

103<sup>D</sup> CONGRESS  
1<sup>ST</sup> SESSION

# S. 1057

To provide for the establishment of a nationwide, universal access health coverage program, and for other purposes.

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IN THE SENATE OF THE UNITED STATES

MAY 27 (legislative day, APRIL 19), 1993

Mr. JEFFORDS introduced the following bill; which was read twice and referred to the Committee on Finance

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## A BILL

To provide for the establishment of a nationwide, universal access health coverage program, and for other purposes.

1        *Be it enacted by the Senate and House of Representa-*  
2        *tives of the United States of America in Congress assembled,*

3        **SECTION 1. SHORT TITLE.**

4        This Act may be cited as the “MediCORE Health Act  
5        of 1993”.

6        **SEC. 2. TABLE OF CONTENTS.**

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1 **SEC. 3. FINDINGS.**

2 Congress finds the following:

3 (1) The rate of growth in health care costs in  
 4 the United States in both the public and private sec-  
 5 tors is excessive and destructive, and more specifi-  
 6 cally—

7 (A)(i) between 1980 and 1992, health care  
 8 spending in the United States increased from 9  
 9 percent of the Gross Domestic Product to 14  
 10 percent and in 1993 it is expected to rise to 15  
 11 percent, a higher percentage of Gross Domestic  
 12 Product than that of any other industrialized  
 13 nation; and

14 (ii) by the year 2000 health care spending  
 15 in the United States will exceed 18 percent of  
 16 the Gross Domestic Product if left at current  
 17 spending levels;

18 (B) expenditures for health care in the  
 19 United States will total approximately

1 \$885,000,000,000 in 1993, a rise of 13 percent  
2 since 1992, while Gross Domestic Product rose  
3 at only a 4.6-percent rate over the same period;

4 (C)(i) health care costs for an average  
5 family in the United States grew by 147 per-  
6 cent while average family income rose by 88  
7 percent during the 1980s;

8 (ii) average family cost for health care was  
9 \$1,742 in 1980 and has grown to \$4,887 in  
10 1992; and

11 (iii) 50 percent of all personal bankruptcies  
12 are caused by unmanageable health care costs;

13 (D) the average cost of private employer  
14 health plans rose approximately 119 percent be-  
15 tween 1984 and 1991, badly eroding company  
16 profits and international competitiveness;

17 (E)(i) the cost of Medicare grew from  
18 \$34,000,000,000 in 1980 to \$104,000,000,000  
19 in fiscal year 1990; and

20 (ii) 27 percent of Medicare costs are paid  
21 for from general funds from the Treasury and  
22 not from specifically dedicated taxes;

23 (F)(i) the cost of Medicaid is expected to  
24 increase 38 percent between 1991 and 1993  
25 and Medicaid has grown from 10.2 percent of

1 State health budgets in 1987 to approximately  
2 46 percent in 1992;

3 (ii) all Federal expenditures for Medicaid  
4 are financed from general funds from the  
5 Treasury; and

6 (iii) by the year 2000 under current spend-  
7 ing levels, State Medicaid will have grown to 56  
8 percent of State health care budgets;

9 (G) the cost of medical care in general in  
10 the United States continues to rise at approxi-  
11 mately three times the rate of the Consumer  
12 Price Index;

13 (H) these disproportionate rises in health  
14 care costs are inflicting undue burdens on the  
15 United States economy, business and citizens in  
16 recessionary and deficit ridden times;

17 (I) the Congressional Budget Office esti-  
18 mates that unless costs are stabilized, medical  
19 care cost increases in Federal programs above  
20 increases in Federal revenues, will by them-  
21 selves increase the Federal debt by over  
22 \$1,500,000,000,000 by the middle of the next  
23 decade, and will result in an increase in annual  
24 Federal medical care costs over baseline by  
25 \$190,000,000,000 at the end of a decade; and

1 (J) unless Federal health care cost in-  
2 creases are halted it will take Draconian meas-  
3 ures to bring the Federal deficit under control.

4 (2) Structural defects in the organization of the  
5 health care system in the United States are leading  
6 to excessive costs, to unequal and limited access, and  
7 to fragmentation, complexity, and confusion in the  
8 delivery of health care because—

9 (A) an anachronism in tax policy carried  
10 forward from World War II has led to great in-  
11 equities in health care between those employed  
12 in firms paying for health care of employees,  
13 and those working for companies without such  
14 coverage and all others paying for health care  
15 coverage;

16 (B) the employer-based system, due to in-  
17 herent limitations, has been ineffective in pro-  
18 viding affordable health care to large segments  
19 of the population including the poor and elderly;

20 (C) the costs of “uncompensated care” are  
21 shifted in concealed and indirect ways to pro-  
22 viders, employers and the insured, and ulti-  
23 mately to governments and taxpayers;

24 (D) the widespread coverage gaps caused  
25 by the employer-based health care system have

1           been inadequately compensated for by public  
2           programs, in terms of the number of people  
3           covered, the scope of services provided, and the  
4           efficiency of providing services;

5           (E) private and public insurance alike have  
6           adopted reimbursement policies which encour-  
7           age providers to maximize income with unneces-  
8           sary services and consumers to overutilize;

9           (F)(i) attempts to reduce costs of overbur-  
10          dened and under funded public programs have  
11          caused increasing cost shifting back to employ-  
12          ers, further diminishing the ability of employers  
13          to provide adequate health insurance and to be  
14          competitive internationally;

15          (ii) for these reasons and others retiree  
16          health benefits are being curtailed dramatically;  
17          and

18          (iii) such shifts are also limiting the avail-  
19          ability and affordability of adequate coverage to  
20          others;

21          (G) piecemeal attempts to control cost es-  
22          calation in both the private and public sectors,  
23          including the use of managed care and other al-  
24          ternative delivery systems, by themselves are

1 not succeeding in significantly controlling cost  
2 or cost shifting;

3 (H) cost escalation has left gaps in cov-  
4 erage, especially with respect to preventive, pri-  
5 mary and long-term care, and protection  
6 against catastrophic costs;

7 (I)(i) increasing costs and cost shifts have  
8 resulted in insurers reducing cost by reducing  
9 risks with the result that more and more indi-  
10 viduals are left uncovered;

11 (ii) this has substantially reduced the ef-  
12 fectiveness of private health insurance as a ade-  
13 quate answer to health care problems because—

14 (I) insurance companies use defensive  
15 practices such as pre-existing conditions  
16 exclusions and “cherry-picking” which re-  
17 duce access rather than promote cost effi-  
18 cient competition on the basis of price and  
19 product design;

20 (II) short-term “experience ratings”  
21 are depriving Americans of consistent pro-  
22 tection against catastrophic health care  
23 occurrences; and

24 (III) employer-group organized health  
25 care has spawned excessive numbers of

1 commercial insurers causing undue adver-  
2 tising costs, administrative expense and  
3 confusion, and redtape for employers, pro-  
4 viders and consumers;

5 (J) tax induced employer-based health care  
6 has diminished the market role of both employ-  
7 ers and employees in making prudent and  
8 thrifty choices for efficient and cost conscious  
9 health care coverage; and

10 (K) the administrative difficulties, payment  
11 inequities, regional differences in cost of serv-  
12 ices, and the cost containment problems of  
13 Medicare exemplify the difficulties of a federally  
14 run program.

15 (3) Other factors, as well, demonstrate the need  
16 for comprehensive reform in the nations health care  
17 systems. These include:

18 (A) Current health care spending with  
19 proper cost sharing and resource allocation is  
20 sufficient to cover presently uncovered benefits,  
21 such as preventative health, long-term health  
22 care, pharmaceutical costs, and catastrophic  
23 protection.

24 (B) The reduction of present administra-  
25 tive inefficiencies, defensive medical costs, and

1 increased use of outcome research will accom-  
2 modate improved coverage and care.

3 (C) State run programs, with single or ad-  
4 ministrative agencies, but federally structured  
5 and coordinated will result in a less costly, more  
6 efficient and diversified system.

7 (D) Present tax inequities can only be cor-  
8 rected at the Federal level, and only Federal  
9 funds can provide sufficient funding for com-  
10 prehensive change.

11 (E) A coordinated global cost containment  
12 structure can only be provided by the Federal  
13 Government.

14 (F) States are best placed to create effi-  
15 cient competition among health care providers  
16 for administrative and service cost reductions.

17 **SEC. 4. DEFINITIONS.**

18 As used in this Act:

19 (1) BOARD.—The term “Board” means the  
20 Federal MediCORE Board established under section  
21 201.

22 (2) CORE SERVICES.—The term “CORE  
23 SERVICES” means those health care services speci-  
24 fied in section 301.

1           (3) SECRETARY.—The term “Secretary” means  
2 the Secretary of Health and Human Services.

3           (4) STATE.—

4           (A) IN GENERAL.—The term “State” in-  
5 cludes the District of Columbia, the Common-  
6 wealth of Puerto Rico, the United States Virgin  
7 Islands, Guam, American Samoa, and the Com-  
8 monwealth of the Northern Mariana Islands.

9           (B) REGION.—A reference to a State  
10 under this Act shall be considered to include a  
11 region implementing a regional program under  
12 the authority of this Act.

13          (5) STATE PLAN.—The term “State plan”  
14 means a health delivery plan approved under a State  
15 program.

16          (6) STATE PROGRAM.—

17          (A) IN GENERAL.—The term “State pro-  
18 gram” means a State health care program ap-  
19 proved under section 501.

20          (B) REGIONAL PROGRAM.—A reference to  
21 a State program under this Act shall be consid-  
22 ered to include a regional program implemented  
23 under the authority of this Act.

1           **TITLE I—ELIGIBILITY AND**  
2                           **ENROLLMENT**

3   **SEC. 101. ELIGIBILITY.**

4           (a) **IN GENERAL.**—Except as otherwise provided in  
5 this section, each individual who is a legal resident of the  
6 United States, including lawful resident aliens, is eligible  
7 for **CORE SERVICES** under the State program in the  
8 State in which the individual maintains a primary resi-  
9 dence.

10          (b) **LAWFUL RESIDENT ALIEN DEFINED.**—For pur-  
11 poses of this section, the term “lawful resident alien”  
12 means an alien lawfully admitted for permanent residence  
13 or for educational purposes and any other alien lawfully  
14 residing permanently in the United States under color of  
15 law, including an alien with lawful temporary resident sta-  
16 tus under section 210, 210A, or 245A of the Immigration  
17 and Nationality Act (8 U.S.C. 1160, 1161, or 1255a).

18          (c) **OVERSEAS RESIDENTS AND TRAVELERS.**—

19               (1) **OVERSEAS RESIDENTS.**—As used in sub-  
20 section (a), the term “legal resident of the United  
21 States” does not include a United States citizen or  
22 lawful resident alien who has established a primary  
23 residence outside of the United States.

24               (2) **TRAVELERS.**—An individual described in  
25 subsection (a) who is traveling at the time at which

1 CORE SERVICES are provided to such individual  
2 shall be covered under the State program in the  
3 State in which the individual maintains a primary  
4 residence.

5 (d) NON-RESIDENT ALIENS AND ILLEGAL IMMI-  
6 GRANTS.—The Board shall develop and implement special  
7 procedures with respect to the eligibility of non-resident  
8 aliens and illegal immigrants for CORE SERVICES  
9 under a State program. In developing such procedures, the  
10 Board shall ensure that those States with the highest inci-  
11 dence of illegal immigrants receive some type of additional  
12 payment under this Act for the provision of CORE SERV-  
13 ICES to such aliens and immigrants.

14 (e) PRIMARY RESIDENCE.—As used in this title, the  
15 term “primary residence” means that State in which the  
16 individual resides for the greatest period of time (not nec-  
17 essarily a consecutive period of time) during the calendar  
18 year. With respect to individuals who are unemancipated  
19 students, the primary residence of such individuals shall  
20 be the primary residence of their parents or legal guard-  
21 ians. With respect to a homeless individual, the State of  
22 primary residence shall be the State in which such individ-  
23 ual applies for CORE benefits.

24 **SEC. 102. ENROLLMENT IN STATE PROGRAMS.**

25 (a) ENROLLMENT PROCESS.—

1           (1) AUTOMATIC ENROLLMENT.—Each State  
2 program shall provide for the automatic enrollment  
3 of an individual described in section 101 who is born  
4 after the effective date described in section 801, on  
5 the date on which such individual is born.

6           (2) ENROLLMENT PROCESS FOR OTHER INDI-  
7 VIDUALS.—With respect to individuals described in  
8 section 101 who are not automatically enrolled  
9 under paragraph (1), each State program shall de-  
10 velop and utilize an understandable and readily  
11 available process for the enrollment of such individ-  
12 uals in the State program.

13           (3) DEFAULT ENROLLMENT.—In the case of an  
14 individual described in section 101 who otherwise is  
15 not enrolled in a State program, such individual  
16 shall be covered by the State program in the State  
17 in which such individual maintains a primary resi-  
18 dence. The State shall provide a process for enroll-  
19 ment of the individual at the time and place in  
20 which the individual first is provided (after the effec-  
21 tive date described in section 801) CORE SERV-  
22 ICES under a State program.

23           (b) MEDICORE CARDS.—Upon enrollment in a State  
24 program, an individual shall be issued a MediCORE card  
25 that shall—

1 (1) indicate the State program in which the in-  
2 dividual is enrolled;

3 (2) contain a brief description of any cost-shar-  
4 ing, benefit or delivery features of the program in  
5 which such individual is enrolled;

6 (3) where feasible, and if privacy interests can  
7 be maintained, contain the health record of the indi-  
8 vidual; and

9 (4) indicate any other information determined  
10 appropriate by the Board.

## 11 **TITLE II—ADMINISTRATION BY** 12 **FEDERAL MEDICORE BOARD**

### 13 **SEC. 201. ESTABLISHMENT AND COMPOSITION.**

14 (a) ESTABLISHMENT.—There is established within  
15 the Department of Health and Human Services a Federal  
16 MediCORE Board.

17 (b) COMPOSITION.—

18 (1) APPOINTMENT.—The Board shall be com-  
19 posed of nine members to be appointed by the Presi-  
20 dent not later than 60 days after the date of enact-  
21 ment of this Act, by and with the advice and consent  
22 of the Senate, from among individuals who will, as  
23 a whole, represent the interests of the following—

24 (A) Federal and State governments;

25 (B) employers;

1 (C) employees and labor unions;

2 (D) health care providers;

3 (E) consumers;

4 (F) academic and industry experts in  
5 health care delivery; and

6 (G) cost containment and quality improve-  
7 ment experts.

8 (2) TERMS.—Individuals appointed to the  
9 Board under paragraph (1) shall serve for a term of  
10 5 years, except that the terms of individuals initially  
11 appointed shall be as follows—

12 (A) three of such individuals shall be ap-  
13 pointed for a term of 2 years;

14 (B) three of such individuals shall be ap-  
15 pointed for a term of 3 years; and

16 (C) three of such individuals shall be ap-  
17 pointed for a term of 4 years.

18 (3) VACANCIES.—The President shall fill any  
19 vacancy in the membership of the Board in the same  
20 manner as the original appointment and such mem-  
21 bers shall serve for the remainder of the term for  
22 which the predecessor of the member was appointed.  
23 The vacancy shall not affect the power of the re-  
24 maining members to execute the duties of the  
25 Board.

1 (4) CHAIRPERSON.—

2 (A) INITIAL CHAIRPERSON.—The initial  
3 chairperson of the Board shall be selected by  
4 the President and serve for a term of 3 years.

5 (B) SUBSEQUENT CHAIRPERSONS.—Ex-  
6 cept as provided in subparagraph (A), the mem-  
7 bers of the Board shall select a chairperson of  
8 the Board from among such members and such  
9 chairperson shall serve for a term of 3 years.

10 (5) COMPENSATION.—Members of the Board  
11 shall be compensated at a level comparable to level  
12 II of the Executive Schedule, in accordance with sec-  
13 tion 5313 of title 5, United States Code. Amounts  
14 for such compensation shall be derived from the  
15 MediCORE Trust Fund.

16 (c) STAFF.—

17 (1) AUTHORITY.—The Board shall employ such  
18 staff as the Board may determine necessary and  
19 such staff shall be compensated in accordance with  
20 paragraph (2).

21 (2) APPLICABILITY OF CIVIL SERVICE PROVI-  
22 SIONS.—The staff of the Board may be appointed  
23 without regard to the provisions of title 5, United  
24 States Code, governing appointments in the competi-  
25 tive service and be compensated without regard to

1 the provisions of chapter 51, and subchapter III of  
2 chapter 53 of title 5 relating to classification and  
3 General Schedule pay rates, except that no individ-  
4 ual may receive pay more than the rate of basic pay  
5 payable for level IV of the Executive Schedule.  
6 Amounts for such compensation shall be derived  
7 from the MediCORE Trust Fund.

8 **SEC. 202. DUTIES OF MEDICORE BOARD.**

9 (a) GENERAL ADMINISTRATION.—The Board shall be  
10 responsible for the overall administration of this Act and  
11 for the oversight of State compliance with this Act, as well  
12 as the development of CORE SERVICES and of specific  
13 guidelines to permit States to carry out this Act.

14 (b) CORE SERVICES.—The Board shall, in accord-  
15 ance with title III, determine a basic, comprehensive pack-  
16 age of health care services (referred to in this Act as  
17 “CORE SERVICES”) that shall be provided under this  
18 Act.

19 (c) FEDERAL MEDICORE GUIDELINES.—The Board  
20 shall, in accordance with title IV, develop and implement  
21 Federal guidelines for the equitable and efficient delivery  
22 of CORE SERVICES through State programs operating  
23 under this Act.

24 (d) APPROVAL AND OVERSIGHT OF STATE PRO-  
25 GRAMS.—Not later than 16 months after the date of en-

1 actment of this Act, the Board shall, in accordance with  
2 title V, develop and administer procedures for the approval  
3 of State programs under this Act and for the monitoring  
4 of State compliance with the requirements of this Act.  
5 Such procedures shall be published in the Federal Register  
6 and made available to States.

7 (e) MODEL MEDICORE ADMINISTRATION MAN-  
8 UAL.—

9 (1) IN GENERAL.—The Board shall develop,  
10 publish and make available to each State a Model  
11 MediCORE Administration Manual.

12 (2) CONTENTS.—The Manual developed under  
13 paragraph (1) shall contain—

14 (A) recommendations, models, policies and  
15 procedures, in sufficient detail, concerning all  
16 aspects of the administration required for a  
17 State program covering CORE SERVICES so  
18 as to avoid any unnecessary duplication of de-  
19 velopment effort by States;

20 (B) sample requests for proposals and  
21 model selection criteria for a claims adminis-  
22 trator, managed care vendors, health care pro-  
23 vider networks and regional or areawide provid-  
24 ers of highly specialized or tertiary health  
25 services;

1 (C) model fee schedules with respect to all  
2 professional and ancillary health services (such  
3 schedules shall allow for regional cost dif-  
4 ferences);

5 (D) model payment systems with respect to  
6 hospitals, skilled nursing facilities and other  
7 health care facilities, developed in a manner  
8 that would encourage the efficient bundling of  
9 services;

10 (E) outcome review procedures that may  
11 be implemented by the States through the es-  
12 tablishment of a State outcome review panel;

13 (F) ethical consideration policies that may  
14 be implemented by the States through the es-  
15 tablishment of a State Medical Ethics Panel;  
16 and

17 (G) any other information determined ap-  
18 propriate by the Board.

19 (3) TIME FOR PROVISION OF MANUALS.—With  
20 respect to the Manual developed under paragraph  
21 (1)—

22 (A) an initial draft of such Manual shall be  
23 provided to the States for comment not later  
24 than 12 months after the date of enactment of  
25 this Act; and

1 (B) the final draft of such Manual shall be  
2 provided to the States not later than 14 months  
3 after the date of enactment of this Act.

4 (f) NATIONAL DATA BANK DATA SYSTEM.—

5 (1) ESTABLISHMENT.—Not later than 12  
6 months after the date of enactment of this Act, the  
7 Board, in consultation with the National Institutes  
8 of Health and the Health Care Financing Adminis-  
9 tration, shall establish and administer the operation  
10 of a National Data Bank System.

11 (2) FUNCTIONS.—The National Data Bank  
12 System shall—

13 (A) function as the nationwide repository  
14 for health care data and information collected  
15 under this Act;

16 (B) collect information, with respect to  
17 State programs, concerning—

18 (i) comprehensive individual medical  
19 records, available health insurance and de-  
20 livery plans and health services under such  
21 plans, and administrative data including  
22 claims, billing and electronic billing infor-  
23 mation; and

24 (ii) outcomes analyses that detail the  
25 effectiveness, efficiency, viability and ethi-

1 cal considerations involved in medical  
2 treatments, technology and practice; and  
3 (C) assist in conducting and supervising  
4 the studies required under subsection (g).

5 (g) STUDIES.—

6 (1) IN GENERAL.—

7 (A) GENERAL REPORT.—Not later than 18  
8 months after the date of enactment of this Act,  
9 the Board, acting through the National Data  
10 Bank System, if appropriate, shall prepare and  
11 submit to the Secretary and the appropriate  
12 committees of Congress, a report concerning  
13 the studies conducted under this paragraph.

14 (B) NATIONAL SERVICE AND HOME  
15 HEALTH CARE.—The Board, acting through the  
16 National Data Bank System, if appropriate, ei-  
17 ther directly or in consultation and cooperation  
18 with the Commission on National and Commu-  
19 nity Service, shall conduct studies or dem-  
20 onstration projects concerning—

21 (i) the feasibility and desirability of  
22 instituting a national service program  
23 under which individuals under the age of  
24 25 who are not serving in the armed forces  
25 would coordinate with other home health

1 service providers to provide assistance to  
2 disabled or older individuals in their  
3 homes; and

4 (ii) the feasibility and desirability of  
5 providing financial assistance to families  
6 that care for and provide financial assist-  
7 ance to disabled or older individuals in  
8 their homes, evaluated both as a cost sav-  
9 ings measure and as an avenue to improve  
10 the quality of care and quality of life of  
11 such individuals.

12 (C) OTHER STUDIES.—The Board, acting  
13 through the National Data Bank System, if ap-  
14 propriate, shall conduct, either directly or  
15 through grant or contract, studies to determine  
16 the feasibility and desirability of—

17 (i) authorizing certain States to im-  
18 plement statewide demonstration health  
19 delivery programs, consistent with the  
20 MediCORE program, prior to the full im-  
21 plementation of this Act as models for the  
22 MediCORE program;

23 (ii) implementing a program to pro-  
24 vide for reduced deductibles or other cost-  
25 sharing mechanisms with respect to CORE

1 SERVICES for individuals or families cer-  
2 tified as being free of substance use or as  
3 abiding by a specified physical fitness  
4 program; and

5 (iii) including health information on a  
6 MediCORE card pursuant to section  
7 102(b)(3), particularly as it relates to the  
8 privacy interests of individuals.

9 (2) IMMIGRANTS AND EARLY RETIREES.—Not  
10 later than 14 months after the date of enactment of  
11 this Act, the Board, acting through the National  
12 Data Bank System, if appropriate, shall conduct a  
13 study, and prepare and submit to the Secretary and  
14 the appropriate committees of Congress a report,  
15 concerning—

16 (A) the provision of CORE SERVICES to  
17 illegal immigrants and, if appropriate, the im-  
18 plementation of a system to compensate those  
19 States with the highest incidence of resident il-  
20 legal immigrants for such services; and

21 (B) the implementation of procedures for  
22 the appropriate recapture of the costs of cov-  
23 erage of CORE SERVICES provided to em-  
24 ployees retired on the date described in section  
25 801, and those who retire after such date, and

1 further procedures, to be developed with the  
2 Secretary of the Treasury, for the equitable  
3 treatment of those retirees who have contrac-  
4 tual agreements with their former employers for  
5 the provision of such health care to ensure that  
6 the employees are treated fairly with respect to  
7 taxation on their retirement income under this  
8 Act.

9 (3) VETERANS AFFAIRS.—

10 (A) STUDY.—The Board shall, either di-  
11 rectly or through grant or contract, conduct a  
12 study of the role of the Department of Veterans  
13 Affairs, and its independent medical care sys-  
14 tem for veterans under title 38, United States  
15 Code, as it relates to the MediCORE program  
16 under this Act.

17 (B) CONDUCT.—In conducting the study  
18 under subparagraph (A), the Board shall—

19 (i) recognize and maintain the inde-  
20 pendent responsibility of the Department  
21 of Veterans Affairs for the special health  
22 care needs and rights of veterans, its  
23 unique and long-standing contributions to  
24 the health of the United States through  
25 medical and mental health care, medical

1 research and health professional education,  
2 and its function as the primary back-up to  
3 military medicine in time of war;

4 (ii) identify opportunities for entering  
5 into health care, research and education  
6 sharing arrangements with the Depart-  
7 ment of Veterans Affairs to optimize the  
8 use of medical and mental health resources  
9 in the United States;

10 (iii) consider the manner in which the  
11 cost containment features of the  
12 MediCORE program under this Act and of  
13 the Department of Veterans Affairs may  
14 be coordinated and integrated in the inter-  
15 est of containing national health care  
16 costs; and

17 (iv) review the findings of the Depart-  
18 ment of Veterans Affairs Commission on  
19 the Future Structure of Veterans Health  
20 Care, the Paralyzed Veterans of America,  
21 study entitled "The VA: Responsibility in  
22 Tomorrow's National Health Care Sys-  
23 tem," and such other publications as it  
24 considers appropriate.

1 (C) STUDY.—Not later than 36 months  
2 after the date of enactment of this Act, the  
3 Board shall prepare and submit to the Sec-  
4 retary and the appropriate committees of Con-  
5 gress a report, concerning the results of the  
6 study conducted under this paragraph.

7 (4) MALPRACTICE REFORM.—

8 (A) STUDY AND MODEL LEGISLATION.—

9 The Board shall conduct a study of Federal and  
10 State medical malpractice laws and proposals  
11 for the reform of such laws. Not later than 24  
12 months after the date of enactment of this Act,  
13 the Board shall develop a model malpractice al-  
14 ternative dispute/claims dispute resolution re-  
15 form law or laws for the guidance of the States.  
16 In developing such model law or laws, the  
17 Board shall consider—

18 (i) alternative dispute resolution sys-  
19 tems and coordination with State claims  
20 dispute resolution systems;

21 (ii) State tort reforms;

22 (iii) payments of future damages;

23 (iv) caps on noneconomic damages;

24 (v) caps on punitive damages and pay-  
25 ment of punitive damages to States for use

1 in monitoring, disciplining and educating  
2 of health care providers;

3 (vi) collateral source rules;

4 (vii) restrictions on attorney fees, in-  
5 cluding contingency fees, and costs;

6 (viii) statutes of limitations;

7 (ix) patient protection and disciplinary  
8 reforms and coordination with professional  
9 self-regulation;

10 (x) joint and several liability;

11 (xi) community and migrant health  
12 care centers and risk retention groups;

13 (xii) practice guidelines and quality  
14 assurance;

15 (xiii) products liability protections for  
16 medical products; and

17 (xiv) others matters determined ap-  
18 propriate.

19 (B) GRANTS.—The Board shall award  
20 grants to selected States from amounts avail-  
21 able under the MediCORE Trust Fund for the  
22 development or implementation of State mal-  
23 practice alternative dispute/claims dispute reso-  
24 lution systems under regulations to be adopted  
25 by the Board. The Board shall monitor and

1 evaluate the effectiveness of State systems and  
2 prepare reports concerning such systems to be  
3 included in the annual report required under  
4 subsection (h).

5 (C) IMPLEMENTATION.—Not later than 2  
6 years after the development of the model law or  
7 laws under subparagraph (A), a State shall  
8 enact and implement a malpractice alternative  
9 dispute/claims dispute resolution system that  
10 the Board determined is in substantial conform-  
11 ity with the requirements and guidelines of the  
12 Board as developed under subparagraphs (A)  
13 and (B).

14 (D) ENFORCEMENT.—If the Board deter-  
15 mines that a State has not complied with the  
16 requirements of subparagraph (C), the Board  
17 may not grant the approval required in title V.

18 (5) COORDINATION OF PROGRAMS.—

19 (A) IN GENERAL.—The Board shall con-  
20 duct a study of any agencies of the Department  
21 of Health and Human Services, including the  
22 Health Care Financing Administration and the  
23 Agency for Health Care Policy and Research,  
24 and any other department and agency of the  
25 Federal Government, to calculate the various

1 programs and activities of such department and  
2 agencies, and to recommend how best to coordi-  
3 nate any of such programs and activities with  
4 the MediCORE Board and the MediCORE pro-  
5 gram under this Act. Such study shall deter-  
6 mine which activities and programs should be  
7 retained, repealed or reorganized, and which  
8 should be consigned to State responsibility.  
9 Within such study, the Board shall review any  
10 ongoing studies being conducted by such de-  
11 partments and agencies, and in particular the  
12 debit/credit card study of the Health Care Fi-  
13 nance Administration, to determine the feasibil-  
14 ity and desirability of such within the  
15 MediCORE program.

16 (B) REPORT.—Not later than 14 months  
17 after the date of enactment of this Act, the  
18 Board shall prepare and submit to the Sec-  
19 retary and the appropriate committees of Con-  
20 gress a report concerning the results of the  
21 study completed under this subparagraph (A).

22 (6) ETHICAL GUIDELINES.—

23 (A) IN GENERAL.—The Board shall con-  
24 duct a study concerning the feasibility and de-  
25 sirability of establishing ethical guidelines on

1           medical and biomedical issues (such as cutting  
2           edge lifesaving techniques and biotechnology  
3           procedures) that are consistent with the  
4           MediCORE program. Such study shall focus on  
5           whether the guidelines can be established prior  
6           to the full implementation of this Act and be  
7           utilized as an ethical model for the MediCORE  
8           program. In conducting such study, the Board  
9           shall conduct a review of existing medical ethi-  
10          cal studies completed or currently being done  
11          within the United States and foreign nations  
12          (such as France).

13           (B) REPORT.—Not later than 18 months  
14          after the date of enactment of this Act, the  
15          Board shall prepare and submit to the Sec-  
16          retary and the appropriate committees of Con-  
17          gress a report concerning the results of the  
18          study completed under this subparagraph (A).

19          (7) PRIMARY CARE.—

20           (A) IN GENERAL.—The Board shall con-  
21          duct a study concerning the feasibility and de-  
22          sirability of establishing, consistent with the  
23          MediCORE program and prior to the full imple-  
24          mentation of this Act—

1 (i) recruitment guidelines to encour-  
2 age or provide incentives for medical stu-  
3 dents to enter into primary care services;  
4 and

5 (ii) guidelines to attract the physician  
6 manpower necessary to insure Americans  
7 have access to continued health care and  
8 preliminary health care, which may include  
9 guidelines for—

10 (I) expanding the National  
11 Health Service Corps;

12 (II) providing increased funding  
13 for innovative training schedules;

14 (III) developing recruitment poli-  
15 cies to increase the number of minor-  
16 ity primary care physicians; and

17 (IV) the development of flexible  
18 loan and loan repayment policies.

19 In conducting such study the Board shall re-  
20 view primary care physician shortages in inner-  
21 city and rural areas.

22 (B) REPORT.—Not later than 18 months  
23 after the date of enactment of this Act, the  
24 Board shall prepare and submit to the Sec-  
25 retary and the appropriate committees of Con-

1           gress a report concerning the results of the  
2           study completed under this subparagraph (A).

3           (h) ANNUAL REPORT.—The Board shall annually  
4 prepare and submit to the appropriate committees of Con-  
5 gress a report entitled “The State of the Nation’s Health  
6 Care Services” which shall concern the effectiveness of the  
7 MediCORE program and the improvement in health care  
8 quality and cost effectiveness of CORE SERVICES pro-  
9 vided under such program.

10 **SEC. 203. ORGANIZATION.**

11           (a) IN GENERAL.—The Board may organize itself  
12 into such subcommittees as the Board determines are ap-  
13 propriate for the efficient and effective administration of  
14 the requirements of this Act.

15           (b) SUBCOMMITTEES.—In addition to any sub-  
16 committees established under subsection (a), the Board  
17 shall establish—

18                   (1) a MediCORE Fund Administration Sub-  
19 committee that shall be responsible for the day to  
20 day administration of this Act and the development  
21 of policies and guidelines for such administration,  
22 including revenue, payment and reimbursement poli-  
23 cies, with special emphasis being placed on the ad-  
24 ministration of the MediCORE Trust Fund; and

1           (2) a MediCORE Health Policy Subcommittee  
2           that shall be responsible for—

3                   (A) the development of health policy rec-  
4                   ommendations;

5                   (B) performance outcomes analyses that  
6                   are based on medical appropriateness deter-  
7                   minations and the issuance of guidelines con-  
8                   cerning such determinations, with special con-  
9                   sideration placed on the ethical implications of  
10                  the implementation of this Act;

11                  (C) the development of CORE SERVICES  
12                  interpretations and access and quality guide-  
13                  lines; and

14                  (D) any other aspects determined appro-  
15                  priate by the Board.

16           (c) ADVISORY PANELS.—The Board may establish  
17           such advisory panels as the Board determines appropriate  
18           to assist the Board in its duties, projects or studies.

## 19           **TITLE III—CORE SERVICES**

### 20           **SEC. 301. CORE SERVICES.**

21           (a) REVIEW.—The Board shall conduct a detailed re-  
22           view of the health services and benefits provided or as-  
23           sisted under—

1           (1) Federal health programs (including pro-  
2           grams under titles XVIII and XIX of the Social  
3           Security Act);

4           (2) health insurance plans available to Federal  
5           and State employees;

6           (3) other private health insurance plans in gen-  
7           eral (such as Blue Cross/Blue Shield); and

8           (4) such other programs or plans determined  
9           appropriate by the Board;

10          that are operating or provided on the date of enactment  
11          of this Act.

12          (b) SCOPE AND CONTENT OF CORE SERVICES.—

13          The Board shall define the content and scope of the  
14          CORE SERVICES to be as comprehensive as practicable  
15          taking into consideration the monetary constraints of the  
16          MediCORE Trust Fund. In making such definition, the  
17          Board shall consider the estimated costs of the CORE  
18          SERVICES and coordinate the content and scope of such  
19          SERVICES to the extent necessary to reconcile such  
20          costs, as outlined in the MediCORE Budget, with the  
21          amount of funds expected to be available with respect to  
22          the year involved from the MediCORE Trust Fund. The  
23          MediCORE Budget Report shall contain a detailed de-  
24          scription of the CORE SERVICES as required by title  
25          VII.

1 (c) SPECIFIC COMPONENTS.—In defining the CORE  
2 SERVICES to be provided under this Act under sub-  
3 section (b), the Board shall include, subject to such limita-  
4 tions, schedules, formularies, appropriateness criteria and  
5 cost sharing requirements as the Board shall determine  
6 appropriate, the following components:

7 (1) MEDICALLY NECESSARY SERVICES.—The  
8 CORE SERVICES shall include those services de-  
9 termined by the Board as being medically necessary,  
10 including prescription drugs, mental health and sub-  
11 stance abuse and rehabilitative services.

12 (2) MEDICARE SERVICES.—The CORE SERV-  
13 ICES shall include those services that otherwise  
14 would have been provided to individuals under title  
15 XVIII of the Social Security Act prior to the effec-  
16 tive date of the amendments made by section 702 as  
17 reconfigured by the Board in consideration of the  
18 MediCORE budget.

19 (3) PREVENTIVE HEALTH CARE SERVICES.—

20 (A) SPECIFICATIONS.—The CORE SERV-  
21 ICES shall include minimum preventive health  
22 care services determined appropriate under  
23 specifications developed by the Board taking  
24 into consideration the cost-effectiveness of such  
25 services in significantly reducing preventable ill-

1 nesses and the administrative efficiency of pro-  
2 viding such services within the scope of appro-  
3 priate State programs.

4 (B) TRANSITION.—Prior to the publication  
5 of the specifications referred to in subparagraph  
6 (A), the preventive health care services that  
7 shall be covered under a State program shall  
8 include:

9 (i) HEALTH SCREENING AND IMMUNI-  
10 ZATION SERVICES.—Those screening and  
11 immunization services recommended in the  
12 document entitled “Guide to Clinical Pre-  
13 ventive Services” published by the Preven-  
14 tive Services Task Force for asymptomatic  
15 low-risk pregnant women, infants and all  
16 other age groups. Screening services shall  
17 include the medical history, physical exam  
18 and laboratory or diagnostic procedures de-  
19 scribed in the Guide, and dental screening  
20 for individuals under the age of 18.

21 (ii) EDUCATION AND COUNSELING  
22 SERVICES.—Those education services pro-  
23 vided as part of a public education pro-  
24 gram administered by the State that are  
25 designed to educate individuals, including

1 school-aged children, concerning taking  
2 personal responsibility for their health.  
3 Such services shall include the health as-  
4 pects of those counseling topics rec-  
5 ommended in the Guide referred to in  
6 clause (i) such as nutrition, exercise, sex-  
7 ual behavior, tobacco use, substance abuse,  
8 injury prevention and the value of periodic  
9 preventive health and dental care.

10 (C) STATE ELECTION.—Services required  
11 under this paragraph shall be delivered under a  
12 State program in a manner determined appro-  
13 priate by the Board. In addition to the services  
14 required under subparagraph (B), a State may  
15 elect to provide enhanced preventive services for  
16 high-risk individuals until such time as such  
17 services are mandated under the guidelines de-  
18 veloped under subparagraph (A). Individual  
19 counseling concerning preventive health care be-  
20 havior and intervention should be made avail-  
21 able as part of a State education or public  
22 health program or otherwise incorporated into  
23 the delivery of other CORE SERVICES under  
24 the State program.

1           (4) LONG-TERM HEALTH, CUSTODIAL OR PER-  
2           SONAL ASSISTANCE.—The Board shall establish  
3           specifications and eligibility criteria with respect to  
4           long-term health, custodial or personal assistance  
5           services that may be provided under this Act. Bene-  
6           fits such as home health, skilled and unskilled care,  
7           respite care and adult day care shall be evaluated by  
8           the Board as options to prevent institutionalization  
9           and to reduce stress on families. Guidance will be  
10          provided to States with respect to supplemental in-  
11          surance and sliding scale supplemental payments for  
12          nursing home care or other additional long-term care  
13          benefits that may not be covered initially under the  
14          MediCORE program.

15          (5) CATASTROPHIC CARE.—The Board shall im-  
16          pose a limitation concerning the amount of expenses  
17          for catastrophic care that an individual shall be lia-  
18          ble for with respect to CORE SERVICES provided  
19          under the MediCORE program.

20          (d) EXCLUSION OF SERVICES.—The Board may not  
21          include as part of CORE SERVICES the hospital care,  
22          medical services and domiciliary care provided to veterans  
23          for service-connected disabilities pursuant to chapter 17  
24          of title 38, United States Code.

1           (e) ADJUSTMENT OR EXPANSION OF CORE SERV-  
2 ICES.—The Board shall annually review the type and  
3 level of CORE SERVICES that are required to be pro-  
4 vided under this Act and adjust such SERVICES if the  
5 Board determines that a more efficient or effective use of  
6 available resources is desirable. In undertaking such re-  
7 view and making any adjustments, the Board shall make  
8 available to the States a description of such adjustments  
9 and provide such States with an appropriate period in  
10 which to comment on such adjustments.

11 **SEC. 302. SPECIAL SUPPLEMENTAL FOOD PROGRAM.**

12           (a) IN GENERAL.—Section 17(c)(1) of the Child Nu-  
13 trition Act of 1966 (42 U.S.C. 1786(c)(1)) is amended—

14               (1) in the first sentence, by striking “may” and  
15               inserting “shall”; and

16               (2) by inserting after the first sentence the fol-  
17               lowing new sentence: “Subject to the other provi-  
18               sions of this section, an eligible individual shall be  
19               entitled to receive the full amount of benefits author-  
20               ized under this section, except for those benefits that  
21               would otherwise be covered under the MediCORE  
22               Health Act of 1993.”.

23           (b) APPROPRIATION.—Section 17(g)(1) of such Act  
24 is amended by striking the first sentence and inserting the  
25 following new sentences: “For purposes of providing bene-

1 fits (except for those benefits that would otherwise be cov-  
2 ered under the MediCORE Health Act of 1993) to all eli-  
3 gible individuals in the program and otherwise carrying  
4 out this section, there are authorized to be appropriated,  
5 and there are appropriated, to carry out this section such  
6 sums as may be necessary for fiscal year 1992 and each  
7 succeeding fiscal year. The Secretary shall make available  
8 the sums described in the previous sentence to carry out  
9 this section.”.

## 10 **TITLE IV—FEDERAL MEDICORE** 11 **GUIDELINES**

### 12 **SEC. 401. FEDERAL MEDICORE GUIDELINES.**

13 (a) PROCEDURE.—

14 (1) SUBMISSION TO STATES.—Not later than  
15 14 months after the date of enactment of this Act,  
16 the Board shall publish in the Federal Register a de-  
17 scription of the preliminary Federal MediCORE  
18 guidelines to be implemented by the Board under  
19 section 202(c). Subsequent to such publication, the  
20 Board shall solicit comments from the States con-  
21 cerning the preliminary guidelines. Not later than 19  
22 months after the date of enactment of this Act, the  
23 Board shall publish in the Federal Register the final  
24 initial Federal guidelines to be implemented by the  
25 Board under section 202(c).

1           (2) ADJUSTMENT OF GUIDELINES.—The Board  
2 shall periodically review the Federal MediCORE  
3 guidelines developed under this section and adjust  
4 such guidelines as the Board determines appro-  
5 priate. In undertaking such review and making any  
6 adjustments, the Board shall make available to the  
7 States a description of such adjustments and provide  
8 the States with an appropriate period in which to  
9 comment on such adjustments.

10          (b) REQUIREMENTS.—Federal guidelines shall be de-  
11 veloped and implemented by the Board under section  
12 202(c) for the delivery of CORE SERVICES to ensure  
13 that:

14           (1) UNIVERSALITY.—CORE SERVICES are  
15 universally accessible and delivered in a nondiscrim-  
16 inatory manner.

17           (2) PORTABILITY.—CORE SERVICES, with  
18 respect to those services and benefits provided by  
19 the State of primary residence (as such term is de-  
20 fined in section 101(d)), will be portable across  
21 State lines, except that preventive health care serv-  
22 ices and other specific services may be limited to the  
23 State of primary residence.

24           (3) SINGLE ADMINISTRATOR.—With respect to  
25 each State with a program approved under section

1 501, a single agency is designated as being respon-  
2 sible for the administration of the State program, in-  
3 cluding ensuring that services and payments to pro-  
4 viders are equitably and efficiently delivered under  
5 such programs.

6 (4) CHOICE AND MANAGED COMPETITION.—

7 (A) CHOICE OF DELIVERY PLANS.—A  
8 State is encouraged to include two or more  
9 CORE SERVICES delivery plans within the  
10 State program to permit market forces to oper-  
11 ate within such State with respect to health  
12 care delivery through managed competition  
13 between such plans.

14 (B) CONSIDERATION BY STATE.—A State  
15 should consider the inclusion of at least one  
16 CORE SERVICES delivery plan that would  
17 permit a significant freedom of choice by con-  
18 sumers with respect to health care providers  
19 (including physicians) for which additional fees  
20 may be assessed by the State. Other plans may  
21 include managed care programs (such as health  
22 maintenance organizations or community health  
23 centers) and health care provider contracts that  
24 share responsibility for cost and outcome man-

1           agement with health care providers or provider  
2           networks.

3           (C) PROVISION OF INFORMATION.—A  
4           State annually shall provide information to resi-  
5           dents of the State concerning the CORE  
6           SERVICES delivery plans available within that  
7           State. Such information shall be in such form  
8           and contain information of such a nature so as  
9           to permit State residents to seek the highest  
10          health care value within the State for the lowest  
11          prices.

12          (5) RURAL AND UNDERSERVED AREAS.—Rural  
13          and underserved areas, and the disability commu-  
14          nity, are provided with fair access to CORE SERV-  
15          ICES on equitable terms.

16          (6) PRIVATE HEALTH INSURANCE.—Private in-  
17          surance covering health care services that are not  
18          otherwise covered under this Act may be sold in a  
19          State.

20          (7) COST SHARING.—A State program may re-  
21          quire or permit the assessment of premiums,  
22          copayments, coinsurance, or annual deductibles with  
23          respect to expenses incurred in the provision of  
24          CORE SERVICES under a program to the extent  
25          and in a manner consistent with specific guidelines

1 to be developed by the Board. In no event shall cost  
2 sharing be permitted with respect to preventive  
3 health care CORE SERVICES. Total cost sharing  
4 may not exceed 15 percent of the cost of CORE  
5 SERVICES as determined in the MediCORE Budg-  
6 et pursuant to section 601. The cost sharing per-  
7 mitted by this paragraph may be income sensitive  
8 and should decrease as the cost of the care  
9 increases.

10 (8) MENTAL HEALTH.—A State program shall  
11 ensure that CORE SERVICES include benefits cov-  
12 ering medically and psychologically necessary treat-  
13 ments for mental health services that are equitable  
14 and comparable to benefits offered for any other  
15 illness.

16 (9) PRIMARY CARE.—A State program shall en-  
17 sure that primary care benefits and services are em-  
18 phasized and focused within the State program in  
19 accordance with the results of the study conducted  
20 under section 202(g)(7). In complying with this  
21 paragraph, a State shall be encouraged and guided  
22 by the Board in order to develop programs to at-  
23 tract, educate and train more primary care physi-  
24 cians, and other primary care providers, and to give

1 the support necessary to retain them in primary  
2 care.

3 **TITLE V—APPROVAL AND OVER-**  
4 **SIGHT OF STATE PROGRAMS**

5 **SEC. 501. APPROVAL AND OVERSIGHT OF STATE PRO-**  
6 **GRAMS**

7 (a) IN GENERAL.—The Board shall administer this  
8 Act, with respect to the approval of, and oversight over,  
9 State programs, in accordance with this section.

10 (b) SUBMISSION OF PROGRAMS.—

11 (1) IN GENERAL.—Not later than 19 months  
12 after the date of enactment of this Act, each State  
13 shall prepare and submit to the Board the State  
14 program in the State.

15 (2) REGIONAL PROGRAMS.—Any State may join  
16 with neighboring States to prepare and submit to  
17 the Board a regional program to operate in all  
18 States so joined in lieu of a State program.

19 (c) REVIEW AND APPROVAL OF PROGRAMS.—Not  
20 later than 20 months after the date of enactment of this  
21 Act, the Board shall review the programs submitted under  
22 subsection (b) and determine whether such programs meet  
23 the requirements and guidelines of the Board for approval.  
24 The Board shall not approve such a program unless it de-

1 termines that the program provides, consistent with the  
2 provisions of this Act, for the following:

3           (1) The equitable and efficient delivery of  
4 CORE SERVICES within the State or for the deliv-  
5 ery of a defined set of health care services deter-  
6 mined by the Board to be substantially equivalent to  
7 the CORE SERVICES, except that no diminution  
8 shall be permitted with respect to the MediCORE  
9 guidelines concerning preventive health care services  
10 included in the CORE SERVICES. A State may  
11 provide additional services and benefits to supple-  
12 ment CORE SERVICES but the cost of any such  
13 additional services or benefits shall be borne solely  
14 by such State and a State may use demonstrated  
15 savings from its MediCORE program to supplement  
16 its CORE SERVICES on terms to be approved by  
17 the Board.

18           (2) Adequate financing of CORE SERVICES  
19 under the program, including the annual submission  
20 of the State program budget to the Board.

21           (3) A system by which the State program shall  
22 provide all enrolled individuals within the State with  
23 standardized information about CORE SERVICES  
24 under the State program.

1           (4) Effective cost containment measures and  
2           payment methodologies consistent with the guide-  
3           lines developed by the Board.

4           (5) Adequate administration, including the des-  
5           ignation of a single agency responsible for adminis-  
6           tration of the program consistent with the guidelines  
7           developed by the Board. Administrative costs of a  
8           State may not exceed 5 percent of the cost of CORE  
9           SERVICES co-determined in the MediCORE  
10          Budget pursuant to section 601.

11          (6) Adequate quality assurance mechanisms.

12          (7) Organization of a State procedure to deter-  
13          mine capital needs and recommend allocation of cap-  
14          ital to localities and institutions consistent with the  
15          guidelines developed by the Board.

16          (8) An organized grievance procedure available  
17          to consumers through which complaints about the  
18          organization and administration of the State pro-  
19          gram and delivery of CORE SERVICES covered by  
20          the State program may be filed, heard, and resolved.

21          (9) A process for developing the State's annual  
22          health budget, fee schedules, cost containment meas-  
23          ures, payment practices, quality assurance mecha-  
24          nisms, grievance procedures, outcomes review proce-  
25          dures, ethical analyses procedures, and other rel-

1 evant aspects of the State program, which process  
2 shall include regular and adequate opportunities in  
3 diverse geographical settings for the citizens of the  
4 State to have their opinions solicited and heard, con-  
5 sistent with the guidelines developed by the Board.

6 (10) An agreement, if sufficient capacity exists,  
7 with veterans hospitals to reimburse the hospitals  
8 for care, not required under Federal law, provided to  
9 veterans and their dependents (any such agreement  
10 shall not be for charges in excess of those charged  
11 other providers under the State program).

12 (11) A process under which self-insured groups  
13 may seek State certification if such groups are made  
14 up of at least 1,000 participants and if such groups  
15 are provided with health care benefits, including  
16 quality of care, that is at least equal to that other-  
17 wise required under the State program. The State  
18 may require such groups to meet other require-  
19 ments, including data collection or surcharge re-  
20 quirements. Self-insured groups certified by the  
21 State shall be reimbursed by the State in an amount  
22 that equals the actual costs incurred in self-insuring,  
23 or 6 percent of the amount the State receives under  
24 section 602 for the fiscal year involved, whichever is  
25 less.

1           (12) Any other matter determined appropriate  
2           by the Board.

3 In assessing the cost containment measures and payment  
4 methodologies of a State for purposes of paragraph (4),  
5 the Board shall consider whether the State program in-  
6 cludes different CORE SERVICES delivery plans as de-  
7 scribed in section 401(4)(A) that permit enrollees to be  
8 presented with a choice of delivery plans and allow for  
9 health care efficiencies and effectiveness to result from the  
10 competition of such plans.

11       (d) ANNUAL REVIEW.—Beginning the second year  
12 after a State program under this Act is in operation, and  
13 annually thereafter, the Board shall review such State pro-  
14 gram and determine whether such program continues to  
15 meet the requirements of this Act. At least 3 months prior  
16 to the conduct of each such review, the Board shall publish  
17 a description of the criteria to be used by the Board in  
18 determining whether a State program complies with the  
19 requirements of this Act.

20       (e) FAILURE OF APPROVAL.—

21           (1) RESUBMISSION.—If the Board determines  
22 that the initial State program submitted under sub-  
23 section (b) does not meet the requirements for ap-  
24 proval under subsection (c), the Board shall provide  
25 notice to the State of such failure and the State

1 shall, not later than 21 months after the date of en-  
2 actment of this Act, resubmit such program with the  
3 modifications required by the Board.

4 (2) SANCTIONS.—

5 (A) RESUBMISSION.—If the Board deter-  
6 mines that a State program resubmitted under  
7 paragraph (1) does not meet the requirements  
8 for approval under subsection (c), the Board  
9 shall provide notice to the State of such failure  
10 and may place the State program in receiver-  
11 ship under the jurisdiction of the Board or im-  
12 pose the other sanctions described in subpara-  
13 graph (C).

14 (B) OTHER FAILURES.—If under a review  
15 conducted under subsection (d) the Board de-  
16 termines that a State program previously ap-  
17 proved under subsection (c) no longer meets the  
18 requirements of such section, the Board shall  
19 provide notice to the State of such failure and  
20 that unless corrective action is taken within a  
21 period of 90 days the sanctions described in  
22 subparagraph (C) may be applied, effective 30  
23 days after the end of such 90-day period.

24 (C) SANCTIONS.—The sanctions described  
25 in subparagraph (B) are—

1 (i) censure;

2 (ii) reductions in the future amounts  
3 otherwise payable by the Federal Govern-  
4 ment under this Act to the State, but in no  
5 event shall such amount be reduced by  
6 more than 5 percent; and

7 (iii) placing the State program in re-  
8 ceivership under the jurisdiction of the  
9 Board.

10 For purposes of clause (ii), no reduction  
11 shall result in the contraction of primary or es-  
12 sential CORE SERVICES as determined ap-  
13 propriate by the Board.

14 (3) RECEIVERSHIP.—In the event that a State  
15 program is placed in receivership under paragraph  
16 (2)(C)(iii), the Board shall ensure that such pro-  
17 gram is administered using managed competition  
18 networks determined appropriate by the Board in all  
19 areas in the State except those areas determined to  
20 lack sufficient health care providers.

21 (f) PAYMENTS, PREMIUMS, COPAYMENTS, DEDUCT-  
22 IBLES, ETC.

23 (1) PAYMENTS.—A State program shall provide  
24 for the payment of CORE service providers accord-  
25 ing to procedures established under the State pro-

1       gram consistent with the guidelines developed by the  
2       Board.

3           (2) MANDATORY ASSIGNMENT.—Each provider  
4       of services or other practitioner, institution or facil-  
5       ity that receives reimbursement related to CORE  
6       SERVICES provided under this Act shall be consid-  
7       ered to have agreed to accept the reimbursement  
8       amount recognized under the State program for the  
9       CORE SERVICES covered under such program as  
10      payment in full for such services and may not im-  
11      pose any charges for such services other than those  
12      permitted with respect to such services under the  
13      procedures established by the State consistent with  
14      the guidelines developed by the Board.

15      (g) ADMINISTRATION BY STATE.—

16           (1) IN GENERAL.—On the January 1 referred  
17      to in section 801, and subject to the approval of a  
18      State program under subsection (c), the State shall  
19      begin the administration, management, and super-  
20      vision of its program under this Act.

21           (2) ADMINISTRATION BY CONTRACT.—A State  
22      may contract with a third party or parties (including  
23      private health insurance carriers, claims administra-  
24      tions, and managed care organizations) or with the  
25      MediCORE Fund Administration for the administra-

1       tion, management, and supervision of its program,  
 2       but in no event shall more than one entity be re-  
 3       sponsible for such duties with respect to CORE  
 4       SERVICES provided under the State program. The  
 5       Board may waive the single entity claims processing  
 6       requirement of the preceding sentence if the Board  
 7       determines such action appropriate.

## 8       **TITLE VI—MEDICORE BUDGET**

### 9       **SEC. 601. MEDICORE BUDGET.**

10       (a) BUDGETARY REQUIREMENT.—The Board shall  
 11       prepare an annual MediCORE Budget containing esti-  
 12       mates of—

13               (1) the total expenditures the Board expects to  
 14       be made during the calendar year for which the  
 15       budget is being prepared by States and the Federal  
 16       Government for CORE SERVICES under this Act  
 17       (including administrative costs); and

18               (2) the total amount that the Board expects to  
 19       be available in the MediCORE Trust Fund for the  
 20       calendar year for which the budget is being pre-  
 21       pared.

22       (b) NATIONAL AVERAGE PER CAPITA COSTS.—

23               (1) IN GENERAL.—The Board shall compute  
 24       the national average per capita cost for each cat-  
 25       egory of the CORE SERVICES described in section

1 301(b) using data from the national health accounts  
2 of the Office of National Cost Estimates of the Of-  
3 fice of the Actuary of the Health Care Financing  
4 Administration, and other available data. On the ef-  
5 fective date of the repeals under section 702, the  
6 National Data Bank System established under sec-  
7 tion 202(f) shall compile and maintain the data pre-  
8 viously collected by the Office of National Cost Esti-  
9 mates of the Office of the Actuary of the Health  
10 Care Financing Administration.

11 (2) ADJUSTMENTS FOR RISK GROUPS.—

12 (A) IN GENERAL.—The Board shall de-  
13 velop an adjustment factor to the national aver-  
14 age per capita costs computed under paragraph  
15 (1) for each risk group (as designated under  
16 subparagraph (B)) to reflect the national aver-  
17 age per capita costs for that risk group.

18 (B) RISK GROUPS.—The Board shall des-  
19 ignate a series of risk groups, determined by  
20 age, sex, and other factors that represent dis-  
21 tinct patterns of health care services and long-  
22 term care services utilization and costs.

23 (3) STATE ADJUSTMENTS TO NATIONAL AVER-  
24 AGE PER CAPITA COSTS.—The Board shall develop  
25 for each State a factor to adjust the national aver-

1       age per capita costs for each risk group to reflect  
2       the differing circumstances with respect to each such  
3       State, including—

4               (A) the number of illegal immigrants in  
5       such State;

6               (B) the number of homeless individuals in  
7       such State;

8               (C) the overall poverty level of the State;

9               (D) the percentage of the State that is de-  
10       termined to be rural and the percentage deter-  
11       mined to be urban;

12               (E) the overall health status of the State;  
13       and

14               (F) other factors determined appropriate  
15       by the Board.

16       (c) STATE TOTAL EXPENDITURES.—The Board shall  
17       compute for each State total projected expenditures for  
18       each of the CORE SERVICES described in subsection (a)  
19       by multiplying the national average per capita costs of  
20       each risk group designated in subsection (b)(2)(B) by the  
21       State adjustment factors described in subsection (b)(3) by  
22       the number of persons in the State estimated by the Bu-  
23       reau of the Census to be resident members of each risk  
24       group.

25       (d) FEDERAL CONTRIBUTIONS.—

1           (1) IN GENERAL.—The Board shall determine  
2           the appropriate Federal health care revenue con-  
3           tribution for each State. The Federal health care  
4           revenue contribution shall be determined by sub-  
5           tracting the State share from 100 percent of the  
6           total State expenditures for such State for the cal-  
7           endar year involved (as described under subsection  
8           (c)).

9           (2) STATE SHARE.—The State share referred to  
10          in paragraph (1) shall not be less than an amount  
11          that equals—

12                 (A) the revenue generated under section  
13                 3101(c) of the Internal Revenue Code of 1986  
14                 with respect to a State; and

15                 (B) the State's share of spending under  
16                 title XVIII of the Social Security Act in 1995,  
17                 as adjusted for each subsequent fiscal year  
18                 based on the increase in the Gross Domestic  
19                 Product for such year and demographic changes  
20                 determined relevant by the Board.

21          (3) STATE PROTECTION.—In determining the  
22          amount of the State share under paragraph (2), the  
23          Board shall consider the ability of the State to pro-  
24          vide for the continued operation of the State pro-  
25          gram at a level sufficient to provide individuals with-

1 in such State with the CORE SERVICES under  
2 such program.

3 (e) SUBSEQUENT CALCULATIONS.—For each subse-  
4 quent calendar year during which a program is in effect  
5 in a State, the Board shall make recomputations under  
6 subsections (a), (b), (c), and (d) for the State at least 7  
7 months before the beginning of such calendar year.

8 **SEC. 602. HEALTH CARE REVENUE SHARE PAYMENTS TO**  
9 **STATES.**

10 (a) IN GENERAL.—Each State with an approved  
11 State program is entitled to receive, from amounts in the  
12 Trust Fund, an amount equal to the annual Federal share  
13 determined under section 601(d) with respect to each such  
14 State.

15 (b) USE OF FUNDS.—Amounts provided to a State  
16 under subsection (a) and the State share, as defined in  
17 section 601(d)(2) shall be used to carry out the State pro-  
18 gram in such State.

19 **SEC. 603. MEDICORE TRUST FUND.**

20 (a) TRUST FUND ESTABLISHED.—

21 (1) IN GENERAL.—There is hereby created on  
22 the books of the Treasury of the United States a  
23 trust fund to be known as the “MediCORE Trust  
24 Fund”. The Trust Fund shall consist of such gifts  
25 and bequests as may be made and such amounts as

1        may be deposited in, or appropriated to, such Trust  
2        Fund as provided in this Act.

3            (2) TRANSFER OF AMOUNTS EQUIVALENT TO  
4        CERTAIN TAXES.—

5            (A) IN GENERAL.—There are hereby ap-  
6        propriated to the Trust Fund amounts equiva-  
7        lent to 100 percent of the taxes imposed under  
8        sections 59B, 1401(b), 1401(c), 3101(b),  
9        3101(c), 3111(b), and 3111(c) of the Internal  
10       Revenue Code of 1986.

11           (B) ADDITIONAL REVENUES.—There are  
12        appropriated to the Trust Fund amounts equiv-  
13        alent to the additional revenues received in the  
14        Treasury as the result of the amendments made  
15        by section 604(d) of this Act.

16           (C) TRANSFERS BASED ON ESTIMATES.—  
17        The amounts appropriated by subparagraphs  
18        (A) and (B) shall be transferred from time to  
19        time (not less frequently than monthly) from  
20        the general fund in the Treasury to the Trust  
21        Fund, such amounts to be determined on the  
22        basis of estimates by the Secretary of the  
23        Treasury of the taxes, specified in such sub-  
24        paragraphs, paid to or deposited into the Treas-  
25        ury; and proper adjustments shall be made in

1 amounts subsequently transferred to the extent  
2 prior estimates were in excess of or were less  
3 than the taxes specified in such subparagraphs.

4 (3) TRANSFER OF FUNDS.—All amounts, not  
5 otherwise obligated, that remain in the Federal Hos-  
6 pital Insurance Trust Fund and the Federal Supple-  
7 mental Medical Insurance Trust Fund on the first  
8 day of the year described in section 801 shall be  
9 transferred to the Trust Fund.

10 (4) APPROPRIATION OF ADDITIONAL SUMS.—  
11 There is hereby appropriated to the Trust Fund—

12 (A) on January 1 of the year described in  
13 section 801 of MediCORE Health Act of 1992,  
14 an amount equal to the amounts appropriated  
15 with respect to titles XVIII and XIX of the So-  
16 cial Security Act, section 1079 of title 10, Unit-  
17 ed States Code (CHAMPUS), and chapter 89  
18 of title 5, United States Code, for the fiscal  
19 year ending before such year,

20 (B) on January 1 of each succeeding year,  
21 an amount equal to the amount determined  
22 under this paragraph for the preceding year in-  
23 creased by the percentage increase (if any) in  
24 Gross Domestic Product.

1           (5) INCORPORATION OF TRUST FUND PROVI-  
2           SIONS.—The provisions of subsections (b) through  
3           (e) of section 1841 of the Social Security Act (42  
4           U.S.C. 1395t), as in effect on the day before the  
5           date of the enactment of this Act, shall apply to the  
6           Trust Fund in the same manner as such provisions  
7           apply to the Federal Supplemental Medical Insur-  
8           ance Trust Fund, except that any reference to the  
9           Secretary of Health and Human Services or the Ad-  
10          ministrator of the Health Care Financing Adminis-  
11          tration shall be deemed a reference to the Board.

12          (b) EXPENDITURES.—

13           (1) RESERVATION.—The Board shall reserve 2  
14           percent of amounts contained in the Trust Fund  
15           each fiscal year to provide supplemental payments to  
16           States determined by the Board to be in need of  
17           such supplemental payments. Such payments may be  
18           made by the Board where the Board determines that  
19           the amount of payment to which a State is entitled  
20           under section 602 is inadequate as a result of an  
21           unforeseen health emergency or other increase in  
22           health care demand in such State.

23           (2) TO STATES.—Payments in each calendar  
24           year to each State from the Trust Fund as deter-

1       mined under section 602 are hereby authorized and  
2       appropriated.

3           (3) ADMINISTRATIVE EXPENSES.—There are  
4       hereby authorized and appropriated such sums as  
5       are necessary for the administrative expenses of the  
6       Board for each year, not to exceed 1 percent of the  
7       total payments made to the States for such year as  
8       determined under section 602.

9           (c) TRUST FUND OFF-BUDGET.—The receipts and  
10       disbursements of the Trust Fund and the taxes described  
11       in subsection (a)(2) shall not be included in the totals of  
12       the budget of the United States Government as submitted  
13       by the President or of the congressional budget and shall  
14       be exempt from any general budget limitation imposed by  
15       statute on expenditures and net lending (budget outlays)  
16       of the United States Government.

17       **SEC. 604. HEALTH CARE REVENUE SHARING PROVISIONS.**

18           (a) PAYROLL TAXES.—

19           (1) TAX ON EMPLOYEES.—Section 3101 of the  
20       Internal Revenue Code of 1986 (relating to rate of  
21       tax on employees) is amended by redesignating sub-  
22       sections (c) and (d) as subsections (d) and (e) and  
23       by inserting after subsection (b) the following new  
24       subsection:

1       “(c) MEDICORE.—In addition to the taxes imposed  
2 by the preceding subsections, there is hereby imposed on  
3 the income of every individual a tax equal to 2 percent  
4 of the wages (as defined in section 3121(a)) received by  
5 such individual on or after January 1 of the year described  
6 in section 801 of MediCORE Health Act of 1992, with  
7 respect to employment (as defined in section 3121(b)).”.

8           (2) TAX ON EMPLOYERS.—Section 3111 of such  
9 Code (relating to rate of tax on employers) is  
10 amended by redesignating subsection (c) as sub-  
11 section (d) and by inserting after subsection (b) the  
12 following new subsection:

13       “(c) MEDICORE.—In addition to the taxes imposed  
14 by the preceding subsections, there is hereby imposed on  
15 every employer an excise tax, with respect to having indi-  
16 viduals in such employer’s employ, equal to 4 percent of  
17 the wages (as defined in section 3121(a)) paid by such  
18 employer during each calendar year beginning on or after  
19 January 1 of the year described in section 801 of  
20 MediCORE Health Act of 1992, with respect to employ-  
21 ment (as defined in section 3121(b)).”.

22           (3) TAX ON SELF-EMPLOYMENT INCOME.—Sec-  
23 tion 1401 of such Code (relating to rate of tax on  
24 self-employment income for hospital insurance) is  
25 amended by redesignating subsection (c) as sub-

1 section (d) and by inserting after subsection (b) the  
 2 following new subsection:

3 “(c) MEDICORE.—In addition to the taxes imposed  
 4 by the preceding subsections, there shall be imposed for  
 5 each taxable year beginning on or after January 1 of the  
 6 year described in section 801 of MediCORE Health Act  
 7 of 1992, on the self-employment income of every individ-  
 8 ual, a tax equal to the sum of—

9 “(1) 2 percent, plus

10 “(2) 4 percent

11 of the amount of the self-employment income for such tax-  
 12 able year.”.

13 (4) ELIMINATION OF LIMIT ON EMPLOYER POR-  
 14 TION OF WAGES OR SELF-EMPLOYMENT INCOME  
 15 SUBJECT TO MEDICORE TAX.—

16 (A) WAGES.—Subsection (x) of section  
 17 3121 of the Internal Revenue Code of 1986 (re-  
 18 lating to applicable contribution base) is amend-  
 19 ed by adding at the end thereof the following  
 20 new paragraph:

21 “(3) MEDICORE.—

22 “(A) EMPLOYEE PORTION.—For purposes  
 23 of the taxes imposed by section 3101(c), the ap-  
 24 plicable contribution base is—

1           “(i) \$100,000 for the calendar year  
2           beginning on January 1 of the year de-  
3           scribed in section 801 of MediCORE  
4           Health Act of 1992, and

5           “(ii) for any calendar year after the  
6           calendar year described in clause (i), the  
7           applicable contribution base for the preced-  
8           ing year adjusted in the same manner as  
9           is used in adjusting the contribution and  
10          benefit base under section 230(b) of the  
11          Social Security Act.

12          “(B) EMPLOYER PORTION.—For purposes  
13          of the taxes imposed by section 3111(c), the ap-  
14          plicable contribution base for any calendar year  
15          is equal to the remuneration for employment  
16          paid to an individual for such calendar year.”.

17          (B) SELF-EMPLOYMENT INCOME.—Sub-  
18          section (k) of section 1402 of such Code (relat-  
19          ing to applicable contribution base) is amended  
20          by adding at the end thereof the following new  
21          paragraph:

22          “(3) MEDICORE.—

23                 “(A) EMPLOYEE PORTION.—For purposes  
24                 of the taxes imposed by section 1402(c)(1), the  
25                 applicable contribution base is—

1           “(i) \$100,000 for calendar year begin-  
2           ning on January 1 of the year described in  
3           section 801 of MediCORE Health Act of  
4           1992, and

5           “(ii) for any calendar year after the  
6           calendar year described in clause (i), the  
7           applicable contribution base for the preced-  
8           ing year adjusted in the same manner as  
9           is used in adjusting the contribution and  
10          benefit base under section 230(b) of the  
11          Social Security Act.

12          “(B) EMPLOYER PORTION.—For purposes  
13          of the tax imposed by section 1401(c)(2), the  
14          applicable contribution base for any calendar  
15          year is equal to the individual’s net earnings  
16          from self-employment for such calendar year.”.

17          (C) CONFORMING AMENDMENT.—Sub-  
18          section (c) of section 6413 of such Code is  
19          amended by adding at the end thereof the fol-  
20          lowing new paragraph:

21          “(4) SEPARATE APPLICATION FOR MEDICORE  
22          TAXES.—In applying this subsection with respect  
23          to—

24                  “(A) the tax imposed by section 3101(c)  
25                  (or any amount equivalent to such tax), and

1           “(B) so much of the tax imposed by sec-  
2           tion 3201 as is determined at a rate not greater  
3           than the rate in effect under section 3101(c),  
4           the applicable contribution base determined under  
5           section 3121(x)(3)(A) for any calendar year shall be  
6           substituted for ‘contribution and benefit base (as de-  
7           termined under section 230 of the Social Security  
8           Act)’ each place it appears.”.

9           (5) ADDITIONAL FEDERAL, STATE, AND LOCAL  
10          EMPLOYEES SUBJECT TO MEDICORE TAXES.—Sec-  
11          tion 3121(u) (relating to application of hospital in-  
12          surance tax to Federal, State, and local employ-  
13          ment) is amended—

14                 (A) by striking “sections 3101(b) and  
15                 3111(b)” in paragraph (1) and inserting “sec-  
16                 tions 3101(b), 3101(c), 3111(b), and 3111(c)”,

17                 (B) by striking “Except as provided in  
18                 subparagraphs (B) and (C)” in paragraph  
19                 (2)(A) and inserting “Except as provided in  
20                 subparagraph (B)” , and

21                 (C) by striking subparagraphs (C) and (D)  
22                 of paragraph (2).

23          (6) EFFECTIVE DATE.—The amendments made  
24          by this subsection shall apply with respect to remu-  
25          neration paid on or after January 1 of the year de-

1 scribed in section 801 of MediCORE Health Act of  
 2 1992, and with respect to earnings from self-employ-  
 3 ment attributable to taxable years beginning on or  
 4 after such date.

5 (b) INDIVIDUAL TAX ON CERTAIN ADJUSTED GROSS  
 6 INCOME.—

7 (1) IN GENERAL.—Subchapter A of chapter 1  
 8 of the Internal Revenue Code of 1986 (relating to  
 9 normal taxes and surtaxes) is amended by adding at  
 10 the end thereof the following new part:

11 **“PART VIII—MEDICORE REVENUE SHARING**  
 12 **TAXES**

“Sec. 59B. Individual MediCORE tax.

13 **“SEC. 59B. INDIVIDUAL MEDICORE TAX.**

14 “(a) IN GENERAL.—In the case of an individual,  
 15 there is hereby imposed (in addition to any other tax im-  
 16 posed by this subtitle) a tax equal to the excess (if any)  
 17 of—

18 “(1) the tax determined under subsection (b),  
 19 over

20 “(2) the sum of—

21 “(A) the tax imposed under section  
 22 3111(c) or 1402(c)(2) for such taxable year  
 23 with respect to the wages or self-employment  
 24 income (as the case may be) of such individual

1 which does not exceed the applicable contribu-  
 2 tion base under section 3121(x)(3)(A) or  
 3 1402(k)(3)(A) (as the case may be), plus

4 “(B) the retiree health care amount avail-  
 5 able to the individual for such taxable year.

6 “(b) TAX ON ADJUSTED GROSS INCOME.—The tax  
 7 imposed under this subsection is as follows:

8 “(1) MARRIED INDIVIDUALS FILING JOINT RE-  
 9 TURNS AND SURVIVING SPOUSES.—There is hereby  
 10 imposed on the adjusted gross income of—

11 “(A) every married individual (as defined  
 12 in section 7703) who makes a single return  
 13 jointly with such individual’s spouse under sec-  
 14 tion 6013, and

15 “(B) every surviving spouse (as defined in  
 16 section 2(a)),

17 a tax determined in accordance with the following  
 18 table:

<b>“If adjusted gross income is:</b>	<b>The tax is:</b>
Not over \$10,000 .....	\$0.
Over \$10,000 but not over \$11,000.	\$0, plus 1% of the excess over \$10,000.
Over \$11,000 but not over \$12,000.	\$10, plus 2% of the excess over \$11,000.
Over \$12,000 but not over \$13,000.	\$30, plus 3% of the excess over \$12,000.
Over \$13,000 but not over \$14,000.	\$60, plus 4% of the excess over \$13,000.
Over \$14,000 but not over \$15,000.	\$100, plus 5% of the excess over \$14,000.
Over \$15,000 but not over \$162,500.	\$150, plus 6% of the excess over \$15,000.

1           “(2) UNMARRIED INDIVIDUALS (OTHER THAN  
2 SURVIVING SPOUSES).—There is hereby imposed on  
3 the adjusted gross income of every individual (other  
4 than a surviving spouse as defined in section 2(a))  
5 who is not a married individual (as defined in sec-  
6 tion 7703) a tax determined in accordance with the  
7 following table:

<b>“If adjusted gross income is:</b>	<b>The tax is:</b>
Not over \$7,000 .....	\$0.
Over \$7,000 but not over \$8,000 ..	\$0, plus 1% of the excess over \$7,000.
Over \$8,000 but not over \$9,000 ..	\$10, plus 2% of the excess over \$8,000.
Over \$9,000 but not over \$10,000	\$30, plus 3% of the excess over \$9,000.
Over \$10,000 but not over \$11,000.	\$60, plus 4% of the excess over \$10,000.
Over \$11,000 but not over \$12,000.	\$100, plus 5% of the excess over \$11,000.
Over \$12,000 but not over \$109,500.	\$150, plus 6% of the excess over \$12,000.

8           “(3) MARRIED INDIVIDUALS FILING SEPARATE  
9 RETURNS.—There is hereby imposed on the adjusted  
10 gross income of every married individual (as defined  
11 in section 7703) who does not make a single return  
12 jointly with such individual’s spouse under section  
13 6013, a tax determined in accordance with the fol-  
14 lowing table:

<b>“If adjusted gross income is:</b>	<b>The tax is:</b>
Not over \$5,000 .....	\$0.
Over \$5,000 but not over \$5,500 ..	\$0, plus 1% of the excess over \$5,000.
Over \$5,500 but not over \$6,000 ..	\$5, plus 2% of the excess over \$5,500.
Over \$6,000 but not over \$6,500 ..	\$15, plus 3% of the excess over \$6,000.
Over \$6,500 but not over \$7,000 ..	\$30, plus 4% of the excess over \$6,500.

<b>“If adjusted gross income is:</b>	<b>The tax is:</b>
Over \$7,000 but not over \$7,500 ..	\$50, plus 5% of the excess over \$7,000.
Over \$7,500 but not over \$81,250	\$75, plus 6% of the excess over \$7,500.

1       “(c) RETIREE HEALTH CARE AMOUNTS.—For pur-  
2 poses of subsection (a)(2)(B), and to the extent provided  
3 by regulation, an individual’s retiree health care amount  
4 is equal to the amount deposited in the MediCORE Trust  
5 Fund by the individual’s employer with respect to such  
6 individual under an agreement with the Secretary.”.

7           (2) CONFORMING AMENDMENT.—The table of  
8 parts of subchapter A of chapter 1 of such Code is  
9 amended by adding at the end thereof the following  
10 new item:

“Part VIII. MediCORE taxes.”.

11           (3) EFFECTIVE DATE.—The amendments made  
12 by this subsection shall apply to taxable years begin-  
13 ning on or after January 1 of the year described in  
14 section 801 of MediCORE Health Act of 1992.

15       (c) TREATMENT OF HEALTH CARE DEDUCTIONS,  
16 EXCLUSIONS, AND CREDITS.—

17           (1) LIMITATION ON EXCLUSION OF COMPENSA-  
18 TION FOR INJURIES OR SICKNESS.—Subsection (a)  
19 of section 104 of the Internal Revenue Code of 1986  
20 (relating to compensation for injuries or sickness) is  
21 amended—

1 (A) by striking paragraph (3) and insert-  
2 ing the following new paragraph:

3 “(3) amounts received through MediCORE for  
4 personal injuries or sickness;”, and

5 (B) by striking the second sentence there-  
6 of.

7 (2) TERMINATION OF EXCLUSION FOR  
8 AMOUNTS RECEIVED UNDER ACCIDENT AND HEALTH  
9 PLANS.—

10 (A) IN GENERAL.—Section 105 of such  
11 Code (relating to amounts received under acci-  
12 dent and health plans) is amended—

13 (i) by striking “income” and all that  
14 follows in subsection (a) and inserting “in-  
15 come.”,

16 (ii) by striking subsections (b), (e),  
17 (f), (g), and (h), and

18 (iii) by redesignating subsections (c)  
19 and (i) as subsections (b) and (c), respec-  
20 tively.

21 (B) CONFORMING AMENDMENT.—Para-  
22 graph (6) of section 7871(a)(6) of such Code is  
23 amended by striking subparagraph (A) and by  
24 redesignating subparagraphs (B), (C), and (D)

1 as subparagraphs (A), (B), and (C), respec-  
2 tively.

3 (3) TERMINATION OF EXCLUSION FOR CON-  
4 TRIBUTIONS BY EMPLOYER TO ACCIDENT AND  
5 HEALTH PLANS.—

6 (A) IN GENERAL.—Section 106 of such  
7 Code (relating to contributions by employer to  
8 accident and health plans) is repealed.

9 (B) CONFORMING AMENDMENTS.—

10 (i) Subsection (c) of section 104 of  
11 such Code is amended to read as follows:

12 “(c) CROSS REFERENCE.—

**“For exclusion of part of disability retirement pay  
from the application of subsection (a)(4) of this sec-  
tion, see section 1403 of title 10, United States Code  
(relating to career compensation laws).”**

13 (ii) Sections 414(n)(3)(C), 414(t)(2),  
14 and 6039D(d)(1) of such Code are each  
15 amended by striking “106,”.

16 (4) LIMITATION ON CAFETERIA PLANS.—Sub-  
17 section (g) of section 125 of such Code (relating to  
18 cafeteria plans) is amended by striking paragraph  
19 (2) and by redesignating paragraphs (3) and (4) as  
20 paragraphs (2) and (3), respectively.

21 (5) PROHIBITION ON USE OF MEDICORE EX-  
22 PENSES AS BUSINESS EXPENSE DEDUCTION FOR EM-  
23 PLOYER.—Subsection (l) of section 162 of such Code

1 (relating to trade or business expenses) is amended  
2 to read as follows:

3 “(l) EMPLOYER MEDICORE EXPENSES.—No  
4 amount paid or incurred with respect to MediCORE may  
5 be allowed as a deduction under this section.”.

6 (6) DEDUCTION FOR MEDICAL EXPENSES LIM-  
7 ITED TO UNCOMPENSATED EXPENSES AND EM-  
8 PLOYEE MEDICORE TAX.—

9 (A) IN GENERAL.—Subsection (a) of sec-  
10 tion 213 of such Code (relating to medical, den-  
11 tal, etc., expenses) is amended to read as fol-  
12 lows:

13 “(a) ALLOWANCE OF DEDUCTION.—There shall be  
14 allowed as a deduction the expenses paid during the tax-  
15 able year, not compensated for by insurance or otherwise  
16 for—

17 “(1) medical care of the taxpayer, the tax-  
18 payer’s spouse, or a dependent of the taxpayer (as  
19 defined in section 152), to the extent that such ex-  
20 penses exceed 7.5 percent of adjusted gross income,  
21 and

22 “(2) the tax imposed under section 3101(c) or  
23 1402(c)(1).”.

1 (B) CONFORMING AMENDMENTS.—Sub-  
2 section (d) of section 213 of such Code (relat-  
3 ing to definitions) is amended—

4 (i) by inserting “or” at the end of  
5 paragraph (1)(A),

6 (ii) by striking “, or” at the end of  
7 paragraph (1)(B) and inserting a period,

8 (iii) by striking paragraph (1)(C),

9 (iv) by striking paragraphs (6) and  
10 (7) and by redesignating paragraphs (8)  
11 and (9) as paragraphs (6) and (7),  
12 respectively.

13 (7) TERMINATION OF PENSION PAYMENT OF  
14 MEDICAL BENEFITS.—Subsection (h) of section 401  
15 of such Code (relating to qualified pension, profit-  
16 sharing, and stock bonus plans) is repealed.

17 (8) TERMINATION OF CHILD HEALTH INSUR-  
18 ANCE CREDIT.—Clause (i) of section 32(b)(2)(A) of  
19 such Code (relating to health insurance credit) is  
20 amended by inserting “(0 percent for taxable years  
21 beginning on or after January 1 of the year de-  
22 scribed in section 801 of MediCORE Health Act of  
23 1992)” after “6 percent”.

24 (9) EFFECTIVE DATE.—The amendments made  
25 by this subsection shall apply with respect to taxable

1 years beginning on or after January 1 of the year  
2 described in section 801 of MediCORE Health Act  
3 of 1992.

4 **TITLE VII—PREPARATION AND**  
5 **SUBMISSION OF MEDICORE**  
6 **BUDGET TO CONGRESS**

7 **SEC. 701. PREPARATION AND SUBMISSION.**

8 The Board shall annually prepare and submit to Con-  
9 gress a MediCORE Budget Report. Such Report shall in-  
10 clude a description of—

11 (1) the content and scope of the CORE SERV-  
12 ICES as required under title III;

13 (2) the MediCORE Budget prepared under sec-  
14 tion 601(a) (1) and (2);

15 (3) the national average per capita cost for each  
16 category of the CORE SERVICES as required  
17 under section 601(b);

18 (4) the adjustments for risk groups as required  
19 under section 601(b)(2) (A) and (B);

20 (5) the State adjustment factor as computed  
21 under section 601(b)(3);

22 (6) the total projected expenditures for each  
23 State for each of the CORE SERVICES as com-  
24 puted under section 601(c); and

1           (7) the recommended Federal contributions and  
2           State share for each State, including the state pro-  
3           tection required under section 601(d).

4 **SEC. 702. PUBLICATION AND COMMENT.**

5           In preparing the MediCORE Budget Report under  
6           section 701, the Board shall—

7           (1) not later than 9 months prior to the first  
8           January 1 referred to in section 801, and each Jan-  
9           uary 1 thereafter, publish in the Federal Register  
10          the preliminary findings and recommendations of the  
11          Board with respect to the Report;

12          (2) not later than 2 months after the publica-  
13          tion required under paragraph (1) is made, solicit  
14          from each State comments concerning the published  
15          preliminary findings and recommendations; and

16          (3) consider the comments received under para-  
17          graph (2) in developing the final MediCORE Budget  
18          Report to be submitted to Congress pursuant to  
19          section 703.

20 **SEC. 703. SUBMISSION TO CONGRESS.**

21          (a) **IN GENERAL.**—Not later than 4 months prior to  
22          the effective date of the Act referred to in section 801,  
23          and prior to January 1 of each succeeding calendar year,  
24          the Board shall submit the final MediCORE Budget  
25          Report to Congress.

1 (b) INCOME REQUIREMENTS.—With respect to a cal-  
2 endar year for which the Board determines in the  
3 MediCORE Budget Report that the Federal income and  
4 administrative expenses required under this Act exceed the  
5 amounts expected to be available from the MediCORE  
6 Trust Fund for such calendar year, the Board shall rec-  
7 ommend in the MediCORE Budget Report one of the  
8 following:

9 (1) That a reduction be made in the CORE  
10 SERVICES covered under section 301 to the extent  
11 necessary to meet the limitation of such Budget,  
12 with a description of the details as to the manner in  
13 which such a reduction will be accomplished (which  
14 may include the establishment of restrictions on the  
15 availability of services so as to achieve the greatest  
16 possible social benefit). The Report shall also con-  
17 tain guidelines for the States as to the methodology  
18 of and the cost containment measures for the States  
19 to accomplish the reduction.

20 (2) That an increase be made in the revenues  
21 generated for deposit into the MediCORE Trust  
22 Fund.

23 (3) That a combination of the measures de-  
24 scribed in paragraphs (1) and (2) be implemented.

1 **SEC. 704. ACTION BY CONGRESS.**

2 If Congress fails to act with respect to any increase  
3 in funds recommended under section 703(b)(2) and (3)  
4 within 2 months of the date of the submission of the  
5 MediCORE Budget, the Board shall proceed to reduce the  
6 CORE SERVICES covered under section 301 as required  
7 by the recommendation referred to in section 703(b)(1).

8 **TITLE VIII—EFFECTIVE DATE;  
9 REPEALS; TRANSITION; RELA-  
10 TION TO ERISA**

11 **SEC. 801. EFFECTIVE DATE.**

12 The program established under this Act shall become  
13 effective in each State on January 1 of the first calendar  
14 year beginning after the date that is 24 months after the  
15 date of enactment of this Act.

16 **SEC. 802. REPEALS.**

17 (a) IN GENERAL.—Titles XVIII and XIX of the So-  
18 cial Security Act and chapter 89 of title 5, United States  
19 Code, are repealed.

20 (b) REPEAL OF CHAMPUS PROVISIONS.—

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

25 (2) TABLE OF SECTIONS.—The table of sections  
26 at the beginning of chapter 55 of title 10, United

1 States Code, is amended by striking out the items  
2 relating to the sections referred to in paragraph (1).

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

6 (A) DEFINITION.—Section 1072 is amend-  
7 ed by striking out paragraph (4).

8 (B) REIMBURSEMENT OF THE DEPART-  
9 MENT OF VETERANS AFFAIRS.—Section  
10 1104(b) is amended—

11 (i) in the subsection heading, by strik-  
12 ing out “**from CHAMPUS funds**”;  
13 and

14 (ii) by striking out “from funds” and  
15 all that follows and inserting in lieu thereof  
16 “for medical care provided by the Depart-  
17 ment of Veterans Affairs pursuant to such  
18 agreement.”.

19 (c) HEALTH CARE FINANCING ADMINISTRATION.—  
20 Upon the effective date of the repeals described in sub-  
21 section (a), the duties and activities of the Health Care  
22 Financing Administration shall be transferred to and  
23 assumed by the Board.

1 (d) EFFECTIVE DATE.—The repeals and amend-  
2 ments made by this section shall take effect on the first  
3 day of the year described in section 801.

4 **SEC. 803. AUTHORIZATION OF APPROPRIATIONS AND**  
5 **TRANSITION.**

6 (a) AUTHORIZATION OF APPROPRIATIONS.—There  
7 are authorized to be appropriated for each of the fiscal  
8 years beginning after the effective date referred to in sec-  
9 tion 801, such sums as may be necessary to provide for  
10 financial assistance to States in the planning and develop-  
11 ment of State programs.

12 (b) REGULATIONS.—The Board shall issue such reg-  
13 ulations as are necessary to provide for a transition to the  
14 MediCORE health care program established under this  
15 Act from the programs repealed under section 802.

16 **SEC. 804. RELATION TO ERISA.**

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

20 **SEC. 805. RELATION TO OTHER LAWS.**

21 (a) IN GENERAL.—Notwithstanding any provision of  
22 the antitrust laws, it shall not be considered a violation  
23 of the antitrust laws for a State to develop or implement  
24 a State program under this Act.

1 (b) DEFINITION.—For purposes of subsection (a),  
2 the term “antitrust laws” means—

3 (1) the Act entitled “An Act to protect trade  
4 and commerce against unlawful restraints and mo-  
5 nopolies”, approved July 2, 1890, commonly known  
6 as the Sherman Act (26 Stat. 209; chapter 647; 15  
7 U.S.C. 1 et seq.);

8 (2) the Federal Trade Commission Act, ap-  
9 proved September 26, 1914 (38 Stat. 717; chapter  
10 311; 15 U.S.C. 41 et seq.);

11 (3) the Act entitled “An Act to supplement ex-  
12 isting laws against unlawful restraints and monop-  
13 lies”, and for other purposes, approved October 15,  
14 1914, commonly known as the Clayton Act (38 Stat.  
15 730; chapter 323; 15 U.S.C. 12 et seq.; 18 U.S.C.  
16 402, 660, 3285, 3691; 29 U.S.C. 52, 53); and

17 (4) any State antitrust laws that would prohibit  
18 the State from carrying out a State program under  
19 this Act.

○

S 1057 IS—2

S 1057 IS—3

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