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AMENDMENT-IN-THE-NATURE-OF-A-SUBSTITUTE TO H.R. 3962, AS REPORTED

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(Amendment is to either H.R. 3200 or to H.R. 3962)

Strike all after the enacting clause and insert the following:

SECTION 1. SHORT TITLE; TABLE OF CONTENTS; REFERENCES.

(a) SHORT TITLE.—This Act may be cited as the "Expanded and Improved Medicare for All Act".

(b) TABLE OF CONTENTS.—The table of contents of this Act is as follows:

(c) REFERENCES TO THIS ACT.—References in section 2 and titles I through V of this Act to "this Act" shall be deemed, unless the context otherwise requires, to such section and such titles.

(d) PURPOSE.—

(1) IN GENERAL.—This Act is intended to provide improved and expanded Medicare benefits to all American through a new Medicare for All program.

(2) PROTECTION OF CURRENT MEDICARE BENEFICIARIES.—Medicare will not be eliminated, but rather current Medicare beneficiaries shall receive improved coverage with no co-pays or deductibles through this Act.

SEC. 2. DEFINITIONS AND TERMS.

In this section and titles I through V:

(1) MEDICARE FOR ALL PROGRAM; PROGRAM.—The terms "Medicare for All Program" and "Program" mean the program of benefits provided under such titles and, unless the context otherwise requires, the Secretary with respect to functions relating to carrying out such program.

(2) NATIONAL BOARD OF UNIVERSAL QUALITY AND ACCESS.—The term "National Board of Universal Quality and Access" means such Board established under section 305.

(3) REGIONAL OFFICE.—The term "regional office" means a regional office established under section 303.

(4) SECRETARY.—The term "Secretary" means the Secretary of Health and Human Services.

(5) DIRECTOR.—The term "Director" means, in relation to the Program, the Director appointed under section 301.

TITLE I—ELIGIBILITY AND BENEFITS

SEC. 101. ELIGIBILITY AND REGISTRATION.

(a) IN GENERAL.—All individuals lawfully residing in the United States (including any territory of the United States) are covered under the Medicare for All Program entitling them to a universal, best quality standard of care. Each such individual shall receive a card with a unique number in the mail. An individual's social security number shall not be used for purposes of registration under this section.

(b) REGISTRATION.—Individuals and families shall receive a United States National Health Insurance Card in the mail, after filling out a United States National Health Insurance application form at a health care provider. Such application form shall be no more than 2 pages long.

(c) PRESUMPTION.—Individuals who present themselves for covered services from a participating provider shall be presumed to be eligible for benefits under this Act, but shall complete an application for benefits in order to

receive a United States National Health Insurance Card and have payment made for such benefits.

(d) RESIDENCY CRITERIA.—The Secretary shall promulgate a rule that provides criteria for determining residency for eligibility purposes under the Medicare for All Program.

(e) COVERAGE FOR VISITORS.—The Secretary shall promulgate a rule regarding visitors from other countries who seek premeditated non-emergency surgical procedures. Such a rule should facilitate the establishment of country-to-country reimbursement arrangements or self pay arrangements between the visitor and the provider of care.

SEC. 102. BENEFITS AND PORTABILITY.

(a) IN GENERAL.—The health care benefits under this Act cover all of the following medically necessary services:

(1) Hospitalization.

(2) Outpatient hospital and outpatient clinic services, including emergency department services.

(3) Professional services of physicians and other health professionals.

(4) Such services, equipment, and supplies incident to the services of a physician's or a health professional's delivery of care in institutional settings,

physician offices, patients' homes or place of residence, or other settings, as appropriate.

(5) Prescription drugs.

(6) Rehabilitative and habilitative services.

(7) Mental health and substance use disorder services, including behavioral health treatments.

(8) Preventive services, including those services recommended with a grade of A or B by the Task Force on Clinical Preventive Services and those vaccines recommended for use by the Director of the Centers for Disease Control and Prevention.

(9) Maternity care.

(10) Well baby and well child care; treatment of a congenital or developmental deformity, disease, or injury; and oral health, vision, and hearing services, equipment, and supplies at least for children under 21 years of age.

(11) Long-term care.

(b) PORTABILITY.—Such benefits are available through any licensed health care clinician anywhere in the United States that is legally qualified to provide the benefits.

(c) NO COST-SHARING.—No deductibles, copayments, coinsurance, or other cost-sharing shall be imposed with respect to covered benefits.

SEC. 103. QUALIFICATION OF PARTICIPATING PROVIDERS.

(a) QUALITY STANDARDS.—

(1) IN GENERAL.—Health care delivery facilities must meet State quality and licensing guidelines as a condition of participation under such program, including guidelines regarding safe staffing and quality of care.

(2) LICENSURE REQUIREMENTS.—Participating clinicians must be licensed in their State of practice and meet the quality standards for their area of care. No clinician whose license is under suspension or who is under disciplinary action in any State may be a participating provider.

(b) PARTICIPATION OF HEALTH MAINTENANCE ORGANIZATIONS.—

(1) IN GENERAL.—Health maintenance organizations that deliver care in their own facilities and employ clinicians on a salaried basis may participate in the program and receive global budgets or capitation payments as specified in section 202.

(2) EXCLUSION OF CERTAIN HEALTH MAINTENANCE ORGANIZATIONS.—Other health maintenance organizations, including those which principally contract to pay for services delivered by non-employees, shall be classified as insurance plans. Such organizations shall not be participating providers, and are

subject to the regulations promulgated by reason of section 104(a) (relating to prohibition against duplicating coverage).

(c) FREEDOM OF CHOICE.—Patients shall have free choice of participating physicians and other clinicians, hospitals, and inpatient care facilities.

SEC. 104. PROHIBITION AGAINST DUPLICATING COVERAGE.

(a) IN GENERAL.—It is unlawful for a private health insurer to sell health insurance coverage that duplicates the benefits provided under this Act.

(b) CONSTRUCTION.—Nothing in this Act shall be construed as prohibiting the sale of health insurance coverage for any additional benefits not covered by this Act, such as for cosmetic surgery or other services and items that are not medically necessary.

TITLE II—FINANCES

Subtitle A—Budgeting and Payments

SEC. 201. BUDGETING PROCESS.

(a) ESTABLISHMENT OF OPERATING BUDGET AND CAPITAL EXPENDITURES BUDGET.—

(1) IN GENERAL.—To carry out this Act there are established on an annual basis consistent with this title—

(A) an operating budget, including amounts for optimal physician, nurse, and other health care professional staffing;

(B) a capital expenditures budget;

(C) reimbursement levels for providers consistent with this subtitle;

(D) a health professional education budget, including amounts for the continued funding of resident physician training programs; and

(E)) a budget, based on historical expenditures for the previous fiscal year, for miscellaneous items, such as building and equipment maintenance, minor equipment purchases, and other general costs, not to exceed a per item amount stipulated annually by the Director.

(2) REGIONAL ALLOCATION.—After Congress appropriates amounts for the annual budget for the Medicare for All Program, the Director shall provide the regional offices with an annual funding allotment to cover the costs of each region's expenditures. Such allotment shall cover global budgets, reimbursements to clinicians, health professional education, and capital expenditures. Regional offices may receive additional funds from the national program at the discretion of the Director.

(b) OPERATING BUDGET.—The operating budget shall be used for—

(1) payment for services rendered by physicians and other clinicians;

(2) global budgets for institutional providers;

(3) capitation payments for capitated groups; and

(4) administration of the Program.

(c) CAPITAL EXPENDITURES BUDGET.—The capital expenditures budget shall be used for funds needed for—

(1) the construction or renovation of health facilities; and

(2) for major equipment purchases.

(d) PROHIBITION AGAINST CO-MINGLING OPERATIONS AND CAPITAL IMPROVEMENT FUNDS.—It is prohibited to use funds under this Act that are earmarked—

(1) for operations for capital expenditures; or

(2) for capital expenditures for operations.

(e) MECHANISMS TO ENSURE BUDGET NEUTRALITY.—The Director, in consultation with the National Board of Universal Quality and Access, shall establish mechanisms in order to seek to ensure that expenditures under this title do not exceed the aggregate amount of revenues available to cover such expenditures , except in the case of unanticipated public health emergencies,

such as pandemics. Such mechanisms may include mechanisms such as the following:

(1) Holding chief executive and financial officers of institutional providers accountable for maintaining expenditures within the institution's global budget under this title.

(2) Requiring that the amount of any expenditures in a fiscal year in excess of the budget for such fiscal year be counted as a reduction of revenues available for expenditure in the succeeding fiscal year.

SEC. 202. PAYMENT OF PROVIDERS AND HEALTH CARE CLINICIANS.

(a) ESTABLISHING GLOBAL BUDGETS FOR INSTITUTIONAL PROVIDERS; QUARTERLY LUMP SUM.—

(1) IN GENERAL.—The Medicare for All Program, through its regional offices, shall pay each institutional provider of care, including hospitals, nursing homes, community or migrant health centers, home care agencies, or other institutional providers or prepaid group practices, a quarterly lump sum to cover all operating expenses under a global budget.

(2) ESTABLISHMENT OF GLOBAL BUDGETS.—The global budget of each institutional provider

shall be set by the Director, following consultations with State and Regional directors. Such budget shall have three main components:

(A) BASE BUDGET.—A base budget consisting of audited and verified expenditures, by such categories as the Director may set, for the previous 2-year period.

(B) ADJUSTED BASE BUDGET.—An adjusted base budget consisting of a fixed percentage increase in the base budget, set by the Director, to allow for inflation from the base period described in subparagraph (A).

(C) ADDITIONAL AMOUNT.—An additional amount, to be negotiated between the Director and the State, Regional, and Institutional directors, to accommodate any new or expanded programs approved by the Director, as well as projected increases or decreases in the volumes of specific services and support activities.

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Negotiations shall occur only under subparagraph (C) and not under subparagraph (A) or (B). The Medicare for All Program, through its regional offices, shall pay each institutional provider of care, including hospitals, nursing homes, community or

migrant health centers, home care agencies, or other institutional providers or pre-paid group practices, a quarterly lump sum to cover all operating expenses under the provider's global budget.

(3) BUDGET APPROVAL PROCESS.—

(A) IN GENERAL.—The Director shall provide budgets only for such institutional providers as the Director has previously received proposals from and approved. Such an approved institutional provider status shall continue for a period established by the Director, except that the Director may terminate such status, after having given due notice and provided funding for the reasonable costs of ending the relationship.

(B) RIGHT TO RAISE FUNDS.—Each approved institutional provider has the right to raise funds for its approved objectives, from local or regional charities and community groups. Such funds may be used at the discretion of the provider, except that they may not be used to establish a new clinical program unless such funding is both in perpetuity and adequate to cover the full cost of such clinical program.

(C) AUDITING.—Each approved institutional provider shall keep audited financial records using categories established by the Director and shall identify to the Director in the course of annual budget process the actual cost of each main clinical service and main operational activity conducted by the provider.

(D) NO BUDGET APPROVAL FOR INSTITUTIONAL PROVIDERS IN STATES FAILING TO PAY AMOUNTS REQUIRED.—The Director shall not approve a budget of an institutional provider in a State, or make payment based on such a budget for such a provider, unless the State has provided for timely payments of amounts owed under section 211(c)(4).

(4) INCENTIVES FOR EFFICIENCY.—In establishing and implementing global budgets, the Director—

(A) shall provide incentives for institutional providers to maintain costs below the global budget amount, such as payment of amounts above such costs;

(B) shall provide for a reduction in the global budget for a succeeding year insofar as

the hospital expenses exceed the global budget for the previous year; and

(C) in the case of repeated instances of unauthorized expenditures above the approved annual budget, may terminate permanently all funding for programs subject to such overages and recommend such changes in management and financial control procedures as the Director believes to be appropriate.

(5) ACCOMMODATION FOR EMERGENCY CARE.—In the case of a hospital that has a high volume of emergency services for individuals not described in section 101(a), the costs of such care shall be taken into account when negotiating the hospital's global budget under this subsection.

(b) THREE PAYMENT OPTIONS FOR PHYSICIANS AND CERTAIN OTHER HEALTH PROFESSIONALS.—

(1) IN GENERAL.—The Program shall pay physicians, dentists, doctors of osteopathy, pharmacists, psychologists, chiropractors, doctors of optometry, nurse practitioners, nurse midwives, physicians' assistants, and other advanced practice clinicians as licensed and regulated by the States by the following payment methods:

(A) Fee for service payment under paragraph (2).

(B) Salaried positions in institutions receiving global budgets under paragraph (3).

(C) Salaried positions within group practices or non-profit health maintenance organizations receiving capitation payments under paragraph (4).

(2) FEE FOR SERVICE.—

(A) IN GENERAL.—The Program shall negotiate a simplified fee schedule that is fair and optimal with representatives of physicians and other clinicians, after close consultation with the National Board of Universal Quality and Access and regional and State directors. Initially, the current prevailing fees or reimbursement would be the basis for the fee negotiation for all professional services covered under this Act.

(B) CONSIDERATIONS.—In establishing such schedule, the Director shall take into consideration the following:

(i) The need for a uniform national standard.

(ii) The goal of ensuring that physicians, clinicians, pharmacists, and other medical professionals be compensated at a rate which reflects their expertise and the value of their services, regardless of geographic region and past fee schedules.

(C) STATE PHYSICIAN PRACTICE REVIEW BOARDS.—The State director for each State, in consultation with representatives of the physician community of that State, shall establish and appoint a physician practice review board to assure quality, cost effectiveness, and fair reimbursements for physician delivered services.

(D) FINAL GUIDELINES.—The Director shall be responsible for promulgating final guidelines to all providers.

(E) BILLING.—Under this Act physicians shall submit bills to the regional director on a simple form, or via computer. Interest shall be paid to providers who are not reimbursed within 30 days of submission.

(F) NO BALANCE BILLING.—Licensed health care clinicians who accept any payment from the Medicare for All Program may not bill any patient for any covered service.

(G) UNIFORM COMPUTER ELECTRONIC BILLING SYSTEM.—The Director shall create a uniform computerized electronic billing system, including those areas of the United States where electronic billing is not yet established.

(3) SALARIES WITHIN INSTITUTIONS RECEIVING GLOBAL BUDGETS.—

(A) IN GENERAL.—In the case of an institution, such as a hospital, health center, group practice, community and migrant health center, or a home care agency that elects to be paid a quarterly global budget for the delivery of health care as well as for education and prevention programs, physicians and other clinicians employed by such institutions shall be reimbursed through a salary included as part of such a budget.

(B) SALARY RANGES.—Salary ranges for health care providers shall be determined in the same way as fee schedules under paragraph (2).

(4) SALARIES WITHIN CAPITATED GROUPS.—

(A) IN GENERAL.—Health maintenance organizations, group practices, and other institutions may elect to be paid capitation payments to cover all outpatient, physician, and medical

home care provided to individuals enrolled to receive benefits through the organization or entity.

(B) SCOPE.—Such capitation may include the costs of services of licensed physicians and other licensed, independent practitioners provided to inpatients. Other costs of inpatient and institutional care shall be excluded from capitation payments, and shall be covered under institutions' global budgets.

(C) PROHIBITION OF SELECTIVE ENROLLMENT.—Patients shall be permitted to enroll or disenroll from such organizations or entities without discrimination and with appropriate notice.

(D) HEALTH MAINTENANCE ORGANIZATIONS.—Under this Act—

(i) health maintenance organizations shall be required to reimburse physicians based on a salary; and

(ii) financial incentives between such organizations and physicians based on utilization are prohibited.

SEC. 203. PAYMENT FOR LONG-TERM CARE.

(a) ALLOTMENT FOR REGIONS.—The Program shall provide for each region a single budgetary allotment to cover a full array of long-term care services under this Act.

(b) REGIONAL BUDGETS.—Each region shall provide a global budget to local long-term care providers for the full range of needed services, including in-home, nursing home, and community based care.

(c) BASIS FOR BUDGETS.—Budgets for long-term care services under this section shall be based on past expenditures, financial and clinical performance, utilization, and projected changes in service, wages, and other related factors.

(d) FAVORING NON-INSTITUTIONAL CARE.—All efforts shall be made under this Act to provide long-term care in a home- or community-based setting, as opposed to institutional care.

SEC. 204. MENTAL HEALTH SERVICES.

(a) IN GENERAL.—The Program shall provide coverage for all medically necessary mental health care on the same basis as the coverage for other conditions. Licensed mental health clinicians shall be paid in the same manner as specified for other health professionals, as provided for in section 202(b).

(b) FAVORING COMMUNITY-BASED CARE.—The Medicare for All Program shall cover supportive residences, occupational therapy, and ongoing mental health and counseling services outside the hospital for patients with serious mental illness. In all cases the highest quality and most effective care shall be delivered, and, for some individuals, this may mean institutional care.

SEC. 205. PAYMENT FOR PRESCRIPTION MEDICATIONS, MEDICAL SUPPLIES, AND MEDICALLY NECESSARY ASSISTIVE EQUIPMENT.

(a) NEGOTIATED PRICES.—The prices to be paid each year under this Act for covered pharmaceuticals, medical supplies, and medically necessary assistive equipment shall be negotiated annually by the Program.

(b) PRESCRIPTION DRUG FORMULARY.—

(1) IN GENERAL.—The Program shall establish a prescription drug formulary system, which shall encourage best-practices in prescribing and discourage the use of ineffective, dangerous, or excessively costly medications when better alternatives are available.

(2) PROMOTION OF USE OF GENERICS.—The formulary shall promote the use of generic medications but allow the use of brand-name and off-formulary medications.

(3) FORMULARY UPDATES AND PETITION RIGHTS.—The formulary shall be updated frequently and clinicians and patients may petition their region or the Director to add new pharmaceuticals or to remove ineffective or dangerous medications from the formulary.

SEC. 206. CONSULTATION IN ESTABLISHING REIMBURSEMENT LEVELS.

Reimbursement levels under this subtitle shall be set after close consultation with regional and State Directors and after the annual meeting of National Board of Universal Quality and Access.

Subtitle B—Funding

SEC. 211. OVERVIEW: FUNDING THE MEDICARE FOR ALL PROGRAM.

(a) IN GENERAL.—The Medicare for All Program is to be funded as provided in subsection (c)(1).

(b) MEDICARE FOR ALL TRUST FUND.—There shall be established a Medicare for All Trust Fund in which funds provided under this section are deposited and from which expenditures under this Act are made.

(c) FUNDING.—

(1) IN GENERAL.—There are appropriated to the Medicare for All Trust Fund amounts sufficient to carry out this Act from the following sources:

(A) Existing sources of Federal Government revenues for health care.

(B) The revenue provisions contained in subtitle C.

(2) SYSTEM SAVINGS AS A SOURCE OF FINANCING.—Funding otherwise required for the Program is reduced as a result of—

(A) vastly reducing paperwork;

(B) requiring a rational bulk procurement of medications under section 205(a); and

(C) improved access to preventive health care.

(3) ADDITIONAL ANNUAL APPROPRIATIONS TO MEDICARE FOR ALL PROGRAM.—Additional sums are authorized to be appropriated annually as needed to maintain maximum quality, efficiency, and access under the Program.

(4) STATE FUNDING REQUIRED; PROHIBITION OF LOCAL CONTRIBUTIONS.—Each State (as defined for purposes of title XIX of the Social Security Act)—

(A) shall provide for payment (on a monthly or such other periodic basis as the Secretary shall specify) to the Director to the credit of the Medicare for All Trust Fund an amount equiva-

lent, on an annual basis, to 75 percent of the aggregate non-Federal payments made under the State's plans under title XIX and XXI of such Act during fiscal year 2009; and

(B) may not require (in any manner, including the manner described in section 1902(a)(2) of such Act) that a political subdivision within the State to contribute towards the payment required under subparagraph (A).

SEC. 212. APPROPRIATIONS FOR EXISTING PROGRAMS.

(a) IN GENERAL.—Notwithstanding any other provision of law, subject to subsection (b), there are hereby transferred and appropriated to carry out this Act, amounts from the Treasury equivalent to the amounts the Secretary estimates would have been appropriated and expended for Federal public health care programs, including funds that would have been appropriated under the Medicare program under title XVIII of the Social Security Act, under the Medicaid program under title XIX of such Act, under the Children's Health Insurance Program under title XXI of such Act, under the Federal employees health benefits program under chapter 89 of title 5, United States Code, health coverage provided through the Department of Defense, community health center grants, and maternal and child health funding, but not including ex-

penditures for health care through the Department of Veterans Affairs and through the Indian Health Service (including expenditures under the Indian Health Care Improvement Act).

(b) AMOUNTS SPECIFIED.—

(1) INITIAL PERIOD.—For purposes of subsection (a), the aggregate amount specified in such subsection for each of fiscal years 2013 through 2018 are as follows (based on estimates as set forth by the Centers for Medicare & Medicaid Services for its National Health Expenditures (NHE) Projections annual report categorized under total public payments as most recently published before the date of the enactment of this Act):

(A) For fiscal year 2013, $1,527,400,000,000.

(B) For fiscal year 2014, $1,640,300,000,000.

(C) For fiscal year 2015, $1,768,400,000,000.

(D) For fiscal year 2016, $1,908,900,000,000.

(E) For fiscal year 2017, $2,064,300,000,000.

(F) For fiscal year 2018, $2,233,000,000,000.

(2) SUBSEQUENT YEARS.—For subsequent fiscal years, the Secretary shall estimate the aggregate amount under subsection (a) based on the average annual percentage increase in the amounts specified in paragraph (1).

Subtitle C—Revenue Provisions

SEC. 221. IMPOSITION OF UNITED STATES HEALTH PROGRAM PAYROLL TAX.

(a) TAX ON EMPLOYEES.—Subsection (b) of section 3101 of the Internal Revenue Code of 1986 is amended to read as follows:

"(b) UNITED STATES HEALTH PROGRAM.—In addition to the tax imposed by the preceding subsection, there is hereby imposed on the income of every individual a tax equal to 6 percent of the wages (as defined in section 3121(a)) received by such individual with respect to employment (as defined in section 3121(b)).".

(b) TAX ON EMPLOYERS.—Subsection (b) of section 3111 of such Code is amended to read as follows:

"(b) UNITED STATES HEALTH PROGRAM.—In addition to the tax imposed by the preceding subsection, there is hereby imposed on every employer an excise tax, with respect to having individuals in the employer's employ,

equal to 8 percent of the wages (as defined in section 3121(a)) paid by the employer with respect to employment (as defined in section 3121(b)).".

(c) SELF-EMPLOYMENT TAX.—Subsection (b) of section 1401 of such Code is amended to read as follows:

"(b) UNITED STATES HEALTH PROGRAM.—In addition to the tax imposed by the preceding subsection, there shall be imposed for each taxable year, on the self-employment income of every individual, a tax equal to the 10 percent of the amount of the self-employment income for such taxable year.".

(d) TRANSFERS TO MEDICARE FOR ALL TRUST FUND.—Notwithstanding any other provision of law, revenues received under sections 3101(b), 3111(b), and 1401(b) of the Internal Revenue Code with respect to periods beginning after December 31, 2010 shall—

(1) be periodically transferred to the Medicare for All Trust Fund, and

(2) no transfers shall be made to the Federal Hospital Insurance Trust Fund with respect to such revenues.

(e) EFFECTIVE DATE.—The amendments made by this section shall apply to periods beginning after December 31, 2012.

SEC. 222. SURCHARGE ON HIGH INCOME INDIVIDUALS.

(a) IN GENERAL.—Part VIII of subchapter A of chapter 1 of the Internal Revenue Code of 1986, as added by this title, is amended by adding at the end the following new subpart:

"Subpart B—Surcharge on High Income Individuals

"Sec. 59C. Surcharge on high income individuals.

"SEC. 59C. SURCHARGE ON HIGH INCOME INDIVIDUALS.

"(a) GENERAL RULE.—In the case of a taxpayer other than a corporation, there is hereby imposed (in addition to any other tax imposed by this subtitle) a tax equal to—

"(1) 1 percent of so much of the modified adjusted gross income of the taxpayer as exceeds $350,000 but does not exceed $500,000,

"(2) 1.5 percent of so much of the modified adjusted gross income of the taxpayer as exceeds $500,000 but does not exceed $1,000,000, and

"(3) 5.4 percent of so much of the modified adjusted gross income of the taxpayer as exceeds $1,000,000.

"(b) TAXPAYERS NOT MAKING A JOINT RETURN.—In the case of any taxpayer other than a taxpayer making a joint return under section 6013 or a surviving spouse (as defined in section 2(a)), subsection (a) shall be applied by substituting for each of the dollar amounts therein

(after any increase determined under subsection (e)) a dollar amount equal to—

"(1) 50 percent of the dollar amount so in effect in the case of a married individual filing a separate return, and

"(2) 80 percent of the dollar amount so in effect in any other case.

"(c) ADJUSTMENTS BASED ON FEDERAL HEALTH REFORM SAVINGS.—

"(1) IN GENERAL.—Except as provided in paragraph (2), in the case of any taxable year beginning after December 31, 2012, subsection (a) shall be applied—

"(A) by substituting '2 percent' for '1 percent', and

"(B) by substituting '3 percent' for '1.5 percent'.

"(2) ADJUSTMENTS BASED ON EXCESS FEDERAL HEALTH REFORM SAVINGS.—

"(A) EXCEPTION IF FEDERAL HEALTH REFORM SAVINGS SIGNIFICANTLY EXCEEDS BASE AMOUNT.—If the excess Federal health reform savings is more than $150,000,000,000 but not more than $175,000,000,000, paragraph (1) shall not apply.

"(B) FURTHER ADJUSTMENT FOR ADDITIONAL FEDERAL HEALTH REFORM SAVINGS.—If the excess Federal health reform savings is more than $175,000,000,000, paragraphs (1) and (2) of subsection (a) (and paragraph (1) of this subsection) shall not apply to any taxable year beginning after December 31, 2012.

"(C) EXCESS FEDERAL HEALTH REFORM SAVINGS.—For purposes of this subsection, the term 'excess Federal health reform savings' means the excess of—

"(i) the Federal health reform savings, over

"(ii) $525,000,000,000.

"(D) FEDERAL HEALTH REFORM SAVINGS.—The term 'Federal health reform savings' means the sum of the amounts described in subparagraphs (A) and (B) of paragraph (3).

"(3) DETERMINATION OF FEDERAL HEALTH REFORM SAVINGS.—Not later than December 1, 2012, the Director of the Office of Management and Budget shall—

"(A) determine, on the basis of the study conducted under paragraph (4), the aggregate reductions in Federal expenditures which have

been achieved as a result of the provisions of, and amendments made by, the Expanded and Improved Medicare for All Act during the period beginning on October 1, 2009, and ending with the latest date with respect to which the Director has sufficient data to make such determination, and

"(B) estimate, on the basis of such study and the determination under subparagraph (A), the aggregate reductions in Federal expenditures which will be achieved as a result of such provisions and amendments during so much of the period beginning with fiscal year 2010 and ending with fiscal year 2019 as is not taken into account under subparagraph (A).

"(4) STUDY OF FEDERAL HEALTH REFORM SAVINGS.—The Director of the Office of Management and Budget shall conduct a study of the reductions in Federal expenditures during fiscal years 2010 through 2019 which are attributable to the provisions of, and amendments made by, the Expanded and Improved Medicare for All Act. The Director shall complete such study not later than December 1, 2012.

"(5) REDUCTIONS IN FEDERAL EXPENDITURES DETERMINED WITHOUT REGARD TO PROGRAM INVESTMENTS.—For purposes of paragraphs (3) and (4), reductions in Federal expenditures shall be determined without regard to program investments under the Expanded and Improved Medicare for All Act.

"(d) MODIFIED ADJUSTED GROSS INCOME.—For purposes of this section, the term 'modified adjusted gross income' means adjusted gross income reduced by any deduction (not taken into account in determining adjusted gross income) allowed for investment interest (as defined in section 163(d)). In the case of an estate or trust, adjusted gross income shall be determined as provided in section 67(e).

"(e) INFLATION ADJUSTMENTS.—

"(1) IN GENERAL.—In the case of taxable years beginning after 2011, the dollar amounts in subsection (a) shall be increased by an amount equal to—

"(A) such dollar amount, multiplied by

"(B) the cost-of-living adjustment determined under section 1(f)(3) for the calendar year in which the taxable year begins, by sub-

stituting 'calendar year 2010' for 'calendar year 1992' in subparagraph (B) thereof.

"(2) ROUNDING.—If any amount as adjusted under paragraph (1) is not a multiple of $5,000, such amount shall be rounded to the next lowest multiple of $5,000.

"(f) SPECIAL RULES.—

"(1) NONRESIDENT ALIEN.—In the case of a nonresident alien individual, only amounts taken into account in connection with the tax imposed under section 871(b) shall be taken into account under this section.

"(2) CITIZENS AND RESIDENTS LIVING ABROAD.—The dollar amounts in effect under subsection (a) (after the application of subsections (b) and (e)) shall be decreased by the excess of—

"(A) the amounts excluded from the taxpayer's gross income under section 911, over

"(B) the amounts of any deductions or exclusions disallowed under section 911(d)(6) with respect to the amounts described in subparagraph (A).

"(3) CHARITABLE TRUSTS.—Subsection (a) shall not apply to a trust all the unexpired interests

in which are devoted to one or more of the purposes described in section 170(c)(2)(B).

"(4) NOT TREATED AS TAX IMPOSED BY THIS CHAPTER FOR CERTAIN PURPOSES.—The tax imposed under this section shall not be treated as tax imposed by this chapter for purposes of determining the amount of any credit under this chapter or for purposes of section 55.".

(b) CLERICAL AMENDMENT.—The table of subparts for part VIII of subchapter A of chapter 1 of such Code, as added by this title, is amended by inserting after the item relating to subpart A the following new item:

"SUBPART B. SURCHARGE ON HIGH INCOME INDIVIDUALS.".

(c) SECTION 15 NOT TO APPLY.—The amendment made by subsection (a) shall not be treated as a change in a rate of tax for purposes of section 15 of the Internal Revenue Code of 1986.

(d) EFFECTIVE DATE.—The amendments made by this section shall apply to taxable years beginning after December 31, 2010.

SEC. 223. DELAY IN APPLICATION OF WORLDWIDE ALLOCATION OF INTEREST.

(a) IN GENERAL.—Paragraphs (5)(D) and (6) of section 864(f) of the Internal Revenue Code of 1986 are each amended by striking "December 31, 2010" and inserting "December 31, 2019".

(b) TRANSITION.—Subsection (f) of section 864 of such Code is amended by striking paragraph (7).

SEC. 224. LIMITATION ON TREATY BENEFITS FOR CERTAIN DEDUCTIBLE PAYMENTS.

(a) IN GENERAL.—Section 894 of the Internal Revenue Code of 1986 (relating to income affected by treaty) is amended by adding at the end the following new subsection:

"(d) LIMITATION ON TREATY BENEFITS FOR CERTAIN DEDUCTIBLE PAYMENTS.—

"(1) IN GENERAL.—In the case of any deductible related-party payment, any withholding tax imposed under chapter 3 (and any tax imposed under subpart A or B of this part) with respect to such payment may not be reduced under any treaty of the United States unless any such withholding tax would be reduced under a treaty of the United States if such payment were made directly to the foreign parent corporation.

"(2) DEDUCTIBLE RELATED-PARTY PAYMENT.—For purposes of this subsection, the term 'deductible related-party payment' means any payment made, directly or indirectly, by any person to any other person if the payment is allowable as a deduction under this chapter and both persons are

members of the same foreign controlled group of entities.

"(3) FOREIGN CONTROLLED GROUP OF ENTITIES.—For purposes of this subsection—

"(A) IN GENERAL.—The term 'foreign controlled group of entities' means a controlled group of entities the common parent of which is a foreign corporation.

"(B) CONTROLLED GROUP OF ENTITIES.—The term 'controlled group of entities' means a controlled group of corporations as defined in section 1563(a)(1), except that—

"(i) 'more than 50 percent' shall be substituted for 'at least 80 percent' each place it appears therein, and

"(ii) the determination shall be made without regard to subsections (a)(4) and (b)(2) of section 1563.

A partnership or any other entity (other than a corporation) shall be treated as a member of a controlled group of entities if such entity is controlled (within the meaning of section 954(d)(3)) by members of such group (including any entity treated as a member of such group by reason of this sentence).

"(4) FOREIGN PARENT CORPORATION.—For purposes of this subsection, the term 'foreign parent corporation' means, with respect to any deductible related-party payment, the common parent of the foreign controlled group of entities referred to in paragraph (3)(A).

"(5) REGULATIONS.—The Secretary may prescribe such regulations or other guidance as are necessary or appropriate to carry out the purposes of this subsection, including regulations or other guidance which provide for—

"(A) the treatment of two or more persons as members of a foreign controlled group of entities if such persons would be the common parent of such group if treated as one corporation, and

"(B) the treatment of any member of a foreign controlled group of entities as the common parent of such group if such treatment is appropriate taking into account the economic relationships among such entities.".

(b) EFFECTIVE DATE.—The amendment made by this section shall apply to payments made after the date of the enactment of this Act.

SEC. 225. CODIFICATION OF ECONOMIC SUBSTANCE DOCTRINE.

(a) IN GENERAL.—Section 7701 of the Internal Revenue Code of 1986 is amended by redesignating subsection (o) as subsection (p) and by inserting after subsection (n) the following new subsection:

"(o) CLARIFICATION OF ECONOMIC SUBSTANCE DOCTRINE.—

"(1) APPLICATION OF DOCTRINE.—In the case of any transaction to which the economic substance doctrine is relevant, such transaction shall be treated as having economic substance only if—

"(A) the transaction changes in a meaningful way (apart from Federal income tax effects) the taxpayer's economic position, and

"(B) the taxpayer has a substantial purpose (apart from Federal income tax effects) for entering into such transaction.

"(2) SPECIAL RULE WHERE TAXPAYER RELIES ON PROFIT POTENTIAL.—

"(A) IN GENERAL.—The potential for profit of a transaction shall be taken into account in determining whether the requirements of subparagraphs (A) and (B) of paragraph (1) are met with respect to the transaction only if the present value of the reasonably expected

pre-tax profit from the transaction is substantial in relation to the present value of the expected net tax benefits that would be allowed if the transaction were respected.

"(B) TREATMENT OF FEES AND FOREIGN TAXES.—Fees and other transaction expenses and foreign taxes shall be taken into account as expenses in determining pre-tax profit under subparagraph (A).

"(3) STATE AND LOCAL TAX BENEFITS.—For purposes of paragraph (1), any State or local income tax effect which is related to a Federal income tax effect shall be treated in the same manner as a Federal income tax effect.

"(4) FINANCIAL ACCOUNTING BENEFITS.—For purposes of paragraph (1)(B), achieving a financial accounting benefit shall not be taken into account as a purpose for entering into a transaction if the origin of such financial accounting benefit is a reduction of Federal income tax.

"(5) DEFINITIONS AND SPECIAL RULES.—For purposes of this subsection—

"(A) ECONOMIC SUBSTANCE DOCTRINE.—The term 'economic substance doctrine' means the common law doctrine under which tax bene-

fits under subtitle A with respect to a transaction are not allowable if the transaction does not have economic substance or lacks a business purpose.

"(B) EXCEPTION FOR PERSONAL TRANSACTIONS OF INDIVIDUALS.—In the case of an individual, paragraph (1) shall apply only to transactions entered into in connection with a trade or business or an activity engaged in for the production of income.

"(C) OTHER COMMON LAW DOCTRINES NOT AFFECTED.—Except as specifically provided in this subsection, the provisions of this subsection shall not be construed as altering or supplanting any other rule of law, and the requirements of this subsection shall be construed as being in addition to any such other rule of law.

"(D) DETERMINATION OF APPLICATION OF DOCTRINE NOT AFFECTED.—The determination of whether the economic substance doctrine is relevant to a transaction (or series of transactions) shall be made in the same manner as if this subsection had never been enacted.

"(6) REGULATIONS.—The Secretary shall prescribe such regulations as may be necessary or appropriate to carry out the purposes of this subsection.".

(b) EFFECTIVE DATE.—The amendments made by this section shall apply to transactions entered into after the date of the enactment of this Act.

SEC. 226. PENALTIES FOR UNDERPAYMENTS.

(a) PENALTY FOR UNDERPAYMENTS ATTRIBUTABLE TO TRANSACTIONS LACKING ECONOMIC SUBSTANCE.—

(1) IN GENERAL.—Subsection (b) of section 6662 of the Internal Revenue Code of 1986 is amended by inserting after paragraph (5) the following new paragraph:

"(6) Any disallowance of claimed tax benefits by reason of a transaction lacking economic substance (within the meaning of section 7701(o)) or failing to meet the requirements of any similar rule of law.".

(2) INCREASED PENALTY FOR NONDISCLOSED TRANSACTIONS.—Section 6662 of such Code is amended by adding at the end the following new subsection:

"(i) INCREASE IN PENALTY IN CASE OF NONDISCLOSED NONECONOMIC SUBSTANCE TRANSACTIONS.—

"(1) IN GENERAL.—In the case of any portion of an underpayment which is attributable to one or more nondisclosed noneconomic substance transactions, subsection (a) shall be applied with respect to such portion by substituting '40 percent' for '20 percent'.

"(2) NONDISCLOSED NONECONOMIC SUBSTANCE TRANSACTIONS.—For purposes of this subsection, the term 'nondisclosed noneconomic substance transaction' means any portion of a transaction described in subsection (b)(6) with respect to which the relevant facts affecting the tax treatment are not adequately disclosed in the return nor in a statement attached to the return.

"(3) SPECIAL RULE FOR AMENDED RETURNS.—Except as provided in regulations, in no event shall any amendment or supplement to a return of tax be taken into account for purposes of this subsection if the amendment or supplement is filed after the earlier of the date the taxpayer is first contacted by the Secretary regarding the examination of the return or such other date as is specified by the Secretary.".

(3) CONFORMING AMENDMENT.—Subparagraph (B) of section 6662A(e)(2) of such Code is amended—

(A) by striking "section 6662(h)" and inserting "subsections (h) or (i) of section 6662", and

(B) by striking "GROSS VALUATION MISSTATEMENT PENALTY" in the heading and inserting "CERTAIN INCREASED UNDERPAYMENT PENALTIES".

(b) REASONABLE CAUSE EXCEPTION NOT APPLICABLE TO NONECONOMIC SUBSTANCE TRANSACTIONS, TAX SHELTERS, AND CERTAIN LARGE OR PUBLICLY TRADED PERSONS.—Subsection (c) of section 6664 of such Code is amended—

(1) by redesignating paragraphs (2) and (3) as paragraphs (3) and (4), respectively,

(2) by striking "paragraph (2)" in paragraph (4), as so redesignated, and inserting "paragraph (3)", and

(3) by inserting after paragraph (1) the following new paragraph:

"(2) EXCEPTION.—Paragraph (1) shall not apply to—

"(A) to any portion of an underpayment which is attributable to one or more tax shelters (as defined in section 6662(d)(2)(C)) or transactions described in section 6662(b)(6), and

"(B) to any taxpayer if such taxpayer is a specified person (as defined in section 6662(d)(2)(D)(ii)).".

(c) APPLICATION OF PENALTY FOR ERRONEOUS CLAIM FOR REFUND OR CREDIT TO NONECONOMIC SUBSTANCE TRANSACTIONS.—Section 6676 of such Code is amended by redesignating subsection (c) as subsection (d) and inserting after subsection (b) the following new subsection:

"(c) NONECONOMIC SUBSTANCE TRANSACTIONS TREATED AS LACKING REASONABLE BASIS.—For purposes of this section, any excessive amount which is attributable to any transaction described in section 6662(b)(6) shall not be treated as having a reasonable basis.".

(d) SPECIAL UNDERSTATEMENT REDUCTION RULE FOR CERTAIN LARGE OR PUBLICLY TRADED PERSONS.—

(1) IN GENERAL.—Paragraph (2) of section 6662(d) of such Code is amended by adding at the end the following new subparagraph:

"(D) SPECIAL REDUCTION RULE FOR CERTAIN LARGE OR PUBLICLY TRADED PERSONS.—

"(i) IN GENERAL.—In the case of any specified person—

"(I) subparagraph (B) shall not apply, and

"(II) the amount of the understatement under subparagraph (A) shall be reduced by that portion of the understatement which is attributable to any item with respect to which the taxpayer has a reasonable belief that the tax treatment of such item by the taxpayer is more likely than not the proper tax treatment of such item.

"(ii) SPECIFIED PERSON.—For purposes of this subparagraph, the term 'specified person' means—

"(I) any person required to file periodic or other reports under section 13 of the Securities Exchange Act of 1934, and

"(II) any corporation with gross receipts in excess of $100,000,000 for the taxable year involved.

All persons treated as a single employer under section 52(a) shall be treated as one person for purposes of subclause (II).".

(2) CONFORMING AMENDMENT.—Subparagraph (C) of section 6662(d)(2) of such Code is amended by striking "Subparagraph (B)" and inserting "Subparagraphs (B) and (D)(i)(II)".

(e) EFFECTIVE DATE.—The amendments made by this section shall apply to transactions entered into after the date of the enactment of this Act.

TITLE III—ADMINISTRATION

SEC. 301. PUBLIC ADMINISTRATION; APPOINTMENT OF DIRECTOR.

(a) IN GENERAL.—Except as otherwise specifically provided, this Act shall be administered by the Secretary through a Director appointed by the Secretary.

(b) LONG-TERM CARE.—The Director shall appoint a director for long-term care who shall be responsible for administration of this Act and ensuring the availability and accessibility of high quality long-term care services.

(c) MENTAL HEALTH.—The Director shall appoint a director for mental health who shall be responsible for administration of this Act and ensuring the availability and accessibility of high quality mental health services.

SEC. 302. OFFICE OF QUALITY CONTROL.

The Director shall appoint a director for an Office of Quality Control. Such director shall, after consultation with state and regional directors, provide annual recommendations to Congress, the President, the Secretary, and other Program officials on how to ensure the highest quality health care service delivery. The director of the Office of Quality Control shall conduct an annual review on the adequacy of medically necessary services, and shall make recommendations of any proposed changes to the Congress, the President, the Secretary, and other Medicare for All Program officials.

SEC. 303. REGIONAL AND STATE ADMINISTRATION; EMPLOYMENT OF DISPLACED CLERICAL WORKERS.

(a) ESTABLISHMENT OF MEDICARE FOR ALL PROGRAM REGIONAL OFFICES.—The Secretary shall establish and maintain Medicare for All regional offices for the purpose of distributing funds to providers of care. Whenever possible, the Secretary should incorporate pre-existing Medicare infrastructure for this purpose.

(b) APPOINTMENT OF REGIONAL AND STATE DIRECTORS.—In each such regional office there shall be—

(1) one regional director appointed by the Director; and

(2) for each State in the region, a deputy director (in this Act referred to as a "State Director") appointed by the governor of that State.

(c) REGIONAL OFFICE DUTIES.—Regional offices of the Program shall be responsible for—

(1) coordinating funding to health care providers and physicians; and

(2) coordinating billing and reimbursements with physicians and health care providers through a State-based reimbursement system.

(d) STATE DIRECTOR'S DUTIES.—Each State Director shall be responsible for the following duties:

(1) Providing an annual state health care needs assessment report to the National Board of Universal Quality and Access, and the regional board, after a thorough examination of health needs, in consultation with public health officials, clinicians, patients, and patient advocates.

(2) Health planning, including oversight of the placement of new hospitals, clinics, and other health care delivery facilities.

(3) Health planning, including oversight of the purchase and placement of new health equipment to ensure timely access to care and to avoid duplication.

(4) Submitting global budgets to the regional director.

(5) Recommending changes in provider reimbursement or payment for delivery of health services in the State.

(6) Establishing a quality assurance mechanism in the State in order to minimize both under utilization and over utilization and to assure that all providers meet high quality standards.

(7) Reviewing program disbursements on a quarterly basis and recommending needed adjustments in fee schedules needed to achieve budgetary targets and assure adequate access to needed care.

(e) FIRST PRIORITY IN RETRAINING AND JOB PLACEMENT; 2 YEARS OF SALARY PARITY BENEFITS.—The Program shall provide that clerical, administrative, and billing personnel in insurance companies, doctors offices, hospitals, nursing facilities, and other facilities whose jobs are eliminated due to reduced administration—

(1) should have first priority in retraining and job placement in the new system; and

(2) shall be eligible to receive two years of Medicare for All employment transition benefits with each year's benefit equal to salary earned during the

last 12 months of employment, but shall not exceed $100,000 per year.

(f) ESTABLISHMENT OF MEDICARE FOR ALL EMPLOYMENT TRANSITION FUND.—The Secretary shall establish a trust fund from which expenditures shall be made to recipients of the benefits allocated in subsection (e).

(g) ANNUAL APPROPRIATIONS TO MEDICARE FOR ALL EMPLOYMENT TRANSITION FUND.—Sums are authorized to be appropriated annually as needed to fund the Medicare for All Employment Transition Benefits.

(h) RETENTION OF RIGHT TO UNEMPLOYMENT BENEFITS.—Nothing in this section shall be interpreted as a waiver of Medicare for All Employment Transition benefit recipients' right to receive Federal and State unemployment benefits.

SEC. 304. CONFIDENTIAL ELECTRONIC PATIENT RECORD SYSTEM.

(a) IN GENERAL.—The Secretary shall create a standardized, confidential electronic patient record system in accordance with laws and regulations to maintain accurate patient records and to simplify the billing process, thereby reducing medical errors and bureaucracy.

(b) PATIENT OPTION.—Notwithstanding that all billing shall be preformed electronically, patients shall have

the option of keeping any portion of their medical records separate from their electronic medical record.

SEC. 305. NATIONAL BOARD OF UNIVERSAL QUALITY AND ACCESS.

(a) ESTABLISHMENT.—

(1) IN GENERAL.—There is established a National Board of Universal Quality and Access (in this section referred to as the "Board") consisting of 15 members appointed by the President, by and with the advice and consent of the Senate.

(2) QUALIFICATIONS.—The appointed members of the Board shall include at least one of each of the following:

(A) Health care professionals.

(B) Representatives of institutional providers of health care.

(C) Representatives of health care advocacy groups.

(D) Representatives of labor unions.

(E) Citizen patient advocates.

(3) TERMS.—Each member shall be appointed for a term of 6 years, except that the President shall stagger the terms of members initially appointed so that the term of no more than 3 members expires in any year.

(4) PROHIBITION ON CONFLICTS OF INTEREST.—No member of the Board shall have a financial conflict of interest with the duties before the Board.

(b) DUTIES.—

(1) IN GENERAL.—The Board shall meet at least twice per year and shall advise the Secretary and the Director on a regular basis to ensure quality, access, and affordability.

(2) SPECIFIC ISSUES.—The Board shall specifically address the following issues:

(A) Access to care.

(B) Quality improvement.

(C) Efficiency of administration.

(D) Adequacy of budget and funding.

(E) Appropriateness of reimbursement levels of physicians and other providers.

(F) Capital expenditure needs.

(G) Long-term care.

(H) Mental health and substance abuse services.

(I) Staffing levels and working conditions in health care delivery facilities.

(3) ESTABLISHMENT OF UNIVERSAL, BEST QUALITY STANDARD OF CARE.—The Board shall

specifically establish a universal, best quality of standard of care with respect to—

(A) appropriate staffing levels;

(B) appropriate medical technology;

(C) design and scope of work in the health workplace;

(D) best practices; and

(E) salary level and working conditions of physicians, clinicians, nurses, other medical professionals, and appropriate support staff.

(4) TWICE-A-YEAR REPORT.—The Board shall report its recommendations twice each year to the Secretary, the Director, Congress, and the President.

(c) COMPENSATION, ETC.—The following provisions of section 1805 of the Social Security Act shall apply to the Board in the same manner as they apply to the Medicare Payment Assessment Commission (except that any reference to the Commission or the Comptroller General shall be treated as references to the Board and the Secretary, respectively):

(1) Subsection (c)(4) (relating to compensation of Board members).

(2) Subsection (c)(5) (relating to chairman and vice chairman).

(3) Subsection (e)(6) (relating to meetings).

(4) Subsection (d) (relating to director and staff; experts and consultants).

(5) Subsection (e) (relating to powers).

TITLE IV—ADDITIONAL PROVISIONS

SEC. 401. TREATMENT OF VA AND IHS HEALTH PROGRAMS.

(a) VA HEALTH PROGRAMS.—This Act provides for health programs of the Department of Veterans' Affairs to initially remain independent for the 10-year period that begins on the date of the establishment of the Medicare for All Program. After such 10-year period, the Congress shall reevaluate whether such programs shall remain independent or be integrated into the Medicare for All Program.

(b) INDIAN HEALTH SERVICE PROGRAMS.—This Act provides for health programs of the Indian Health Service to initially remain independent for the 5-year period that begins on the date of the establishment of the Medicare for All Program, after which such programs shall be integrated into the Medicare for All Program.

SEC. 402. PUBLIC HEALTH AND PREVENTION.

It is the intent of this Act that the Program at all times stress the importance of good public health through the prevention of diseases.

SEC. 403. REDUCTION IN HEALTH DISPARITIES.

It is the intent of this Act to reduce health disparities by race, ethnicity, income and geographic region, and to provide high quality, cost-effective, culturally appropriate care to all individuals regardless of race, ethnicity, sexual orientation, or language.

TITLE V—GENERAL EFFECTIVE DATE

SEC. 501. EFFECTIVE DATE.

Except as otherwise specifically provided, this Act shall take effect on January 1, 2013, and shall apply to items and services furnished on or after such date.

TITLE VI—[INSERT HERE TITLES I-IV OF DIVISION C OF HR 3200 AS REPORTED BY COMMITTEE ON ENERGY AND COMMERCE]