and may be used for the following: 1) planning for the provision of school health services; 2) recruitment, compensation and training of health and administrative staff; 3) development and acquisition of equipment and information services necessary to support the exchange of information between health service sites and health plans, health providers and other entities authorized to collect relevant information; and 4) other activities necessary to administer school health services. A local community partnership is “a local health care provider with experience in delivering services to school-aged children; or one or more local public schools; and at least one community based organization located in the community to be served that has a history of providing services to school-aged children in the community who are at-risk.” The term “school-aged children” refers to individuals who are between the ages of 4 and 19. Partnerships should seek the participation of parents, adolescent children, health and social service providers, teachers and other school personnel, development and service organizations for adolescent children, and interested business leaders.

Grants for School-Related Health Services

Grants for school-related health services shall be for a period determined by the Secretary. Entities eligible to receive grants include state health agencies that apply on behalf of local community partnerships and other communities in need of health services for school-age children and local community partnerships in states in which health agencies have not applied. Preference will be given to communities that show the most substantial level of need for such services among school-age children, as measured by indicators of community health including: high levels of poverty; presence of a medically underserved population; presence of a health professional shortage area; high rates of health risk indicators among school-aged children; and linkage to community health centers.

Grants may be used to support the cost of furnishing health services that are not otherwise covered under any public or private insurer including: the cost of furnishing services that will increase the capacity of individuals to use available health services; training, recruitment and compensation of health professionals and other staff; outreach services to school-age children who are at risk and to their parents; linkage of individuals to health plans; community health services and social services; and other activities deemed necessary by the Secretary.

Title VIII: FINANCING PROVISIONS; AMERICAN HEALTH SECURITY TRUST FUND

Subtitle A – American Health Security Trust Fund

American Health Security Trust Fund

Establishes the American Health Security Trust Fund which, beginning fiscal year 2011, will be appropriated with funds each year that would otherwise have been appropriated to carry out the following programs: Medicare parts A, B, and D (other than amounts attributable to any premiums); Medicaid; Federal Employee Health Benefit Plan (FEHBP); TRICARE; the maternal and child health program under Title V of the Social Security Act, vocational rehabilitation programs, programs for drug abuse and mental health services under the Public Health Service Act, programs providing general hospital or medical assistance, and other federal programs identified by the Board overseeing the Trust Fund.

Subtitle B – Taxes Based on Income and Wages

Taxes Based on Income and Wages

An excise tax is imposed on employers, self-employed, and individual taxpayers as follows: 1) for employers, an excise tax equal to 8.7 percent of the wages paid; 2) for self-employed individuals, a tax equal to 8.7 percent of the amount of the self-employment income; 3) for individual taxpayers, an income tax equal to 2.2 percent of taxable income.

Title IX – CONFORMING AMENDMENTS TO THE EMPLOYEE RETIREMENT INCOME SECURITY ACT OF 1974

The Employee Retirement Income Security Act (“ERISA”) of 1974 (29 U.S.C. 1003) is amended to provide that ERISA will not apply to any arrangement forming a part of a state health security program. Furthermore, no employee benefit plan can provide benefits which duplicate payment for services for which payment may be made under a state health security program. Finally, a workers compensation carrier that is liable for payment in a state must reimburse the state health security program for the cost of those services. Changes to the Employee Retirement Income Security Act of 1974 will take effect January 1, 2012.

Title X – ADDITIONAL CONFORMING AMENDMENTS

Title X includes a series of conforming amendments repealing provisions of the Health Insurance Portability and Accountability Act of 1996, the Employee Retirement Income Security Act of 1974, and the Public Health Service Act related to group health plan requirements.