Originally Processed With FOIA(s):
1999-0118-F

FOIA Number:
1999-0118-F

FOIA MARKER

This is not a textual record. This is used as an administrative marker by the George Bush Presidential Library Staff.

Record Group/Collection: George H.W. Bush Presidential Records
Collection/Office of Origin: Cabinet Affairs, White House Office of
Series: Porter, Richard, Files
Subseries:

OA/ID Number: 07136
Folder ID Number: 07136-002

Folder Title:
Health Care Reform Studies I

Stack:	Row:	Section:	Shelf:	Position:
G	10	14	7	1

HEALTH CARE REFORM STUDIES

I

THE WHITE HOUSE

WASHINGTON

April 2, 1990

MEMORANDUM FOR DAVID Q. BATES

FROM: KEN YALE KY

SUBJECT: Health Care Reform Studies

The President gave the DPC a mandate to review studies and recommendations for health care delivery system reform.

Due to the growing interest in the health care reform debate, there are many such studies currently underway or recently completed. Some are major government initiatives: ie., the "Pepper Commission", Social Security Quadrennial Commission, and Treasury Department Health Care Financing. Others are major private sector reports and recommendations: ie., the American Medical Association and Health Insurance Association of America reports. In addition, there are several major legislative proposals introduced or in the formative stages on the Hill.

We are working with HHS to develop a system to compile these reports and recommendations. You will recall that Governor Sununu had asked about the different reports at an earlier meeting. At some point it may be appropriate to develop a side-by-side comparison, to address questions such as those raised by the Governor. In addition, we can produce a summary of any report for your use, should it be necessary.

cc: Stephen Danzansky
Dan Heimbach
John Schall
Justine D'Andrea
Sara Sumner

HEALTH CARE REFORM STUDIES

1. A National Health System for America, The Heritage Foundation (1989)

2. A National Health Program for the United States: A Physician's Proposal, The New England Journal of Medicine (January 12, 1989)

3. National Governors' Association Study on Medicaid Eligibility and Coverage for Pregnant Women, Children and Families (July 1989)

4. Insurance Association of Connecticut Proposal on Medically Uninsured (January 9, 1990)

5. S.2032, Health Care Insurance Credit Legislation (Cohen, introduced January 30, 1990)

6. S.2050, Medigap Fraud and Abuse Prevention Act (Kohl, introduced February 1,1990)

7. H.R. 3931-3, Medicaid Expansions (Waxman, reintroduced February 1, 1990)

8. Health Insurance Association of America (HIAA) Proposal to Expand Access to Health Care (February 19, 1990)

9. AFL-CIO Principles For National Health Care Reform (February 20, 1990)

10. S.2163, Universal Health Insurance for Seniors (Kennedy, introduced February 22, 1990)

11. H.R.4070, The Health Care Empowerment and Access Legislation (Grandy, introduced February 22, 1990)

12. S.2199, The Health and Long-Term Security Act of 1990 (Packwood, introduced February 28, 1990)

13. Department of the Treasury Report: Financing Health and Long-Term Care (March 1990)

14. A Report to the Governor and Members of the California Legislature on Health Insurance Coverage (March 1, 1990)

15. Pepper Commission Report on Access to Health Care and Long-Term Care (March 2, 1990)

16. American Medical Association (AMA) Health Care Reform Proposal (March 5, 1990)

17. S.2246, Medicare Home Benefits Improvement Act (Bradley, introduced March 7, 1990)

18. H.R. 4253, Universal Health Program for All Americans (Oaker, introduced March 13, 1990)

19. H.R. 4280, Health Insurance for Children and Mothers Act of 1990 (Stark, introduced March 15, 1990)

20. Steelman Report

Abstracts in the advertising sections

The New England Journal of Medicine

Established in 1812 as The NEW ENGLAND JOURNAL OF MEDICINE AND SURGERY

VOLUME 320 JANUARY 12, 1989 NUMBER 2

Original Articles

Effect of Omeprazole and Ranitidine on Ulcer Healing and Relapse Rates in Patients with Benign Gastric Ulcer 69
Anders Walan, Jean-Pierre Bader, Meinhard Classen, Cornelis B.H.W. Lamers, Douglas W. Piper, Kerstin Rutgersson, and Sven Eriksson

Patterns of Transmission in Measles Outbreaks in the United States, 1985–1986 75
Lauri E. Markowitz, Stephen R. Preblud, Walter A. Orenstein, Elizabeth Z. Rovira, Nancy C. Adams, Carl E. Hawkins, and Alan R. Hinman

The Efficacy of Endoscopic Sphincterotomy after Cholecystectomy in Patients with Sphincter-of-Oddi Dysfunction 82
Joseph E. Geenen, Walter J. Hogan, Wylie J. Dodds, James Toouli, and Rama P. Venu

High-Frequency Oscillatory Ventilation Compared with Conventional Mechanical Ventilation in the Treatment of Respiratory Failure in Preterm Infants 88
The HIFI Study Group

Special Articles

A Consumer-Choice Health Plan for the 1990s: Universal Health Insurance in a System Designed to Promote Quality and Economy (Second of Two Parts)... 94
Alain Enthoven and Richard Kronick

A National Health Program for the United States: A Physicians' Proposal......... 102
David U. Himmelstein, Steffie Woolhandler, and the Writing Committee of the Working Group on Program Design

Case Records of the Massachusetts General Hospital

A 59-Year-Old Woman with Asthma and Multiple Pulmonary Nodules 108
Barry W. Levine and Eugene J. Mark

Editorial

Universal Health Insurance: Its Time Has Come................................ 117

Sounding Board

Technology and the Allocation of Resources 118
Maurice McGregor

Correspondence

Do Physicians Have an Obligation to Treat Patients with AIDS? 120
Aplastic Anemia after Liver Transplantation for Non-A, Non-B Hepatitis................. 122
Diltiazem and Mortality and Reinfarction after Myocardial Infarction 123
Atrial Fibrillation Induced by Breath Spray 124
Release of Endogenous Digitalis-like Factor with Sodium Loading 124
Treatment of Ethylene Glycol Poisoning with Intravenous 4-Methylpyrazole 125
Recognizing the Alcoholic Patient 125
Critical Care Medicine 126
Teenagers' Concerns about Nuclear War 127

Book Reviews 127

Books Received 130

Notices 132

Owned, Published, and ©Copyrighted, 1989, by the Massachusetts Medical Society

The New England Journal of Medicine (ISSN 0028-4793) is published weekly from editorial offices at 10 Shattuck Street, Boston, MA 02115-6094. Subscription price: $74.00 per year. Second-class postage paid at Boston and at additional mailing offices.
POSTMASTER: Send address changes to P.O. Box 803, Waltham, MA 02254-0803.

A NATIONAL HEALTH PROGRAM FOR THE UNITED STATES

A Physicians' Proposal

DAVID U. HIMMELSTEIN, M.D., STEFFIE WOOLHANDLER, M.D., M.P.H.,
AND THE WRITING COMMITTEE OF THE WORKING GROUP ON PROGRAM DESIGN*

Abstract Our health care system is failing. Tens of millions of people are uninsured, costs are skyrocketing, and the bureaucracy is expanding. Patchwork reforms succeed only in exchanging old problems for new ones. It is time for basic change in American medicine. We propose a national health program that would (1) fully cover everyone under a single, comprehensive public insurance program; (2) pay hospitals and nursing homes a total (global) annual amount to cover all operating expenses; (3) fund capital costs through separate appropriations; (4) pay for physicians' services and ambulatory services in any of three ways: through fee-for-service payments with a simplified fee schedule and mandatory acceptance of the national health program payment as the total payment for a service or procedure (assignment), through global budgets for hospitals and clinics employing salaried physicians, or on a per capita basis (capitation); (5) be funded, at least initially, from the same sources as at present, but with all payments disbursed from a single pool; and (6) contain costs through savings on billing and bureaucracy, improved health planning, and the ability of the national health program, as the single payer for services, to establish overall spending limits. Through this proposal, we hope to provide a pragmatic framework for public debate of fundamental health-policy reform. (N Engl J Med 1989; 320:102-8.)

OUR health care system is failing. It denies access to many in need and is expensive, inefficient, and increasingly bureaucratic. The pressures of cost control, competition, and profit threaten the traditional tenets of medical practice. For patients, the misfortune of illness is often amplified by the fear of financial ruin. For physicians, the gratifications of healing often give way to anger and alienation. Patchwork reforms succeed only in exchanging old problems for new ones. It is time to change fundamentally the trajectory of American medicine — to develop a comprehensive national health program for the United States.

We are physicians active in the full range of medical endeavors. We are primary care doctors and surgeons, psychiatrists and public health specialists, pathologists and administrators. We work in hospitals, clinics, private practices, health maintenance organizations (HMOs), universities, corporations, and public agencies. Some of us are young, still in training; others are greatly experienced, and some have held senior positions in American medicine.

As physicians, we constantly confront the irrationality of the present health care system. In private practice, we waste countless hours on billing and bureaucracy. For uninsured patients, we avoid procedures, consultations, and costly medications. Diagnosis-related groups (DRGs) have placed us between administrators demanding early discharge and elderly patients with no one to help at home — all the while glancing over our shoulders at the peer-review organization. In HMOs we walk a tightrope between thrift and penuriousness, too often under the pressure of surveillance by bureaucrats more concerned with the bottom line than with other measures of achievement. In public health work we are frustrated in the face of plenty; the world's richest health care system is unable to ensure such basic services as prenatal care and immunizations.

Despite our disparate perspectives, we are united by dismay at the current state of medicine and by the conviction that an alternative must be developed. We hope to spark debate, to transform disaffection with what exists into a vision of what might be. To this end, we submit for public review, comment, and revision a working plan for a rational and humane health care system — a national health program.

We envisage a program that would be federally mandated and ultimately funded by the federal government but administered largely at the state and local level. The proposed system would eliminate financial barriers to care; minimize economic incentives for both excessive and insufficient care, discourage administrative interference and expense, improve the distribution of health facilities, and control costs by curtailing bureaucracy and fostering health planning. Our plan borrows many features from the Canadian national health program and adapts them to the unique circumstances of the United States. We suggest that, as in Canada's provinces, the national

From the Working Group on Program Design, Physicians for a National Health Program, Center for National Health Program Studies, Cambridge Hospital–Harvard Medical School, 1493 Cambridge St., Cambridge, MA 02139, where reprint requests should be addressed to Dr. Himmelstein.

*This proposal was drafted by a 30-member Writing Committee, then reviewed and endorsed by 412 other physicians representing virtually every state and medical specialty. A full list of the endorsers is available on request. The members of the Writing Committee were as follows: David U. Himmelstein, M.D., Cambridge, Mass. (cochair); Steffie Woolhandler, M.D., M.P.H., Cambridge, Mass. (cochair); Thomas S. Bodenheimer, M.D., San Francisco; David H. Bor, M.D., Cambridge, Mass.; Christine K. Cassel, M.D., Chicago; Mardge Cohen, M.D., Chicago; David A. Danielson, M.P.H., Newton, Mass.; Alan Drabkin, M.D., Cambridge, Mass.; Paul Epstein, M.D., Brookline, Mass.; Kenneth Frisof, M.D., Cleveland; Howard Frumkin, M.D., M.P.H., Philadelphia; Martha S. Gerrity, M.D., Chapel Hill, N.C.; Jerome D. Gorman, M.D., Richmond, Va.; Michelle D. Holmes, M.D., Cambridge, Mass.; Henry S. Kahn, M.D., Atlanta; Robert S. Lawrence, M.D., Cambridge, Mass.; Joanne Lukomnik, M.D., Bronx, N.Y.; Arthur Mazer, M.P.H., Cambridge, Mass.; Alan Meyers, M.D., Boston; Patrick Murray, M.D., Cleveland; Vicente Navarro, M.D., Dr.P.H., Baltimore; Peter Orris, M.D., Chicago; David C. Parish, M.D., M.P.H., Macon, Ga.; Richard J. Pels, M.D., Boston; Leonard S. Rodberg, Ph.D., New York City; Jeffrey Scavron, M.D., Springfield, Mass.; Gordon Schiff, M.D., Chicago; Isaac M. Taylor, M.D., Boston; Howard Waitzkin, M.D., Ph.D., Anaheim, Calif.; Paul H. Wise, M.D., M.P.H., Boston; and William Zinn, M.D., Cambridge, Mass.

health program be tested initially in statewide demonstration projects. Thus, our proposal addresses both the structure of the national health program and the transition process necessary to implement the program in a single state. In each section below, we present a key feature of the proposal, followed by the rationale for our approach. Areas such as long-term care; public, occupational, environmental, and mental health; and medical education need much more development and will be addressed in detail in future proposals.

Coverage

Everyone would be included in a single public plan covering all medically necessary services, including acute, rehabilitative, long-term, and home care; mental health services; dental services; occupational health care; prescription drugs and medical supplies; and preventive and public health measures. Boards of experts and community representatives would determine which services were unnecessary or ineffective, and these would be excluded from coverage. As in Canada, alternative insurance coverage for services included under the national health program would be eliminated, as would patient copayments and deductibles.

Universal coverage would solve the gravest problem in health care by eliminating financial barriers to care. A single comprehensive program is necessary both to ensure equal access to care and to minimize the complexity and expense of billing and administration. The public administration of insurance funds would save tens of billions of dollars each year. The more than 1500 private health insurers in the United States now consume about 8 percent of revenues for overhead, whereas both the Medicare program and the Canadian national health program have overhead costs of only 2 to 3 percent. The complexity of our current insurance system, with its multiplicity of payers, forces U.S. hospitals to spend more than twice as much as Canadian hospitals on billing and administration and requires U.S. physicians to spend about 10 percent of their gross incomes on excess billing costs.[1] Eliminating insurance programs that duplicated the national health program coverage, though politically thorny, would clearly be within the prerogative of the Congress.[2] Failure to do so would require the continuation of the costly bureaucracy necessary to administer and deal with such programs.

Copayments and deductibles endanger the health of poor people who are sick,[3] decrease the use of vital inpatient medical services as much as they discourage the use of unnecessary ones,[4] discourage preventive care,[5] and are unwieldy and expensive to administer. Canada has few such charges, yet health costs are lower than in the United States and have risen slowly.[6,7] In the United States, in contrast, increasing copayments and deductibles have failed to slow the escalation of costs.

Instead of the confused and often unjust dictates of insurance companies, a greatly expanded program of technology assessment and cost-effectiveness evaluation would guide decisions about covered services, as well as about the allocation of funds for capital spending, drug formularies, and other issues.

Payment for Hospital Services

Each hospital would receive an annual lump-sum payment to cover all operating expenses — a "global" budget. The amount of this payment would be negotiated with the state national health program payment board and would be based on past expenditures, previous financial and clinical performance, projected changes in levels of services, wages and other costs, and proposed new and innovative programs. Hospitals would not bill for services covered by the national health program. No part of the operating budget could be used for hospital expansion, profit, marketing, or major capital purchases or leases. These expenditures would also come from the national health program fund, but monies for them would be appropriated separately.

Global prospective budgeting would simplify hospital administration and virtually eliminate billing, thus freeing up substantial resources for increased clinical care. Before the nationwide implementation of the national health program, hospitals in the states with demonstration programs could bill out-of-state patients on a simple per diem basis. Prohibiting the use of operating funds for capital purchases or profit would eliminate the main financial incentive for both excessive intervention (under fee-for-service payment) and skimping on care (under DRG-type prospective-payment systems), since neither inflating revenues nor limiting care could result in gain for the institution. The separate appropriation of funds explicitly designated for capital expenditures would facilitate rational health planning. In Canada, this method of hospital payment has been successful in containing costs, minimizing bureaucracy, improving the distribution of health resources, and maintaining the quality of care.[6-9] It shifts the focus of hospital administration away from the bottom line and toward the provision of optimal clinical services.

Payment for Physicians' Services, Ambulatory Care, and Medical Home Care

To minimize the disruption of existing patterns of care, the national health program would include three payment options for physicians and other practitioners: fee-for-service payment, salaried positions in institutions receiving global budgets, and salaried positions within group practices or HMOs receiving per capita (capitation) payments.

Fee-for-Service Payment

The state national health program payment board and a representative of the fee-for-service practition-

ers (perhaps the state medical society) would negotiate a simplified, binding fee schedule. Physicians would submit bills to the national health program on a simple form or by computer and would receive extra payment for any bill not paid within 30 days. Payments to physicians would cover only the services provided by physicians and their support staff and would exclude reimbursement for costly capital purchases of equipment for the office, such as CT scanners. Physicians who accepted payment from the national health program could bill patients directly only for uncovered services (as is done for cosmetic surgery in Canada).

Global Budgets

Institutions such as hospitals, health centers, group practices, clinics serving migrant workers, and medical home care agencies could elect to receive a global budget for the delivery of outpatient, home care, and physicians' services, as well as for preventive health care and patient-education programs. The negotiation process and the regulations covering capital expenditures and profits would be similar to those for inpatient hospital services. Physicians employed in such institutions would be salaried.

Capitation

HMOs, group practices, and other institutions could elect to be paid fees on a per capita basis to cover all outpatient care, physicians' services, and medical home care. The regulations covering the use of such payments for capital expenditures and for profits would be similar to those that would apply to hospitals. The capitation fee would not cover inpatient services (except care provided by a physician), which would be included in hospitals' global budgets. Selective enrollment policies would be prohibited, and patients would be permitted to leave an HMO or other health plan with appropriate notice. Physicians working in HMOs would be salaried, and financial incentives to physicians based on the HMO's financial performance would be prohibited.

The diversity of existing practice arrangements, each with strong proponents, necessitates a pluralistic approach. Under all three proposed options, capital purchases and profits would be uncoupled from payments to physicians and other operating costs — a feature that is essential for minimizing entrepreneurial incentives, containing costs, and facilitating health planning.

Under the fee-for-service option, physicians' office overhead would be reduced by the simplification of billing.[1] The improved coverage would encourage preventive care.[10] In Canada, fee-for-service practice with negotiated fee schedules and mandatory assignment (acceptance of the assigned fee as total payment) has proved to be compatible with cost containment, adequate incomes for physicians, and a high level of access to and satisfaction with care on the part of patients.[6,7] The Canadian provinces have responded to the inflationary potential of fee-for-service payment in various ways: by limiting the number of physicians, by monitoring physicians for outlandish practice patterns, by setting overall limits on a province's spending for physicians' services (thus relying on the profession to police itself), and even by capping the total reimbursement of individual physicians. These regulatory options have been made possible (and have not required an extensive bureaucracy) because all payment comes from a single source. Similar measures might be needed in the United States, although our penchant for bureaucratic hypertrophy might require a concomitant cap on spending for the regulatory apparatus. For example, spending for program administration and reimbursement bureaucracy might be restricted to 3 percent of total costs.

Global budgets for institutional providers would eliminate billing, while providing a predictable and stable source of income. Such funding could also encourage the development of preventive health programs in the community, such as education programs on the acquired immunodeficiency syndrome (AIDS), whose costs are difficult to attribute and bill to individual patients.

Continuity of care would no longer be disrupted when patients' insurance coverage changed as a result of retirement or a job change. Incentives for providers receiving capitation payments to skimp on care would be minimized, since unused operating funds could not be devoted to expansion or profit.

Payment for Long-Term Care

A separate proposal for long-term care is under development, guided by three principles. First, access to care should be based on need rather than on age or ability to pay. Second, social and community-based services should be expanded and integrated with institutional care. Third, bureaucracy and entrepreneurial incentives should be minimized through global budgeting with separate funding for capital expenses.

Allocation of Capital Funds, Health Planning, and Return on Equity

Funds for the construction or renovation of health facilities and for purchases of major equipment would be appropriated from the national health program budget. The funds would be distributed by state and regional health-planning boards composed of both experts and community representatives. Capital projects funded by private donations would require approval by the health-planning board if they entailed an increase in future operating expenses.

The national health program would pay owners of for-profit hospitals, nursing homes, and clinics a reasonable fixed rate of return on existing equity. Since

virtually all new capital investment would be funded by the national health program, it would not be included in calculating the return on equity.

Current capital spending greatly affects future operating costs, as well as the distribution of resources. Effective health planning requires that funds go to high-quality, efficient programs in the areas of greatest need. Under the existing reimbursement system, which combines operating and capital payments, prosperous hospitals can expand and modernize, whereas impoverished ones cannot, regardless of the health needs of the population they serve or the quality of services they provide. The national health program would replace this implicit mechanism for distributing capital with an explicit one, which would facilitate (though not guarantee) allocation on the basis of need and quality. Insulating these crucial decisions from distortion by narrow interests would require the rigorous evaluation of the technology and assessment of needs, as well as the active involvement of providers and patients.

For-profit providers would be compensated for existing investments. Since new for-profit investment would be barred, the proprietary sector would gradually shrink.

Public, Environmental, and Occupational Health Services

Existing arrangements for public, occupational, and environmental health services would be retained in the short term. Funding for preventive health care would be expanded. Additional proposals dealing with these issues are planned.

Prescription Drugs and Supplies

An expert panel would establish and regularly update a list of all necessary and useful drugs and outpatient equipment. Suppliers would bill the national health program directly for the wholesale cost, plus a reasonable dispensing fee, of any item in the list that was prescribed by a licensed practitioner. The substitution of generic for proprietary drugs would be encouraged.

Funding

The national health program would disburse virtually all payments for health services. The total expenditure would be set at the same proportion of the gross national product as health costs represented in the year preceding the establishment of the national health program. Funds for the national health program could be raised through a variety of mechanisms. In the long run, funding based on an income tax or other progressive tax might be the fairest and most efficient solution, since tax-based funding is the least cumbersome and least expensive mechanism for collecting money. During the transition period in states with demonstration programs, the following structure would mimic existing funding patterns and minimize economic disruption.

Medicare and Medicaid

All current federal funds allocated to Medicare and Medicaid would be paid to the national health program. The contribution of each program would be based on the previous year's expenditures, adjusted for inflation. Using Medicare and Medicaid funds in this manner would require a federal waiver.

State and Local Funds

All current state and local funds for health care expenditures, adjusted for inflation, would be paid to the national health program.

Employer Contributions

A tax earmarked for the national health program would be levied on all employers. The tax rate would be set so that total collections equaled the previous year's statewide total of employers' expenditures for health benefits, adjusted for inflation. Employers obligated by preexisting contracts to provide health benefits could credit the cost of those benefits toward their national health program tax liability.

Private Insurance Revenues

Private health insurance plans duplicating the coverage of the national health program would be phased out over three years. During this transition period, all revenues from such plans would be turned over to the national health program, after the deduction of a reasonable fee to cover the costs of collecting premiums.

General Tax Revenues

Additional taxes, equivalent to the amount now spent by individual citizens for insurance premiums and out-of-pocket health costs, would be levied.

It would be critical for all funds for health care to flow through the national health program. Such single-source payment (monopsony) has been the cornerstone of cost containment and health planning in Canada. The mechanism of raising funds for the national health program would be a matter of tax policy, largely separate from the organization of the health care system itself. As in Canada, federal funding could attenuate inequalities among the states in financial and medical resources.

The transitional proposal for demonstration programs in selected states illustrates how monopsony payment could be established with limited disruption of existing patterns of health care funding. The employers' contribution would represent a decrease in costs for most firms that now provide health insurance and an increase for those that do not currently pay for benefits. Some provision might be needed to cushion the impact of the change on financially strapped small

businesses. Decreased individual spending for health care would offset the additional tax burden on individual citizens. Private health insurance, with its attendant inefficiency and waste, would be largely eliminated. A program of job placement and retraining for insurance and hospital-billing employees would be an important component of the program during the transition period.

Discussion

The Patient's View

The national health program would establish a right to comprehensive health care. As in Canada, each person would receive a national health program card entitling him or her to all necessary medical care without copayments or deductibles. The card could be used with any fee-for-service practitioner and at any institution receiving a global budget. HMO members could receive nonemergency care only through their HMO, although they could readily transfer to the non-HMO option.

Thus, patients would have a free choice of providers, and the financial threat of illness would be eliminated. Taxes would increase by an amount equivalent to the current total of medical expenditures by individuals. Conversely, individuals' aggregate payments for medical care would decrease by the same amount.

The Practitioner's View

Physicians would have a free choice of practice settings. Treatment would no longer be constrained by the patient's insurance status or by bureaucratic dicta. On the basis of the Canadian experience, we anticipate that the average physician's income would change little, although differences among specialties might be attenuated.

Fee-for-service practitioners would be paid for the care of anyone not enrolled in an HMO. The entrepreneurial aspects of medicine — with the attendant problems as well as the possibilities — would be limited. Physicians could concentrate on medicine; every patient would be fully insured, but physicians could increase their incomes only by providing more care. Billing would involve imprinting the patient's national health program card on a charge slip, checking a box to indicate the complexity of the procedure or service, and sending the slip (or a computer record) to the physician-payment board. This simplification of billing would save thousands of dollars per practitioner in annual office expenses.[1]

Bureaucratic interference in clinical decision making would sharply diminish. Costs would be contained by controlling overall spending and by limiting entrepreneurial incentives, thus obviating the need for the kind of detailed administrative oversight that is characteristic of the DRG program and similar schemes. Indeed, there is much less administrative intrusion in day-to-day clinical practice in Canada (and most other countries with national health programs) than in the United States.[11,12]

Salaried practitioners would be insulated from the financial consequences of clinical decisions. Because savings on patient care could no longer be used for institutional expansion or profits, the pressure to skimp on care would be minimized.

The Effect on Other Health Workers

Nurses and other health care personnel would enjoy a more humane and efficient clinical milieu. The burdens of paperwork associated with billing would be lightened. The jobs of many administrative and insurance employees would be eliminated, necessitating a major effort at job placement and retraining. We advocate that many of these displaced workers be deployed in expanded programs of public health, health promotion and education, and home care and as support personnel to free nurses for clinical tasks.

The Effect on Hospitals

Hospitals' revenues would become stable and predictable. More than half the current hospital bureaucracy would be eliminated,[1] and the remaining administrators could focus on facilitating clinical care and planning for future health needs.

The capital budget requests of hospitals would be weighed against other priorities for health care investment. Hospitals would neither grow because they were profitable nor fail because of unpaid bills — although regional health planning would undoubtedly mandate that some expand and others close or be put to other uses. Responsiveness to community needs, the quality of care, efficiency, and innovation would replace financial performance as the bottom line. The elimination of new for-profit investment would lead to a gradual conversion of proprietary hospitals to not-for-profit status.

The Effect on the Insurance Industry

The insurance industry would feel the greatest impact of this proposal. Private insurance firms would have no role in health care financing, since the public administration of insurance is more efficient[1,13] and single-source payment is the key to both equal access and cost control. Indeed, most of the extra funds needed to finance the expansion of care would come from eliminating the overhead and profits of insurance companies and abolishing the billing apparatus necessary to apportion costs among the various plans.

The Effect on Corporate America

Firms that now provide generous employee health benefits would realize savings, because their contribution to the national health program would be less than their current health insurance costs. For example, health care expenditures by Chrysler, currently $5,300 annually per employee,[14] would fall to about

$1,600, a figure calculated by dividing the total current U.S. spending on health by private employers by the total number of full-time-equivalent, nongovernment employees. Since most firms that compete in international markets would save money, the competitiveness of U.S. products would be enhanced. However, costs would increase for companies that do not now provide health benefits. The average health care costs for employers would be unchanged in the short run. In the long run, overall health costs would rise less steeply because of improved health planning and greater efficiency. The funding mechanism ultimately adopted would determine the corporate share of those costs.

Health Benefits and Financial Costs

There is ample evidence that removing financial barriers to health care encourages timely care and improves health. After Canada instituted a national health program, visits to physicians increased among patients with serious symptoms.[15] Mortality rates, which were higher than U.S. rates through the 1950s and early 1960s, fell below those in the United States.[16] In the Rand Health Insurance Experiment, free care reduced the annual risk of dying by 10 percent among the 25 percent of U.S. adults at highest risk.[3] Conversely, cuts in California's Medicaid program led to worsening health.[17] Strong circumstantial evidence links the poor U.S. record on infant mortality with inadequate access to prenatal care.[18]

We expect that the national health program would cause little change in the total costs of ambulatory and hospital care; savings on administration and billing (about 10 percent of current health spending[1]) would approximately offset the costs of expanded services.[19,20] Indeed, current low hospital-occupancy rates suggest that the additional care could be provided at low cost. Similarly, many physicians with empty appointment slots could take on more patients without added office, secretarial, or other overhead costs. However, the expansion of long-term care (under any system) would increase costs. The experience in Canada suggests that the increased demand for acute care would be modest after an initial surge[21,22] and that improvements in health planning[8] and cost containment made possible by single-source payment[9] would slow the escalation of health care costs. Vigilance would be needed to stem the regrowth of costly and intrusive bureaucracy.

Unsolved Problems

Our brief proposal leaves many vexing problems unsolved. Much detailed planning would be needed to ease dislocations during the implementation of the program. Neither the encouragement of preventive health care and healthful life styles nor improvements in occupational and environmental health would automatically follow from the institution of a national health program. Similarly, racial, linguistic, geographic, and other nonfinancial barriers to access would persist. The need for quality assurance and continuing medical education would be no less pressing. High medical school tuitions that skew specialty choices and discourage low-income applicants, the underrepresentation of minorities, the role of foreign medical graduates, and other issues in medical education would remain. Some patients would still seek inappropriate emergency care, and some physicians might still succumb to the temptation to increase their incomes by encouraging unneeded services. The malpractice crisis would be only partially ameliorated. The 25 percent of judgments now awarded for future medical costs would be eliminated, but our society would remain litigious, and legal and insurance fees would still consume about two thirds of all malpractice premiums.[23] Establishing research priorities and directing funds to high-quality investigations would be no easier. Much further work in the area of long-term care would be required. Regional health planning and capital allocation would make possible, but not ensure, the fair and efficient allocation of resources. Finally, although insurance coverage for patients with AIDS would be ensured, the need for expanded prevention and research and for new models of care would continue. Although all these problems would not be solved, a national health program would establish a framework for addressing them.

Political Prospects

Our proposal will undoubtedly encounter powerful opponents in the health insurance industry, firms that do not now provide health benefits to employees, and medical entrepreneurs. However, we also have allies. Most physicians (56 percent) support some form of national health program, although 74 percent are convinced that most other doctors oppose it.[24] Many of the largest corporations would enjoy substantial savings if our proposal were adopted. Most significant, the great majority of Americans support a universal, comprehensive, publicly administered national health program, as shown by virtually every opinion poll in the past 30 years.[25,26] Indeed, a 1986 referendum question in Massachusetts calling for a national health program was approved two to one, carrying all 39 cities and 307 of the 312 towns in the commonwealth.[27] If mobilized, such public conviction could override even the most strenuous private opposition.

References

1. Himmelstein DU, Woolhandler S. Cost without benefit: administrative waste in U.S. health care. N Engl J Med 1986; 314:441-5.
2. Advisory opinion regarding House of Representatives Bill 85-H-7748 (No. 86-269-MP, R.I. Sup. Ct. Jan 5, 1987).
3. Brook RH, Ware JE Jr, Rogers WH, et al. Does free care improve adults' health? Results from a randomized controlled trial. N Engl J Med 1983; 309:1426-34.

4. Siu AL, Sonnenberg FA, Manning WG, et al. Inappropriate use of hospitals in a randomized trial of health insurance plans. N Engl J Med 1986; 315:1259-66.
5. Brian EW, Gibbens SF. California's Medi-Cal copayment experiment. Med Care 1974; 12:Suppl 12:1-303.
6. Iglehart JK. Canada's health care system. N Engl J Med 1986; 315:202-8, 778-84.
7. *Idem.* Canada's health care system: addressing the problem of physician supply. N Engl J Med 1986; 315:1623-8.
8. Detsky AS, Stacey SR, Bombardier C. The effectiveness of a regulatory strategy in containing hospital costs: the Ontario experience, 1967-1981. N Engl J Med 1983; 309:151-9.
9. Evans RG. Health care in Canada: patterns of funding and regulation. In: McLachlan G, Maynard A, eds. The public/private mix for health: the relevance and effects of change. London: Nuffield Provincial Hospitals Trust, 1982:369-424.
10. Woolhandler S, Himmelstein DU. Reverse targeting of preventive care due to lack of health insurance. JAMA 1988; 259:2872-4.
11. Reinhardt UE. Resource allocation in health care: the allocation of lifestyles to providers. Milbank Q 1987; 65:153-76.
12. Hoffenberg R. Clinical freedom. London: Nuffield Provincial Hospitals Trust, 1987.
13. Horne JM, Beck RG. Further evidence on public versus private administration of health insurance. J Public Health Policy 1981; 2:274-90.
14. Cronin C. Next Congress to grapple with U.S. health policy, competitiveness abroad. Bus Health 1986; 4(2):55.
15. Enterline PE, Salter V, McDonald AD, McDonald JC. The distribution of medical services before and after "free" medical care — the Quebec experience. N Engl J Med 1973; 289:1174-8.
16. Roemer R, Roemer MI. Health manpower policy under national health insurance: the Canadian experience. Hyattsville, Md.: Health Resources Administration, 1977. (DHEW publication no. (HRA) 77-37.)
17. Lurie N, Ward NB, Shapiro MF, et al. Termination of Medi-Cal benefits: a follow-up study one year later. N Engl J Med 1986; 314:1266-8.
18. Institute of Medicine. Preventing low birthweight. Washington, D.C.: National Academy Press, 1985.
19. Newhouse JP, Manning WG, Morris CN, et al. Some interim results from a controlled trial of cost sharing in health insurance. N Engl J Med 1981; 305:1501-7.
20. Himmelstein DU, Woolhandler S. Free care: a quantitative analysis of the health and cost effects of a national health program. Int J Health Serv 1988; 18:393-9.
21. LeClair M. The Canadian health care system. In: Andreopoulos S, ed. National health insurance: can we learn from Canada? New York: John Wiley, 1975:11-92.
22. Evans RG. Beyond the medical marketplace: expenditure, utilization and pricing of insured health care in Canada. In: Andreopoulos S, ed. National health insurance: can we learn from Canada? New York: John Wiley, 1975:129-78.
23. Danzon PM. Medical malpractice: theory, evidence, and public policy. Cambridge, Mass.: Harvard University Press, 1985.
24. Colombotas J, Kirchner C. Physicians and social change. New York: Oxford University Press, 1986.
25. Navarro V. Where is the popular mandate? N Engl J Med 1982; 307:1516-8.
26. Pokorny G. Report card on health care. Health Manage Q 1988; 10(1):3-7.
27. Danielson DA, Mazer A. Results of the Massachusetts Referendum on a national health program. J Public Health Policy 1987; 8:28-35.

NATIONAL GOVERNORS' ASSOCIATION

Terry E. Branstad
Governor of Iowa
Chairman

Booth Gardner
Governor of Washington
Vice Chairman

Raymond C. Scheppach
Executive Director

Hall of the States
444 North Capitol Street
Washington, D.C. 20001-1572
Telephone (202) 624-5300

August 17, 1989

MEMORANDUM

TO: Interested Parties

FROM: Ian Hill
Senior Policy Analyst

RE: Medicaid Eligibility and Coverage for Pregnant Women, Children and Families

In our continuing effort to monitor and report on state Medicaid programs' coverage of low-income pregnant women, children, and families, the Health Programs unit of NGA's Center for Policy Research has developed the enclosed, updated summary tables.

Please find attached: 1) a map displaying states' responses to both OBRA-86 and OBRA-87 authority to raise income eligibility thresholds for pregnant women and children; 2) a more detailed summary of state OBRA-86/87 program characteristics including information on income thresholds as a percent of poverty, coverage of children, treatment of assets, continuous eligibility, and presumptive eligibility; 3) a table displaying annualized income eligibility thresholds, by state for family size three, for AFDC programs, Medically Needy programs, and OBRA-86/87 programs; 4) a table displaying AFDC Need and Payment Standards for family sizes one through four; and 5) a table displaying Medically Needy Protected Income Levels for family sizes one through four. All information is current as of July 1989.

To summarize, a full 44 states and the District of Columbia have expanded their Medicaid programs by creating special income limits for pregnant women and children. This spring 8 more states raised their income thresholds above the poverty level to as high as 185% ofpoverty, bringing the total number of states in this range to 20. Twenty-four other states have established limits at 100% of poverty and 1 state maintains a level above AFDC limits but below 100% of poverty. Also, one state covers a similar population of pregnant women and children under a state-funded assistance program. A total of just 5 states were affected by mandated expansions under the Catastrophic Coverage Act of 1988 and expanded eligibility to 75% of poverty.

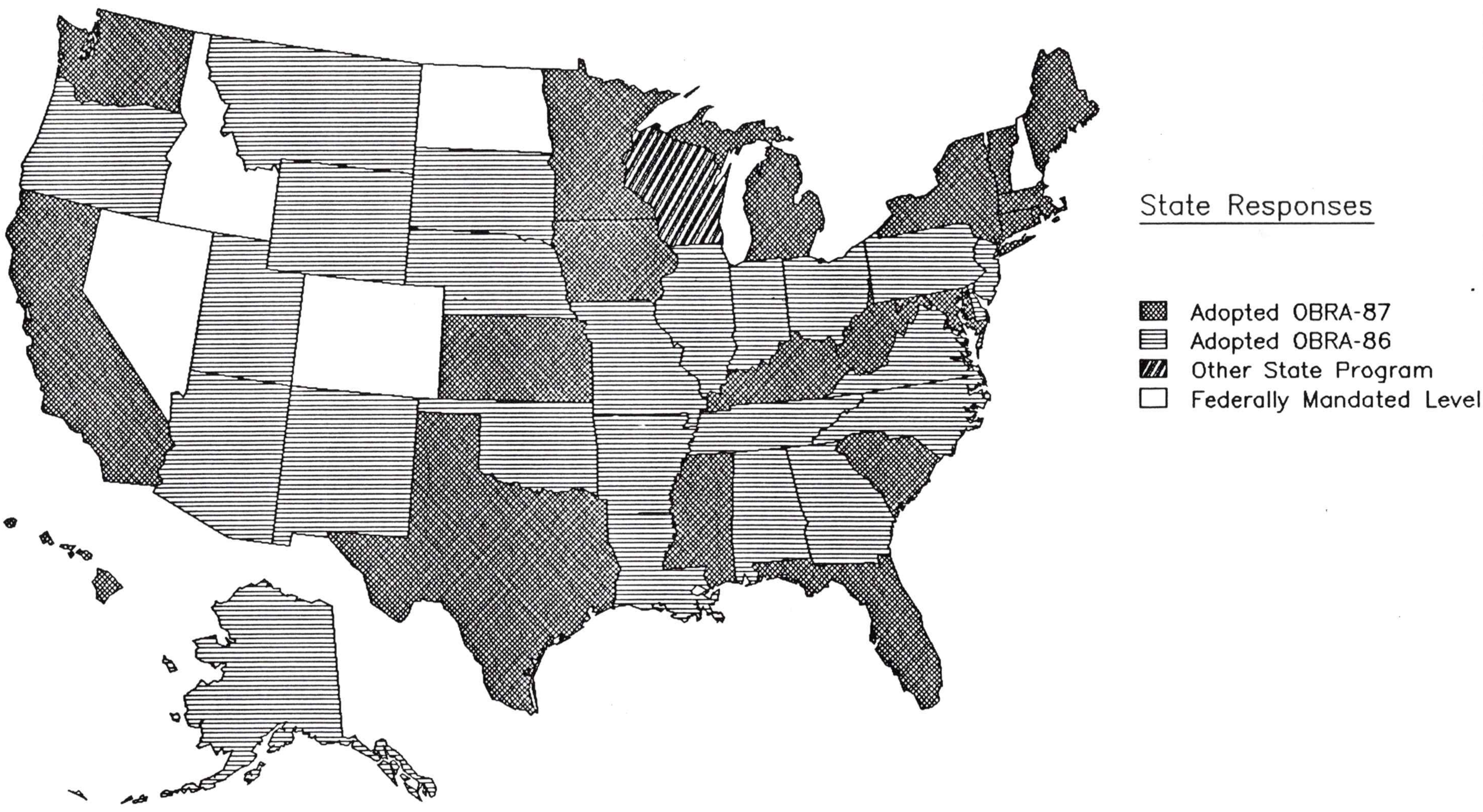
In addition to these expansions for pregnant women and infants, a number of states have taken advantage of OBRA-87 flexibility to accelerate coverage of older children. This spring the number of states covering children up to the poverty level between the ages of 5 and 8 more than doubled from 9 to 19, while 19 other states will continue phasing in coverage of children between the ages of 2 and 5 one year at a time.

In an encouraging effort to simplify and streamline eligibility systems, 6 more states have done away with resource restrictions this spring, bringing the total number of states who have dropped their assets test to 42. In addition, 41 states have guaranteed pregnant women continuous eligibility throughout their pregnancy regardless of fluctuations in income. Twenty-three states have adopted the presumptive eligibility option in order to extend temporary eligibility to women so that they can receive Medicaid-reimbursed prenatal care while their formal application is being reviewed.

Approximately two-fifths of the states increased their AFDC income eligibility thresholds in July 1989. These increases tended to only keep pace with inflation. In the average state, the AFDC threshold for a family of three stands at $4942 per year, or 48.6% of the federal poverty level. This average threshold has hovered at just under 50% of poverty for the last several years. Similarly, the Medically Needy threshold in the average state increased only slightly from 60% to 61% of poverty, although 17 of the 36 state Medically Needy programs experienced increases.

We appreciate the assistance states provided in compiling this information and hope that it will be useful in your work. If you have any questions or require further information, please call Ian Hill at (202) 624-7820 or Haiden Huskamp at (202) 624-5348.

STATES BROADENING MEDICAID ELIGIBILITY
Coverage of Pregnant Women and Children Up To/Above Poverty
July 1989



SOURCE: NATIONAL GOVERNORS' ASSOCIATION, JULY 1989

OBRA - '86/'87 SUMMARY STATUS

COVERAGE OPTIONS FOR PREGNANT WOMEN AND CHILDREN, AS OF JULY 1989

	PREGNANT WOMEN AND INFANTS PERCENT POVERTY	OLDER CHILDREN COVERED UNDER POVERTY TO AGE		DROPPED ASSETS TEST	CONTINUOUS ELIGIBILITY	PRESUMPTIVE ELIGIBILITY	ORIGINAL EFFECTIVE DATE
		2 - 4	5 - 8				
Alabama	100			X	X	X	7/88
Alaska	100	X		X	X		1/89
Arizona	100		X	X	X		1/88
Arkansas	100		X	X	X	X	4/87
California	185						7/89*
Colorado	75**					X*	7/89
Connecticut	185			X	X		4/88
Delaware	100	X		X	X		1/88
DC	100	X		X	X		4/87
Florida	150		X	X	X	X	10/87
Georgia	100	X		X	X		1/89
Hawaii	185*		X	X	X	X	1/89
Idaho	75**			X	X	X	1/89
Illinois	100				X	X	7/88
Indiana	100	X		X	X	X	7/88
Iowa	185		X		X	X	1/89
Kansas	150		X	X			7/88
Kentucky	125	X			X		10/87
Louisiana	100		X	X	X	X	1/89
Maine	185		X	X		X	10/88
Maryland	185	X		X	X	X	7/87
Massachusetts	185		X	X	X	X	7/87
Michigan	185	X		X	X		1/88
Minnesota	185		X	X	X		7/88
Mississippi	185		X	X	X		10/87
[illegible]ouri	100	X			X		1/88
[illegible]ana	100			X			7/89
[illegible]ebraska	100	X		X	X	X	7/88
Nevada	75**		X	X			7/89
New Hampshire	75**			X			7/89
New Jersey	100	X		X	X	X	7/87
New Mexico	100	X		X	X	X	1/88
New York	185			X	X	X	1/90*
North Carolina	100	X		X	X	X	10/87
North Dakota	75**						7/89
Ohio	100			X	X		1/89
Oklahoma	100	X		X	X		1/88
Oregon	85	X		X	X		11/87
Pennsylvania	100	X		X		X	4/88
Rhode Island	185		X	X	X		4/87
South Carolina	185		X	X	X		10/87
South Dakota	100	X		X	X		7/88
Tennessee	100		X	X	X	X	7/87
Texas	130	X			X	X	9/88
Utah	100			X	X	X	1/89
Vermont	185		X	X	X		10/87
Virginia	100	X		X	X		7/88
Washington	185		X	X	X		7/87
West Virginia	150		X	X	X		7/87
Wisconsin	***					X	4/88
Wyoming	100		X	X	X		10/88
TOTAL	45	19	19	42	41	23	

FUTURE IMPLEMENTATION DATE
COMPLIANCE WITH MINIMUM MANDATED COVERAGE
*** STATE FUNDED PROGRAM COVERS PREGNANT WOMEN AND INFANTS BELOW 120% OF POVERTY

SOURCE: NATIONAL GOVERNORS' ASSOCIATION - JULY, 1989

ANNUALIZED MEDICAID ELIGIBILITY THRESHOLDS [a]

AFDC, MEDICALLY NEEDY, OBRA 86/87 PREGNANT WOMEN – JULY 1989

	AFDC FAMILY OF 3	PERCENT OF POVERTY $10,060	MEDICALLY NEEDY FAMILY OF 3	PERCENT OF POVERTY $10,060	OBRA-86/87 PREGNANT WOMEN FAMILY OF 3	PERCENT OF POVERTY $10,060 [b]	
Alabama	$1,416	14.1%	$--------		$10,060	100.0%	
Alaska	9,708	77.2%			12,580	100.0%	
Arizona	3,516	35.0%			10,060	100.0%	
Arkansas	2,448	24.3%	3,300	32.8%	10,060	100.0%	
California	8,328	82.8%	10,704	106.4%	18,611	185.0%	
Colorado	5,052	50.2%			7,545	75.0%	*
Connecticut	6,660	66.2%	8,857	88.0%	18,611	185.0%	
Delaware	3,996	39.7%			10,060	100.0%	
D.C.	4,716	46.9%	6,288	62.5%	10,060	100.0%	
Florida	3,444	34.2%	4,596	45.7%	15,090	150.0%	
Georgia	4,968	49.4%	4,404	43.8%	10,060	100.0%	
Hawaii	7,224	62.4%	7,224	62.4%	21,405	185.0%	
Idaho	3,780	37.6%			7,545	75.0%	*
Illinois	4,104	40.8%	5,496	54.6%	10,060	100.0%	
Indiana	3,456	34.4%			10,060	100.0%	
Iowa	4,920	48.9%	6,600	65.6%	18,611	185.0%	
Kansas	4,920	48.9%	5,760	57.3%	15,090	150.0%	
Kentucky	6,312	62.7%	3,696	36.7%	12,575	125.0%	
Louisiana	2,280	22.7%	3,096	30.8%	10,060	100.0%	
Maine	7,584	75.4%	7,092	70.5%	18,611	185.0%	
Maryland	4,752	47.2%	5,508	54.8%	18,611	185.0%	
Massachusetts	6,948	69.1%	9,300	92.4%	18,611	185.0%	
Michigan	6,900	68.6%	6,660	66.2%	18,611	185.0%	
Minnesota	6,384	63.5%	8,508	84.6%	18,611	185.0%	
Mississippi	4,416	43.9%			18,611	185.0%	
Missouri	3,420	34.0%			10,060	100.0%	
Montana	4,308	42.8%	4,896	48.7%	10,060	100.0%	
Nebraska	4,368	43.4%	5,904	58.7%	10,060	100.0%	
Nevada	3,960	39.4%			7,545	75.0%	*
New Hampshire	6,072	60.4%	6,900	68.6%	7,545	75.0%	*
New Jersey	5,088	50.6%	6,792	67.5%	10,060	100.0%	
New Mexico	3,168	31.5%			10,060	100.0%	
New York	6,468	64.3%	8,508	84.6%	18,611	185.0%	
North Carolina	3,192	31.7%	4,296	42.7%	10,060	100.0%	
North Dakota	4,632	46.0%	5,220	51.9%	7,545	75.0%	*
Ohio	3,852	38.3%			10,060	100.0%	
Oklahoma	5,652	56.2%	5,196	51.7%	10,060	100.0%	
Oregon	5,184	51.5%	6,900	68.6%	8,591	85.4%	
Pennsylvania	4,608	45.8%	5,400	53.7%	10,060	100.0%	
Rhode Island	6,516	64.8%	8,700	86.5%	18,611	185.0%	
South Carolina	5,028	50.0%			18,611	185.0%	
South Dakota	4,524	45.0%			10,060	100.0%	
Tennessee	4,644	46.2%	3,000	29.8%	10,060	100.0%	
Texas	2,208	21.9%	3,204	31.8%	13,078	130.0%	
Utah	6,192	61.6%	6,192	61.6%	10,060	100.0%	
Vermont	7,812	77.7%	10,500	104.4%	18,611	185.0%	
Virginia	3,492	34.7%	4,296	42.7%	10,060	100.0%	
Washington	5,904	58.7%	7,188	71.5%	18,611	185.0%	
West Virginia	2,988	29.7%	3,480	34.6%	15,090	150.0%	
Wisconsin	6,204	61.7%	8,268	82.2%			
Wyoming	4,320	42.9%			10,060	100.0%	
AVG. STATE	$4,942	48.6%	$6,165	61.0%	$14,617	144.1%	

* COMPLYING WITH FEDERAL MANDATE

SOURCE: NATIONAL GOVERNORS' ASSOCIATION, JULY 1989

ANNUALIZED MEDICAID ELIGIBILITY THRESHOLDS a
AFDC, MEDICALLY NEEDY,
OBRA 86/87 PREGNANT WOMEN – JULY 1989

NOTES:

a. AFDC and Medically Needy thresholds current through July 1989. Under AFDC, the term "threshold" refers to that income limit that truly drives program eligibility. In most states, this is the Payment Standard. In COLORADO, GEORGIA, KENTUCKY, MAINE, MICHIGAN, MISSISSIPPI, OKLAHOMA, SOUTH CAROLINA, TENNESSEE and UTAH, the threshold is the state's Need Standard. Please note, in these ten states, the threshold that appears on the table is not what the state pays to AFDC recipients. These states' Payment Standards are actually significantly lower than the eligibility threshold.

b. Poverty levels for Hawaii and Alaska differ from other states: Alaska - family of three = $12,580; Hawaii - family of three = $11,570.

SOURCE: NATIONAL GOVERNORS' ASSOCIATION, JULY 1989

AID TO FAMILIES WITH DEPENDENT CHILDREN (AFDC)
MONTHLY NEED AND PAYMENT AMOUNTS - JULY 1989

	FAMILY OF ONE		FAMILY OF TWO		FAMILY OF THREE		FAMILY OF FOUR	
	NEED STANDARD	MAXIMUM PAYMENT	NEED STANDARD	MAXIMUM PAYMENT	NEED STANDARD	MAXIMUM PAYMENT	NEED STANDARD	MAXIMUM PAYMENT
Alabama	$390	$59	$479	$88	$571	$118	$670	$147
Alaska	453	453	719	719	809	809	899	899
Arizona	367	173	494	233	621	293	748	353
Arkansas	280	81	560	162	705	204	850	247
California	341	341	560	560	694	694	824	824
Colorado	253	214	331	280	421	356	510	432
Connecticut	340	340	452	452	555	555	652	652
Delaware	184	184	247	247	333	333	402	402
DC	450	248	560	309	712	393	870	480
Florida	498	163	668	220	838	287	1008	338
Georgia	229	151	347	229	414	273	488	322
Hawaii	572	357	768	480	964	602	1160	725
Idaho	365	208	446	254	554	315	627	357
Illinois	427	198	539	250	740	342	835	386
Indiana	155	139	255	229	320	288	385	346
Iowa	213	176	421	347	497	410	578	476
Kansas	243	243	330	330	410	410	480	480
Kentucky	394	162	460	196	526	228	592	285
Louisiana	245	72	472	138	658	190	809	234
Maine	299	207	470	326	632	438	794	551
Maryland	243	175	428	309	548	396	660	477
Massachusetts	392	392	486	486	579	579	668	668
Michigan	348	291	466	388	575	479	702	585
Minnesota	250	250	437	437	532	532	621	621
Mississippi	218	60	293	96	368	120	443	144
Missouri	145	132	250	228	312	285	365	333
Montana	256	212	346	286	434	359	523	433
Nebraska	222	222	293	293	364	364	435	435
Nevada	350	210	450	270	550	330	650	390
New Hampshire	380	380	442	442	506	506	563	563
New Jersey	162	162	322	322	424	424	488	488
New Mexico	156	156	210	210	264	264	317	317
New York	334	334	439	439	539	539	639	639
North Carolina	354	177	462	231	532	266	582	291
North Dakota	209	209	313	313	386	386	472	472
Ohio	440	191	606	263	739	321	914	397
Oklahoma	291	201	364	252	471	325	583	403
Oregon	289	289	369	369	432	432	526	526
Pennsylvania	298	195	461	301	587	384	724	474
Rhode Island	321	321	440	440	543	543	620	620
South Carolina	249	123	335	165	419	206	504	248
South Dakota	265	265	333	333	377	377	421	421
Tennessee	198	94	297	141	387	184	472	224
Texas	235	75	493	158	574	184	691	221
Utah	299	224	414	310	516	387	603	452
Vermont	670	431	817	547	973	651	1090	730
Virginia	174	157	257	231	322	291	386	347
Washington	557	314	705	397	872	492	1026	578
West Virginia	289	145	401	201	497	249	623	312
Wisconsin	311	248	550	440	647	517	772	617
Wyoming	195	195	320	320	360	360	390	390

SOURCE: NATIONAL GOVERNORS' ASSOCIATION, JULY 1989

AID TO FAMILIES WITH DEPENDENT CHILDREN (AFDC)
MONTHLY NEED AND PAYMENT AMOUNTS - JULY 1989

NOTES:

IN A NUMBER OF STATES, NEED AND PAYMENT AMOUNTS VARY DEPENDING ON FACTORS SUCH AS REGION, SEASON (SUMMER OR WINTER), AND WHAT COMPONENTS ARE INCLUDED IN THE STANDARD (E.G., RENTAL ALLOWANCE. IN ALL SUCH CASES, THE REGION WITH THE HIGHEST CONCENTRATION OF RECIPIENTS AND/OR THE HIGHEST SEASONAL RATE IS DISPLAYED. DETAILED NOTES BY STATE (WHERE APPLICABLE) APPEAR BELOW.

CT - REGION B
KS - METROPOLITAN AREAS
LA - URBAN AREAS
MA - RENTAL ALLOWANCE INCLUDED
MI - ANNUALIZED SUMMER/WINTER AVERAGE
NY - NEW YORK CITY REGION
PA - PHILADELPHIA REGION
VT - CHITTENDEN COUNTY
VA - GROUP 2
WI - AREA 1

SOURCE: NATIONAL GOVERNORS' ASSOCIATION, JULY 1989

MEDICALLY NEEDY MONTHLY PROTECTED INCOME LEVELS
FAMILY SIZE ONE THROUGH FOUR - JULY 1989

	FAMILY OF ONE	FAMILY OF TWO	FAMILY OF THREE	FAMILY OF FOUR
Alabama	$------	$------	$------	$------
Alaska				
Arizona				
Arkansas	108	217	275	333
California	575	714	892	1059
Colorado				
Connecticut	452	601	738	867
Delaware				
DC	391	412	524	640
Florida	300	300	383	458
Georgia	208	308	367	433
Hawaii	357	480	602	725
Idaho				
Illinois	267	333	458	517
Indiana				
Iowa	466	466	550	633
Kansas	368	475	480	506
Kentucky	217	267	308	383
Louisiana	100	192	258	317
Maine	400	441	591	741
Maryland	375	417	459	500
Massachusetts	483	650	775	891
Michigan	391	525	555	585
Minnesota	466	582	709	828
Mississippi				
Missouri				
Montana	368	383	408	433
Nebraska	392	392	492	584
Nevada				
New Hampshire	382	554	575	597
New Jersey	350	433	566	658
New Mexico				
New York	459	659	709	850
North Carolina	242	308	358	392
North Dakota	345	400	435	530
Ohio				
Oklahoma	275	341	433	541
Oregon	385	491	575	701
Pennsylvania	408	425	450	542
Rhode Island	550	592	725	833
South Carolina				
South Dakota				
Tennessee	175	192	250	300
Texas	100	211	267	301
Utah	337	413	516	602
Vermont	733	733	875	975
Virginia	250	308	358	400
Washington	396	532	599	667
West Virginia	200	275	290	312
Wisconsin	471	592	689	823
Wyoming				

SOURCE: NATIONAL GOVERNORS' ASSOCIATION, JULY 1989

MEDICAID ELIGIBILITY:
SELECTED PROGRAM CHARACTERISTICS
September, 1989

Medicaid eligibility is acknowledged to be the most intricate piece of a very complex program. Designed in 1965 as a medical program for persons on existing welfare programs, the Medicaid program originally served only those eligible for Aid to Families with Dependent Children (AFDC) or for the programs now encompassed by the Supplemental Security Income (SSI) program.

However, since that time there have been numerous revisions and additions to the original list of mandated and optional eligibility categories. Some changes added large numbers of Medicaid eligibles, while others developed to protect selected groups of individuals added few new recipients. Over the years the revisions have resulted in overlapping categories rendering several unnecessary and others impossible to distinguish.

The myriad categories present program management challenges to Medicaid directors in terms of training eligibility workers, accounting for the various categories of individuals, and program budgeting. For local eligibility workers, there is the difficult task of learning all the different "boxes" into which an individual might fit and then the challenge of determining how the boxes relate to the real live applicant sitting at your desk. A person placed in the wrong box, especially a person allowed Medicaid access in error, can result in penalties imposed by the federal government against the state. Eligibility errors can result in substantial financial penalties.

This narrative and attached tables provide information on state coverage of major eligibility options as of September 30, 1989, the end of the federal fiscal year. Following a brief discussion on recent changes in Medicaid eligibility concepts, there is a description of state eligibility criteria. In that description, the myriad separate categories are combined into four general ways of achieving Medicaid access. Each of the four are discussed with special attention paid to state response to recent federal legislative changes. Finally, there is a comparison of eligibility across the four major categories. While the attempt is to create an overview of Medicaid eligibility across states, it must be remembered that the attached only addresses major issues and eligibility categories. A comprehensive analysis would require detailed examination of all eligibility categories and requirements.

RECENT DIRECTIONS IN MEDICAID ELIGIBILITY

Most revisions to Medicaid eligibility were actually changes to eligibility for the welfare programs, until the Omnibus Budget Reconciliation Act of 1986 (OBRA 86) added new categories of poverty-related rather than welfare-related persons. While the OBRA 86 provisions broadened eligibility options for needy persons through the addition of new categories and the severing of traditional links between Medicaid eligibility and the financial requirements of income assistance programs, they also further complicated Medicaid eligibility.

Prior to OBRA 86 individuals became Medicaid eligible because they met the characteristics, income thresholds and resource standards of the AFDC program or the SSI program, or because they met the AFDC or SSI characteristics and had sufficient medical bills to reduce their countable income to Medicaid Medically Needy income thresholds.

OBRA 86 established new Medicaid eligibility options. The new categories include poor pregnant women and children, and aged and disabled, who do not meet AFDC or SSI income standards, but do meet a state-selected percentage of the federal poverty guidelines. The new coverage groups represent a first severing of the link between AFDC and Medicaid eligibility for poor pregnant women and children as well as a severing of the link between SSI and Medicaid eligibility for the elderly.

Since OBRA 86, there have been several expansions to the poor pregnant women and children groups and an expansion for the poor elderly. OBRA 87 allowed states to increase income standards for pregnant women and infants up to 185 percent of poverty. It also permitted broader coverage of children under poverty. The Medicare Catastrophic Coverage Act of 1988 (MCCA 88) mandated that all states phase-in coverage of pregnant women and infants up to 100 percent of poverty. It also required state Medicaid programs to pay Medicare cost-sharing amounts for poor Medicare beneficiaries. OBRA '89 added additional coverages effective in 1990. Most importantly, as of April 1990, states must cover pregnant women and children up to age 6 in families with incomes up to 133 percent of poverty.

MAJOR ELIGIBILITY CATEGORIES

The numerous eligibility categories can be grouped into four routes to Medicaid eligibility: AFDC; SSI; Medically Needy; and Poverty-related Pregnant Women and Children, and Aged/Disabled. AFDC is generally the route to Medicaid for families with children where one parent is absent from the home. SSI is the route for aged, blind, and disabled meeting that program's requirements. Medically Needy individuals are those who have income in excess of AFDC or SSI income thresholds, but have sufficient medical bills that reduce their countable income to Medically Needy income thresholds. The process of counting medical bills against income is known as "spenddown." Poverty-related Pregnant Women and Children are those who have income exceeding the AFDC income standard up to a state-selected percentage of poverty. Similarly, the Aged/Disabled may have income in excess of SSI standards up to the state-selected poverty figure.

However, within these categories there are many permutations of the general program rules. For example, while Medicaid is required to cover AFDC recipients, there are AFDC "type" or "AFDC-related" individuals who must also be covered, including: families losing AFDC because of employment, families losing AFDC because earned income disregard provisions do not apply, families losing AFDC because of child support, and persons whose AFDC cash payment would be less than $10.

At the same time that there are different family types within one category, a particular type of individual may qualify through more than one eligibility route. For example, a poor pregnant woman may qualify as AFDC-related, Medically Needy, or through the Poverty-related Pregnant Women category. To qualify as AFDC-related, the woman must be single and meet AFDC income and resource standards. If she is married and has income above the AFDC standard, but below the state-selected percentage of poverty, she may qualify under the Poverty-related Pregnant Women category. In most states, under this option, her resources are not considered. If she has income and resources exceeding the standards in either of these programs, but can spenddown to the state's Medically Needy income level, she can qualify through the Medically Needy program. Because Medically Needy income standards are considerably lower than the poverty-related standards, she spends down to a significantly lower percentage of poverty to qualify for Medicaid.

AFDC-Related Groups

Nearly three-quarters of all recipients access Medicaid because of their AFDC-related status. States must provide Medicaid to all persons receiving AFDC. Generally, AFDC payments are made to families with children where one parent is absent from the home.

States establish income and resource standards for their AFDC programs. As part of the income standard, states establish a monthly "need standard," representing the state's determination of the minimum amount of money a family of a given size needs to subsist, and a monthly "payment standard," the actual maximum payment a state makes to an eligible family. States use these standards differently to calculate payments and depending upon the method used either the need or payment standard may drive program eligibility. (For further explanation of calculation methods refer to "Medicaid Eligibility: Summary Status of Selected Program Characteristics," Catalogue of State Medicaid Program Characteristics, 1989.)

Table 1 lists each state's **AFDC Need Standard and Maximum Payment.** Using these standards along with the information on which standard drives eligibility determinations in each state, it is possible to determine that for a family of three, which is the average AFDC family size, the income threshold across states averages $412/month. This amount represents 49.7 percent of the 1989 federal poverty level standard for that family. For an AFDC family of two, the income threshold averages $335/month (50 percent of poverty). Twenty-one states have income standards that are above 50 percent of poverty.

States have the option of covering two-parent families who meet AFDC income and resource standards when the principal breadwinner is unemployed. Thirty-four states extend Medicaid coverage to such **AFDC-unemployed parent (AFDC-UP)** families (Table 2). Beginning October 1, 1990, this optional group becomes mandatory because of a Medicaid provision in the Family Support Act of 1988.

Another AFDC-related optional group is **"Ribicoff Children."** These are children who meet AFDC income and resource requirements, but not the characteristics of a "dependent" child. States may cover all such children up to a specified age limit including those from intact two-parent families. Alternatively, a state may cover selected categories of Ribicoff children. Major categories of these children include those whose adoptions were partially or fully subsidized through public funds, children in foster homes or private institutions, children in intermediate care facilities, those in intermediate care facilities for the mentally retarded, and children in inpatient psychiatric facilities. In addition, states may define other reasonable categories of such children (Table 3).

To cover children in foster homes or private institutions, states must have assumed partial or full financial responsibility for the children. If states cover such publicly supported children, they may choose to cover children placed in foster homes or private institutions when placed by private non-profit agencies. Coverage of children in institutions is contingent upon that institutional coverage being a part of the state plan. Three states do not cover psychiatric facilities and, therefore, do not cover this category of Ribicoff children.

All states cover some Ribicoff children. Thirty states cover all such AFDC-related children, including those in intact families, up to age 18. Of these states, twenty cover these children up to age 21. Six of the nine states covering all children up to

age 18 cover selected categories of them up to age 21. The remaining states cover some categories, often using different age limits for the various categories. Six of these states have developed additional reasonable classifications of Ribicoff children.

In addition to optional coverage of Ribicoff children. It is important to note that all states are required to cover some "Ribicoff-type" children. The Deficit Reduction Act of 1984 (DEFRA) mandated a phase-in of all children who meet AFDC financial requirements and were born after September 30, 1983, regardless of family structure. The DEFRA requirement only applied to such **qualified children** up to age 5. Subsequent amendments have been made to that provision so that currently states are required to cover all children up to age 7 who meet AFDC income and resource requirements. As of September 30, 1989, the oldest children in this AFDC-related group were age 6. States may cover additional children in this age bracket through the poverty-related coverages.

Other optional AFDC-related individuals include those eligible for, but not receiving AFDC payments (28 states) and those who would be eligible for Medicaid if not in a Medicaid institution or intermediate care facility because of lower income standards used to determine eligibility in these institutions (29 states). Another category is of families who would be eligible if their child care costs were paid from their earnings, rather than by a state agency (12 states)(Table 4).

Supplemental Security Income-Related Groups

Aged, blind, and disabled persons often access Medicaid by meeting the characteristics, income thresholds, and resource standards of the SSI program. The non-financial requirements include that the individual be age 65 or over, blind, or have a permanent disability preventing that person from engaging in substantial gainful activity. For children, qualifying disabilities are those that would qualify an adult for SSI payments.

Unlike the AFDC program, federal statute dictates a uniform SSI program income or payment standard. In 1989, the standard was $368/month for an individual and $553/month for a couple. The statute set resource standard was $2,000 for an individual and $3,000 for couples.

The payment standard plus any state supplement payments (SSPs) made to an SSI recipient constitutes the eligibility threshold for an SSI recipient. Most states make such optional SSPs to some categories of **SSI elderly and disabled individuals** in selected assisted living arrangements. The amount of these payments generally relates to the level of assistance provided in the living arrangement. The most typical SSP category that applies equally across states is the SSP for individuals and couples living independently in the community. About half of the states make this category of SSP payment (Table 6).

All states cover some SSI individuals. Thirty-eight provide Medicaid to all SSI recipients. Thirteen states, commonly referred to as "209(b)" states, cover only SSI individuals who meet their generally more restrictive criteria. The "209(b)" states use disability definitions, income disregards, or resource standards which vary from those used by the SSI program (The term "209(b)" refers to the section of the enabling legislation authorizing this latitude.) States using more restrictive financial standards must allow higher income individuals to spenddown to those standards even if the state does not have a Medically Needy program. The standards used by these 13 states are listed on Table 7. There were 14 such states, but Utah indicates that it has elected to cover all SSI eligibles.

In twenty-seven states, **institutionalized individuals** may qualify for Medicaid based upon a higher income standard than that used for AFDC or SSI individuals. States are allowed to use an income standard that is as much as 300 percent of the SSI uniform payment, which in 1989 meant states could use an income threshold up to $1104. The resource standard for this group is the same as for non-institutionalized SSI persons.

If a state uses a higher income threshold for this group, the same standard may be used for home- and community-based services (HCBS) waiver recipients and must be used for optional disabled children who are served in the home in lieu of institutionalization.

Ten states do not use an income threshold for institutional individuals, instead treating them as Medically Needy and allowing them to spenddown to Medically Needy Income Levels (MNIL). All states use either Medically Needy programs or higher income standards to qualify persons in institutions with income and/or resources in excess of SSI standards.

Another SSI-related group is disabled children under age 18 who require an institutional level of care, but can be cared for cost-effectively at home. Coverage for this group, authorized by the Tax Equity and Fiscal Responsibility Act of 1982 (TEFRA), has been adopted by eighteen states (Table 9). All of these states and most other states operate HCBS waivers which include such children, thus using a service option to extend eligibility for disabled children (For further information, see Medicaid Home Care Options for Disabled Children, NGA 1990).

Similar to the disabled children option is the option for **ventilator-dependent individuals** authorized by OBRA 87 which has been adopted by six states (Table 9). However, as they do for disabled children, many states use HCBS waivers to provide cost-effective home care to these individuals who would otherwise require institutionalization.

Other eligibility expansions authorized in MCCA 88, which are significant for disabled and institutionalized individuals include those related to "spousal impoverishment." These provisions, which were effective September 30, 1989, protect a portion of the couple's income and resources for the community spouse.

Under the provisions, the community spouse's income is protected up to at least 122 percent of the 1989 poverty level for a family of two ($815/month). In terms of resources, community spouses retain their home, as well as a **community spouse resource allowance** (CSRA). The allowance may vary from $12,000 up to $60,000 depending on the couple's resources and the state-selected CSRA minimum. States must allow community spouses to keep the greater of $12,000 and one-half of the couple's joint assets up to $60,000. However, states may choose to raise the $12,000 minimum as high as $60,000, which allows the community spouse to retain all resources up to $60,000. Sixteen states have chosen $60,000 as the minimum allowance (Table 9).

Medically Needy Individuals

Medically needy persons are those whose income and/or resources exceed the AFDC or SSI standards, but meet the higher income and resource standards of a state's Medically Needy program, or have sufficient medical expenses to reduce their countable income to Medically Needy Income Levels. The process of subtracting medical expenses from income is referred to as "spenddown."

Medically Needy programs must cover pregnant women and children under age 18. In addition, categories of individuals selected for the Medically Needy program must already be covered in the state's Medicaid program.

Thirty-six states have Medically Needy programs. Of these, thirty cover all the classifications shown on Table 11. Six cover selected categories. Twenty-five states with Medically Needy programs cover qualifying **children up to age 21**; eleven states cover children up to age 18 or 19. Moreover, nearly all the states cover **caretaker relatives, aged, blind, and disabled.**

States specify income standards for each group within their Medically Needy program. Standards must be based on family size and be uniform for all individuals within the group. Several states have varying rates for geographic regions within the state or for seasons of the year. The income standards may not exceed 133 1/3 percent of the state's AFDC payment for the same size family. The Medically Needy Income Levels for a family of two across all states averages $435/month which represents 65 percent of poverty (Table 12).

Poverty-Related Pregnant Women, Children, and Aged/Disabled

Poverty-Related Pregnant Women and Infants

The optional coverage of **Poverty-related Pregnant Women and Infants** was established in OBRA 86 and expanded upon in OBRA 87 and MCCA 88. As of July 1989, states were required to cover pregnant women and their infants in families with incomes up to 75 percent of poverty ($629/month for a family of three). Forty-six states exceeded the mandate and extended eligibility to pregnant women and infants up to as much as 185 percent of poverty ($1,551/month for a family of three)(Table 5). On average, states cover this group up to 126 percent of poverty ($1,056/month for a family of three). A family of two at 126 percent of poverty translates to $848/month.

Also for this group, states can simplify eligibility by waiving resource standards (assets tests) (42 states) or by adopting continuous eligibility (41 states). Twenty-three states have established presumptive eligibility for this group. Thus, the majority of states have increased eligibility thresholds and streamlined applications in order to improve Medicaid access for pregnant women. (For additional information, see "Medicaid Eligibility: Summary Status of Selected Program Characteristics," Catalogue of State Medicaid Program Characteristics, 1989 and Reaching Women Who Need Prenatal Care: Strategies for Improving State Perinatal Programs, 1988.)

Poverty-Related Children

Increased options for **Poverty-related Children** were also authorized in OBRA 86 and OBRA 87. The options in these statutes allow states to phase-in children up to age 8, born after September 30, 1983, and in families with incomes above AFDC and up to the poverty level. Thirty-seven states extend eligibility to such children, using either the original OBRA 86 phase-in and cover children in the 2-4 age range or on the accelerated OBRA 87 plan and cover children in the 5-6 age bracket. As of September 30, 1989, age 6 was the upper limit for poor children covered through these options. Table 5 shows coverage of these children as implemented in September 1989, although some states have already selected higher age groups and will "age-in" these children as they grow older.

Aged/Disabled and Qualified Medicare Beneficiaries

OBRA 86 allowed states to extend Medicaid coverage to the **Poverty-related Aged and Disabled** with incomes up to 100 percent of poverty and resources at the SSI level or the state's Medically Needy Income Level. OBRA 86 also required states selecting this option to simultaneously adopt the Poverty-related Pregnant Women and Infants option. Six states have selected the Aged/Disabled option, four of them adopted it in 1989.

Additional assistance is available for poverty-related aged and disabled as a result of MCCA 88 provisions on Medicare cost-sharing for certain poor Medicare persons whether or not they are Medicaid eligible. Prior to MCCA 88, Medicaid programs could choose to pay Medicare cost-sharing expenses for Medicaid recipients who were also Medicare eligible. All states covered some cost-sharing expenses for at least some dually eligible recipients. The new provisions require states to cover Medicare premiums, deductibles, and coinsurance cost-sharing amounts for all **qualified Medicare beneficiaries (QMBs)** whether or not they are Medicaid eligible.

Beginning in January 1989, states were required to pay Medicare cost-sharing payments for Medicare beneficiaries who are Medicare Part A eligible persons with incomes up to 85 percent of poverty and resources up to two times the SSI program resource standard. Thus, in 1989, an elderly individual could qualify for this cost-sharing coverage if he or she had income up to $424/month and resources up to $4,000.

On January 1, 1990, states are required to cover QMBs up to 90 percent of poverty. The resource limit remains the same. The mandated phase-in continues until QMBs are covered up to 100 percent of poverty in January 1992. A more gradual phase-in was granted to states that as of January 1987 used more restrictive income standards for persons over age 65 than those used by the SSI program. Four states are following the 5-year phase-in plan and will reach 100 percent of poverty by January 1993.

While QMB coverage was mandated at 85 percent of poverty, states were allowed to select a higher percentage, up to 100 percent. Twelve states opted for immediate implementation of the 100 percent standard (Table 9).

Five of the six states having selected the Poverty-related Aged and Disabled option have matched the percentage of poverty for this optional group to the percentage used for QMBs, thus somewhat simplifying eligibility and coverage issues relating to the aged and disabled.

SUMMARY

The monthly eligibility threshold, the maximum amount of income or protected income, for each major group is presented in Table 13. The thresholds are then expressed as a percentage of the 1989 federal poverty level. The attempt is to provide some comparison across eligibility categories, by comparing eligibility thresholds for each group. For this comparison, a family size of two was chosen because a pregnant woman is always counted as two persons and a family size of two can be assessed for the other programs.

The Medicaid eligibility route with the lowest average eligibility threshold is AFDC at $335/month or 50 percent of poverty. The elderly, who are primarily in the SSI and QMB programs, fare better because these programs cover individuals up to about 91 percent of poverty. The highest threshold is for Poverty-related Pregnant Women and Infants who, on average, are covered up to 126 percent of poverty ($848/month).

While this table provides some interesting comparisons among groups, the percentage for each group is only calculated against the federal poverty which is a national standard. Further study of these thresholds might be enhanced by comparing each state's eligibility thresholds with data specific to the state. For example, state average per capita income or the income distribution data for each state would be useful. Such comparisons might develop a better picture of how each Medicaid program serves its low-income people.

What is clear from this comparison is that the different routes to Medicaid offer access at varying levels of generosity. These variations reflect policymakers' concerns over the years as to each group's need for Medicaid coverage in order to access adequate health care. As adjustments were made to facilitate access for selected groups, Medicaid eligibility has become more complex, as has Medicaid agencies' task of administering the Medicaid program.

For further information or clarification of material presented in this narrative or the attached tables, please contact Linda A. Hall (202) 624-7729.

SOURCE: National Governors' Association, 1990.

TABLE 1

AID TO FAMILIES WITH DEPENDENT CHILDREN (AFDC)
MONTHLY NEED AND PAYMENT AMOUNTS - SEPTEMBER 1989

	FAMILY OF ONE		FAMILY OF TWO		FAMILY OF THREE		FAMILY OF FOUR	
	NEED STANDARD	MAXIMUM PAYMENT	NEED STANDARD	MAXIMUM PAYMENT	NEED STANDARD	MAXIMUM PAYMENT	NEED STANDARD	MAXIMUM PAYMENT
Alabama	$390	$59	$479	$88	$571	$118	$670	$147
Alaska	453	453	719	719	809	809	899	899
Arizona	367	173	494	233	621	293	748	353
Arkansas	280	81	560	162	705	204	850	247
California	341	341	560	560	694	694	824	824
Colorado	253	214	331	280	421	356	510	432
Connecticut	340	340	452	452	555	555	652	652
Delaware	184	184	247	247	333	333	402	402
DC	450	248	560	309	712	393	870	480
Florida	498	163	668	220	838	287	1008	338
Georgia	229	151	347	229	414	273	488	322
Hawaii	572	357	768	480	964	602	1160	725
Idaho	365	208	446	254	554	315	627	357
Illinois	427	198	539	250	740	342	835	386
Indiana	155	139	255	229	320	288	385	346
Iowa	213	176	421	347	497	410	578	476
Kansas	243	243	330	330	410	410	480	480
Kentucky	394	162	460	196	526	228	592	285
Louisiana	245	72	472	138	658	190	809	234
Maine	299	207	470	326	632	438	794	551
Maryland	243	175	428	309	548	396	660	477
Massachusetts	392	392	486	486	579	579	668	668
Michigan	348	291	466	388	575	479	702	585
Minnesota	250	250	437	437	532	532	621	621
Mississippi	218	60	293	96	368	120	443	144
Missouri	145	134	250	232	312	289	365	338
Montana	256	212	346	286	434	359	523	433
Nebraska	222	222	293	293	364	364	435	435
Nevada	350	210	450	270	550	330	650	390
New Hampshire	380	380	442	442	506	506	563	563
New Jersey	162	162	322	322	424	424	488	488
New Mexico	156	156	210	210	264	264	317	317
New York	334	334	439	439	539	539	639	639
North Carolina	354	177	462	231	532	266	582	291
North Dakota	209	209	313	313	386	386	472	472
Ohio	440	191	606	263	739	321	914	397
Oklahoma	291	201	364	252	471	325	583	403
Oregon	289	289	369	369	432	432	526	526
Pennsylvania	298	195	461	315	587	402	724	490
Rhode Island	321	321	440	440	543	543	620	620
South Carolina	249	123	335	165	419	206	504	248
South Dakota	265	265	333	333	377	377	421	421
Tennesee	198	94	297	141	387	184	472	224
Texas	235	75	493	158	574	184	691	221
Utah	299	224	414	310	516	387	603	452
Vermont	670	448	817	547	973	651	1090	730
Virginia	174	157	257	231	322	291	386	347
Washington	579	314	733	397	907	492	1068	578
West Virginia	289	145	401	201	497	249	623	312
Wisconsin	311	248	550	440	647	517	772	617
Wyoming	195	195	320	320	360	360	390	390

SEE NOTES ON NEXT PAGE

SOURCE: NATIONAL GOVERNORS' ASSOCIATION, SEPTEMBER 1989

TABLE 1

AID TO FAMILIES WITH DEPENDENT CHILDREN (AFDC)
MONTHLY NEED AND PAYMENT AMOUNTS - SEPTEMBER 1989

NOTES:

In a number of states, need and payment amounts vary depending on factors such as region, season (summer or winter), and what components are included in the standard (e.g., allowance). In all such cases, the region with the highest concentration of recipients and/or the highest seasonal rate is displayed. Detailed notes by state (where applicable) appear below.

CT - REGION B
KS - METROPOLITAN AREAS
LA - URBAN AREAS
MA - RENTAL ALLOWANCE INCLUDED
MI - ANNUALIZED SUMMER/WINTER AVERAGE
NY - NEW YORK CITY REGION
PA - PHILADELPHIA REGION
VT - CHITTENDEN COUNTY
VA - GROUP 2
WI - AREA 1

SOURCE: NATIONAL GOVERNORS' ASSOCIATION, SEPTEMBER 1989

TABLE 2

*FAMILIES WITH UNEMPLOYED PARENTS**

AFDC-UP Families

State	*AFDC Cash & Medicaid*	*Medicaid-Only*	*Does Not Cover*
Alabama			X
Alaska			X
Arizona			X
Arkansas			X
California	X		
Colorado			X
Connecticut	X		
Delaware	X		
District of Columbia	X		
Florida		X	
Georgia		X	
Hawaii	X		
Idaho			X
Illinois	X		
Indiana			X
Iowa	X		
Kansas	X		
Kentucky		X	
Lousiana		X	
Maine	X		
Maryland	X		
Massachusetts	X(19)	X(21)	
Michigan	X		
Minnesota	X		
Mississippi			X
Missouri	X		
Montana	X		
Nebraska	X		
Nevada			X
New Hampshire			X
New Jersey	X		
New Mexico			X
New York	X		
North Carolina	X		
North Dakota			X
Ohio	X		
Oklahoma		X	
Oregon	X		
Pennsylvania	X		
Rhode Island	X		
South Carolina	X		
South Dakota			X
Tennessee			X
Texas			X
Utah	X**		
Vermont	X		
Virginia			X
Washington	X		
West Virginia	X		
Wisconsin	X		
Wyoming			X
TOTAL	29	6	17

* The Family Support Act makes this option mandatory as of October 1, 1990.

** Limited coverage under 1115 demonstration project

SOURCE: NATIONAL GOVERNORS' ASSOCIATION, SEPTEMBER 1989

TABLE 3

AFDC-RELATED CHILDREN COVERAGE

State	*RIBICOFF CHILDREN**						
	*All Under Age ** *	*Reasonable Classification*					
		Foster Homes/ Private Inst.	Adoptions	ICFs	ICFs/MR	Psych. Facit.	Other Defined Groups
Alabama		18	18	18	18	18	
Alaska	21						
Arizona	18						
Arkansas	18	21	18	18	18	21	
California	21						
Colorado		21	21	21	21	21	
Connecticut	21						
Delaware		21	21	21	21	21	
District of Columbia	21						
Florida	18	21	18				21
Georgia		18	18	18	18		
Hawaii		19	21	19	19	19	
Idaho		21	21	21	21	N/C	18
Illinois	18	21	21	21	21	N/C	
Indiana						21	21
Iowa	21						
Kansas	18	21	21	21	21	21	
Kentucky		19	19	19	19	19	
Lousiana		18	18	18	18	18	
Maine	21						
Maryland	21						
Massachusetts	21						
Michigan	21						
Minnesota	21						
Mississippi	18						
Missouri		21	21	21	21	21	
Montana		21	21	21			
Nebraska	21						
Nevada		19	19	19	19	N/C	
New Hampshire		19	19				18
New Jersey	21						
New Mexico		18	18	21	21		
New York	21						
North Carolina	21	21	18	21	21	21	
North Dakota	21						
Ohio	21						
Oklahoma	21						
Oregon		18	18	21	21	21	
Pennsylvania	21	19	19	21	21	21	
Rhode Island		18		21	21	21	
South Carolina	18	21	21	21	21	21	
South Dakota		21	21	21	21		21
Tennessee	21						
Texas	19						
Utah	18						
Vermont	21						
Virginia		21	21	21	21	N/C	
Washington		21	21	21	21	21	18
West Virginia		18	18	18	18	18	
Wisconsin	18	18	18	18	18	21	
Wyoming		19	19				

Key: N/C = Service not covered in the state

NOTES:

* Ribicoff children meet the AFDC financial criteria, but not the " dependent" criteria, i.e.; deprived of the support of a parent. Most come from two-parent households; some are in other living arrangements.

** All Ribicoff children are covered up to the specified age, unless otherwise indicated in the adjacent columns.

SOURCE: NATIONAL GOVERNORS' ASSOCIATION, SEPTEMBER 1989

TABLE 4

FAMILIES WITH DEPENDENT CHILDREN: SELECTED OPTIONAL MEDICAID ELIGIBILITY GROUPS

State	Eligible For But Not Receiving AFDC	Would Be Eligible If Not In An Institution	Would Be Eligible If Child Care Costs Were Paid From Earnings
Alabama	No	Yes	No
Alaska	Yes	Yes	No
Arizona	Yes	Yes	No
Arkansas	Yes	Yes	No
California	No	No	No
Colorado	Yes	No	Yes
Connecticut	Yes	Yes	Yes
Delaware	No	Yes	No
District of Columbia	Yes	Yes	Yes
Florida	No	Yes	No
Georgia	No	Yes	No
Hawaii	Yes	Yes	Yes
Idaho	Yes	Yes	No
Illinois	No	No	No
Indiana	No	No	No
Iowa	Yes	Yes	No
Kansas	No	No	No
Kentucky	No	No	No
Lousiana	No	Yes	No
Maine	Yes	Yes	No
Maryland	Yes	Yes	No
Massachusetts	Yes	Yes	No
Michigan	No	No	No
Minnesota	Yes	Yes	No
Mississippi	No	Yes	No
Missouri	No	No	No
Montana	Yes	Yes	Yes
Nebraska	No	No	No
Nevada	No	Yes	No
New Hampshire	Yes	Yes	No
New Jersey	Yes	Yes	No
New Mexico	No	Yes	No
New York	Yes	Yes	Yes
North Carolina	Yes	No	No
North Dakota	No	No	No
Ohio	No	Yes	Yes
Oklahoma	Yes	Yes	Yes
Oregon	Yes	Yes	No
Pennsylvania	Yes	Yes	Yes
Rhode Island	Yes	Yes	Yes
South Carolina	No	Yes	No
South Dakota	No	Yes	No
Tennessee	Yes	Yes	No
Texas	No	Yes	No
Utah	Yes	Yes	Yes
Vermont	Yes	Yes	Yes
Virginia	Yes	Yes	No
Washington	Yes	Yes	No
West Virginia	Yes	No	No
Wisconsin	Yes	Yes	Yes
Wyoming	No	Yes	No
TOTALS:			
Yes	28	39	12
No	23	12	39

SOURCE: NATIONAL GOVERNORS' ASSOCIATION, SEPTEMBER 1989

TABLE 5

COVERAGE OPTIONS FOR PREGNANT WOMEN AND CHILDREN, AS OF SEPTEMBER 1989

	PREGNANT WOMEN AND INFANTS PERCENT POVERTY	OLDER CHILDREN COVERED UNDER POVERTY TO AGE 6*	DROPPED ASSETS TEST	CONTINUOUS ELIGIBILITY	PRESUMPTIVE ELIGIBILITY	ORIGINAL EFFECTIVE DATE
Alabama	100		X	X	X	7/88
Alaska	100	3	X	X		1/89
Arizona	100	6	X	X		1/88
Arkansas	100	6	X	X	X	4/87
California	185					7/89
Colorado	75				X**	7/89
Connecticut	185		X	X		4/88
Delaware	100	3	X	X		1/88
DC	100	3	X	X		4/87
Florida	150	6	X	X	X	10/87
Georgia	100	3	X	X		1/89
Hawaii	185**	5	X	X	X	1/89
Idaho	75		X	X	X	1/89
Illinois	100			X	X	7/88
Indiana	100	3	X	X	X	7/88
Iowa	185	6		X	X	1/89
Kansas	150	5	X			7/88
Kentucky	125	2		X		10/87
Louisiana	100	6	X	X	X	1/89
Maine	185	6	X		X	10/88
Maryland	185	2	X	X	X	7/87
Massachusetts	185	5	X	X	X	7/87
Michigan	185	3	X	X		1/88
Minnesota	185	6	X	X		7/88
Mississippi	185	5	X	X		10/87
Missouri	100	3		X		1/88
Montana	100		X			7/89
Nebraska	100	3	X	X	X	7/88
Nevada	75	6	X			7/89
New Hampshire	75		X			7/89
New Jersey	100	2	X	X	X	7/87
New Mexico	100	3	X	X	X	1/88
New York	185		X	X	X	1/90**
North Carolina	100	6	X	X	X	10/87
North Dakota	75					7/89
Ohio	100		X	X		1/89
Oklahoma	100	2	X	X		1/88
Oregon	85	3	X	X		11/87
Pennsylvania	100	3	X		X	4/88
Rhode Island	185	6	X	X		4/87
South Carolina	185	6	X	X		10/87
South Dakota	100	2	X	X		7/88
Tennessee	100	5	X	X	X	7/87
Texas	130	4		X	X	9/88
Utah	100		X	X	X	1/89
Vermont	185	6	X	X		10/87
Virginia	100	2	X	X		7/88
Washington	185	6	X	X		7/87
West Virginia	150	6	X	X		7/87
Wisconsin	82				X	4/88
Wyoming	100		X	X		10/88
TOTAL	46***	37	42	41	23	

* This column does not include children's coverage groups supported by state only funds. Effective April 1, 1990 coverage is mandatory for children up to age 6 in families with income up to 133% of poverty.

** Future implementation date.

*** Forty-six states exceed minimum mandated coverage of 75% of poverty. Wisconsin covers pregnant women up to 130% of poverty but receives federal match up to 82%. Effective April 1, 1990 all states must cover pregnant women and infants up to 133% of poverty.

SOURCE: NATIONAL GOVERNORS' ASSOCIATION, September 1989

TABLE 6

SSI INCOME THRESHOLDS AND SUPPLEMENTS

State	*INDIVIDUALS* (Living independently in the community) SSI Base	State Supplement Payment	Total Cash Payment	*COUPLES* (Living independently in the community) SSI Base	State Supplement Payment	Total Cash Payment	*Other Supp Programs (other Indp living)*
Alabama	368	0	368	553	0	553	N
Alaska	368	317	685	553	462	1015	Y
Arizona	368	0	368	552	0	552	N
Arkansas	368	0	368	553	0	553	N
California	368	234	602	553	563	1116	Y
Colorado	368	58	426	553	284	837	Y
Connecticut	368	170	538	553	312	865	N
Delaware	368	0	368	553	0	553	Y
District of Columbia	368	0	368	553	0	553	N/R
Florida	368	0	368	553	0	553	N
Georgia	368	0	368	553	0	553	N
Hawaii	368	4.9	372.9	553	8.8	561.8	Y
Idaho	368	73	441	553	45	598	Y
Illinois	368		368	553		553	Y
Indiana	368	0	368	553	0	553	Y
Iowa	368	0	368	553	0	553	Y
Kansas	368	0	368	553	0	553	N
Kentucky	368	0	368	553	0	553	Y
Lousiana	368	0	368	553	0	553	N
Maine	368	10	378	553	15	568	Y
Maryland	368	0	368	553	0	553	N
Massachusetts	368	128.82	496.82	553	201.72	754.72	N/R
Michigan	368	30.2	398.2	553	45.3	598.3	Y
Minnesota	368	46	414	553	41	594	Y
Mississippi	368	0	368	553	0	553	N
Missouri	368	0	368	553	0	553	Y
Montana	368	0	368	553	0	553	Y
Nebraska	368	62.5	430.5	553	91.5	644.5	Y
Nevada	368	36.4	404.4	553	74.46	627.46	Y
New Hampshire	368	14	382	553	1	554	Y
New Jersey	368	31.25	399.25	553	25.36	578.36	Y
New Mexico	368	0	368	553	0	553	N
New York	368	86	454	553	102.5	655.5	Y
North Carolina	368	0	368	553	0	553	N
North Dakota	368	0	368	553	0	553	N
Ohio	368	0	368	553	0	553	Y
Oklahoma	368	64	432	553	128	681	N
Oregon	368	1.7	369.7	553	0	553	Y
Pennsylvania	368	32.4	400.4	553	48.7	601.7	Y
Rhode Island	368	61.45	429.45	553	115.1	668.1	Y
South Carolina	368	0	368	553	0	553	Y
South Dakota	368	15	383	553	15	568	Y
Tennessee	368	0	368	553	0	553	N
Texas	368	0	368	553	0	553	N
Utah	368	6	374	553	12	565	N
Vermont	368	61.9	429.9	553	112.6	665.6	Y
Virginia	368	0	368	553	0	553	Y
Washington	368	28	396	553	22	575	N
West Virginia	368	0	368	553	0	553	N
Wisconsin	368	102.72	470.72	553	165.86	718.86	Y
Wyoming	368	20	388	553	40	593	N

Key: N/R = NO RESPONSE

SOURCE: NATIONAL GOVERNORS' ASSOCIATION, SEPTEMBER 1989

TABLE 7

States with Disability Definitions, Income, and Resource Standards Which Vary from Supplemental Security Income Program Standards (209(b) States)

	DISABILITY DEFINITION	*INCOME RULES AND DISREGARDS*	*RESOURCES*
CT	Coverage not provided to disabled individuals under age 18. Blind are covered regardless of age.	UNEARNED INCOME: $202.20 if residing in the community. EARNED INCOME: AGED/DISABLED: $65 + 1/2 of the remainder. BLIND: first $85, and half the excess over $85.	$1,600
HI	More restrictive than SSI.	ALL GROUPS: (1) deduct $20, first from unearned income and any remainder from earned income. (2) from earned income, $65 plus 1/2 of remainder of earned income.	Same as SSI.
IL	Same as SSI.	AGED/DISABLED: first $25 of any income. Next $20 of earnings plus half of next $60 earned income. BLIND: first $25 of any income. Next $85 of earnings plus half of remaining balance of earnings.	Same as SSI.
IN	Impairment must appear reasonably certain to continue throughout a lifetime without significant improvement, and must impair ability to perform labor/services.	ALL GROUPS: first $15.50 of any income. BLIND: first $15.50 of any income. First $85 of earnings plus half of the remaining earnings if blind before 12/73. First $65 plus half remaining income if after 1/74.	Limits placed on resources of parents of unmarried blind or disabled applicants or recipients.
MN	Same as SSI.	Same as SSI, except Aged/Disabled: Income Taxes and FICA payments withheld are disregarded up to FFP limit. Parental income is deemed available to children < 21 who reside with parents.	$1,500 - Individual, $3,000 - Couple Aged/Blind/Disabled: household goods and personal effects are excluded.
MO	State does not cover blind and disabled children under age 18.		AGED/DISABLED: Individuals: cash/securities < $1000. Couples: cash/securities < $2000. No property worth > $31,000; no real property not lived in with equity > $1,000 if single, > $2000 if married. BLIND: Individuals: cash/securities < $2000. Couples: cash/securities < $4000.
NE	Same as SSI.	AGED/DISABLED: Unearned - $7.50. Earned - $65 plus half of the remainder. BLIND: Unearned - $7.50. Earned - $85 plus half the remainder.	
NH	Disability must be permanent, with no improvement likely throughout the lifetime. Also, state has more restrictive definition of blindness.	Aged/Disabled: Unearned - $13. Earned - $20 plus half of the next $60 up to $30 (50 total). Blind unearned - $13. Earned - $85 plus 1/2 of remainder. All Groups: Work expenses - $18 standard or actual mandatory expenses, whichever is higher. Parental income and resources deemed available to disabled children < 18 who reside with parents.	Categorically Needy: Individuals--$1500 Couples--$1500. Medically Needy: Individuals--$2500. Couples--$4000.
NC		ALL GROUPS: $4 general disregard. First $20 and half the remaining earnings not to exceed a total of $50 disregarded. Financial responsibility: spouse to spouse if living together. Parent to dependent unless blind, disabled child under 18 anticipated stay in SNF, ICF/MR, or hospital for 12 months	Aged/Blind/Disabled: $1500, $2,250.
ND	Same as SSI.		State sets more restrictive resource limits.

SOURCE: NATIONAL GOVERNORS' ASSOCIATION, SEPTEMBER 1989

TABLE 7

States with Disability Definitions, Income, and Resource Standards Which Vary from Supplemental Security Income Program Standards (209(b) States)

	DISABILITY DEFINITION	*INCOME DISREGARD*	*RESOURCES*
OH	Same as SSI.	Earned or Unearned disregard: $20. $65 plus one-half of the remaining income. Work expenses of the blind: ordinary and necessary; work expenses may be deducted from the earned income.	Exempt: reasonable value of household goods and personal effects. Motor vehicle used for employment or medical appointments; or specially equipped; or value > $4500. Life insurance policy < or = $1500. Real and personal income-producing property <$6000 or > 6% annual return. Burial contracts exempt if irrevocable. Home is exempt only if it is principle residence. Countable: Total value of liquid assets.
OK		Maximum monthly countable income (all groups): Individual: $265; Couple: $397. No income other than SSI - $79, other income $59.	Countable: Total value of $6000 limit on prepaid burial contract if irrevocable.
VA	Presumptive disabled or blind SSI recipients are not covered. Conditionally eligible SSI recipients are not covered.		

SOURCE: NATIONAL GOVERNORS' ASSOCIATION, SEPTEMBER 1989

TABLE 8

INCOME THRESHOLDS FOR INSTITUTIONALIZED INDIVIDUALS

State	***Program Standard Used****	***Institutionalized Individual Income Threshold***	***Percentage of SSI Income Threshold***
Alabama	SSI	$950	258
Alaska	SSI	$1,104	300
Arizona	SSI	$1,104	300
Arkansas	SSI	$1,104	300
California	MNIL**	$600	163
Colorado	SSP	$1,104	300
Connecticut	SSI	$1,104	300
Delaware	SSI	$662	180
District of Columbia	N/R	$391	106
Florida	SSI	$1,104	300
Georgia	SSI	$1,104	300
Hawaii	MNIL**	$357	97
Idaho	SSI	$1,104	300
Illinois	SSI	$368	100
Indiana	SSI	$368	100
Iowa	SSI	$1,104	300
Kansas	MNIL**	$368	100
Kentucky	SSI	$1,104	300
Lousiana	SSI	$1,104	300
Maine	SSI	$368	100
Maryland	MNIL**	$375	102
Massachusetts	MNIL**	$483	131
Michigan	MNIL**	$391	106
Minnesota	MNIL**	$466	127
Mississippi	SSI	$1,104	300
Missouri	SSI	$368	100
Montana	SSI	$368	100
Nebraska	N/R		
Nevada	SSI	$736	200
New Hampshire	SSP	$931	253
New Jersey	SSI	$1,104	300
New Mexico		$944	257
New York	MNIL**	$459	125
North Carolina	MNIL**	$242	66
North Dakota	MNIL**	$345	94
Ohio	SSI	$1,104	300
Oklahoma	SSI	$1,104	300
Oregon	SSI	$1,104	300
Pennsylvania	N/R		
Rhode Island	SSI	$1,104	300
South Carolina	SSI	$1,104	300
South Dakota	SSI	$1,104	300
Tennessee	SSI	$1,104	300
Texas	SSI	$1,104	300
Utah	SSI	$1,104	300
Vermont	SSI	$1,104	300
Virginia	SSI	$368	100
Washington	SSI	$1,104	300
West Virginia	SSI	$1,104	300
Wisconsin	SSI	$1,104	300
Wyoming	SSI	$1,104	300

Key: N/R = No Response

* This column provides the methodology for calculating the income threshold shown in the next column.

** In these states, there is no income threshold, medical need is calculated for each individual.

SOURCE: NATIONAL GOVERNORS' ASSOCIATION, SEPTEMBER 1989

TABLE 9

HOME CARE FOR THE DISABLED AND OTHER ELIGIBILITY OPTIONS

	HOME CARE FOR THE DISABLED		*OTHER ELIGIBILITY OPTIONS*	
	Disabled Child. < 18 (TEFRA opt., Sec. 1902(e)(3))	***Ventilator-depen. opt. (Section 1902(e)(9))***	***Poverty-related Aged/Disabled (OBRA 86 opt.)***	***Community Spouse Resource Allowance Minimum (MCCA 88)***
AL	No	No	No	$12,000
AK	No	No	No	$60,000
AZ	No	Yes	No	$12,000
AR	Yes	Yes	No	$12,000
CA	No	No	No	$60,000
CO	No	No	No	$60,000
CT	No	No	No	$12,000
DE	Yes	No	No	$12,000
DC	No	No	N/R	N/R
FL	No	No	100%	$60,000
GA	Yes	No	No	$60,000
HI	Yes	No	100%	$60,000
ID	Yes	No	No	$12,000
IL	No	No	No	$60,000
IN	No	No	No	$12,000
IA	No	No	No	$12,000
KS	No	No	No	$12,500
KY	No	No	No	$60,000
LA	No	No	No	$12,000
ME	Yes	Yes	100%	$12,000
MD	No	No	No	$12,000
MA	Yes	No	N/R	N/R
MI	Yes	Yes	85%	$12,000
MN	Yes	No	No	$12,000
MS	Yes	No	85%	$60,000
MO	No	No	No	$12,000
MT	No	No	No	$12,000*
NE	Yes	No	No	$12,000
NV	Yes	No	No	$12,000
NH	Yes	No	No	$12,000
NJ	No	No	100%	$12,000
NM	No	No	No	$30,000
NY	No	No	No	$60,000
NC	No	No	No	$12,000
ND	No	No	No	$60,000
OH	No	No	No	$12,000
OK	No	No	No	$25,000
OR	No	No	No	$12,000
PA	No	No	No	$12,000
RI	Yes	No	No	$60,000
SC	No	No	No	$60,000
SD	Yes	No	No	$20,000
TN	No	No	No	$12,000
TX	No	No	No	$12,000
UT	No	No	No	$12,000
VT	Yes	No	No	$60,000
VA	No	No	No	$12,000
WA	No	Yes	No	$60,000
WV	Yes	No	No	$12,000
WI	Yes	Yes	No	$60,000
WY	No	No	No	$12,000
TOTAL:	18	6	6	

Key: N/R = No response

* To be implemented January 1990 , ** To be implemented October 1, 1989

SOURCE: NATIONAL GOVERNORS' ASSOCIATION, SEPTEMBER 1989

TABLE 10

*QUALIFIED MEDICARE BENEFICIARIES (QMBs)**

State	% of Poverty 1989	% of Poverty 1990	% of Poverty 1991	% of Poverty 1992
Alabama	85	90	95	100
Alaska	100	100	100	100
Arizona	85	90	95	100
Arkansas	85	90	95	100
California	85	90	95	100
Colorado	85	90	95	100
Connecticut	85	90	95	100
Delaware	85	100	100	100
District of Columbia	100	100	100	100
Florida	100	100	100	100
Georgia	85	90	95	100
Hawaii	100	100	100	100
Idaho	85	90	95	100
Illinois**	80	85	90	95
Indiana**	80	85	90	95
Iowa	85	90	95	100
Kansas	85	90	95	100
Kentucky	85	90	95	100
Lousiana	85	90	95	100
Maine	85	90	95	100
Maryland	85	90	95	100
Massachusetts	100	100	100	100
Michigan	85	90	95	100
Minnesota	85	90	95	100
Mississippi	85	90	95	100
Missouri	85	90	95	100
Montana	85	90	95	100
Nebraska	85	90	95	100
Nevada	100	100	100	100
New Hampshire	85	90	95	100
New Jersey	100	100	100	100
New Mexico	85	90	95	100
New York	100	100	100	100
North Carolina**	80	85	90	95
North Dakota**	85	90	95	100
Ohio**	80	85	90	95
Oklahoma	90	90	95	100
Oregon	85	90	95	100
Pennsylvania	100	100	100	100
Rhode Island	85	90	95	100
South Carolina	100	100	100	100
South Dakota	85	90	95	100
Tennessee	85	90	95	100
Texas	85	90	95	100
Utah	100	100	100	100
Vermont	86	91	96	100
Virginia	85	90	95	100
Washington	85	90	95	100
West Virginia	85	90	95	100
Wisconsin	100	100	100	100
Wyoming	85	90	95	100

* The Medicare Catastrophic Coverage Act 1988 mandated 1/89, 85%; 1/90, 90%; 1/91, 95%; and 1/92, 100%.

** MCCA 88 also allowed a more gradual phase-in for states that as of January 1987 used more restrictive income standards for persons over 65, than those used by the SSI program.

SOURCE: NATIONAL GOVERNORS' ASSOCIATION, SEPTEMBER 1989

TABLE 11

MEDICALLY NEEDY PROGRAMS AND OPTIONAL COVERAGE GROUPS

STATE	PRESENCE OF MEDICALLY NEEDY PROGRAM*	AGE LIMIT FOR MEDICALLY NEEDY CHILDREN 18 TO 21	CARE-TAKER REL.	AGED	BLIND	DIS-ABLED
Alabama	No	N/A	N/A	N/A	N/A	N/A
Alaska	No	N/A	N/A	N/A	N/A	N/A
Arizona	No	N/A	N/A	N/A	N/A	N/A
Arkansas	Yes	21	Yes	Yes	Yes	Yes
California	Yes	21	Yes	Yes	Yes	Yes
Colorado	No	N/A	N/A	N/A	N/A	N/A
Connecticut	Yes	21	Yes	Yes	Yes	Yes
Delaware	No	N/A	N/A	N/A	N/A	N/A
District of Columbia	Yes	21	Yes	Yes	Yes	Yes
Florida	Yes	21	Yes	Yes	Yes	Yes
Georgia	Yes	18	No	No	No	No
Hawaii	Yes	19	No	Yes	Yes	Yes
Idaho	No	N/A	N/A	N/A	N/A	N/A
Illinois	Yes	19	Yes	Yes	Yes	Yes
Indiana	No	N/A	N/A	N/A	N/A	N/A
Iowa	Yes	21	Yes	Yes	Yes	Yes
Kansas	Yes	21	Yes	Yes	Yes	Yes
Kentucky	Yes	19	Yes	Yes	Yes	Yes
Louisiana	Yes	18	Yes	Yes	Yes	Yes
Maine	Yes	21	Yes	Yes	Yes	Yes
Maryland	Yes	21	Yes	Yes	Yes	Yes
Massachusetts	Yes	21	Yes	Yes	Yes	Yes
Michigan	Yes	21	Yes	Yes	Yes	Yes
Minnesota	Yes	21	Yes	Yes	Yes	Yes
Mississippi	No	N/A	N/A	N/A	N/A	N/A
Missouri	No	N/A	N/A	N/A	N/A	N/A
Montana	Yes	21	Yes	Yes	Yes	Yes
Nebraska	Yes	21	Yes	Yes	Yes	Yes
Nevada	No	N/A	N/A	N/A	N/A	N/A
New Hampshire	Yes	19	Yes	Yes	Yes	Yes
New Jersey	Yes	21	No	Yes	Yes	Yes
New Mexico	No	N/A	N/A	N/A	N/A	N/A
New York	Yes	21	Yes	Yes	Yes	Yes
North Carolina	Yes	21	Yes	Yes	Yes	Yes
North Dakota	Yes	21	Yes	Yes	Yes	Yes
Ohio	No	N/A	N/A	N/A	N/A	N/A
Oklahoma	Yes	21	Yes	Yes	Yes	Yes
Oregon	Yes	18	Yes	Yes	Yes	Yes
Pennsylvania	Yes	21	Yes	Yes	Yes	Yes
Rhode Island	Yes	18	Yes	Yes	Yes	Yes
South Carolina	No**	N/A	N/A	N/A	N/A	N/A
South Dakota	No	N/A	N/A	N/A	N/A	N/A
Tennessee	Yes	21	Yes	Yes	Yes	Yes
Texas	Yes	18	Yes	No	No	No
Utah	Yes	18	Yes	Yes	Yes	Yes
Vermont	Yes	21	Yes	Yes	Yes	Yes
Virginia	Yes	21	No	Yes	Yes	Yes
Washington	Yes	21	Yes	Yes	Yes	Yes
West Virginia	Yes	19	Yes	Yes	Yes	Yes
Wisconsin	Yes	21	No	Yes	Yes	Yes
Wyoming	No	N/A	N/A	N/A	N/A	N/A
TOTALS	36	36	32	34	34	34

Key: N/A = Not applicable, no Medically Needy Program

* Pregnant women are required in Medically Needy programs.

** Planned implementation, March 1990.

SOURCE: NATIONAL GOVERNORS' ASSOCIATION, September 1989

TABLE 12

MEDICALLY NEEDY MONTHLY PROTECTED INCOME LEVELS
FAMILY SIZE ONE THROUGH FOUR - SEPTEMBER 1989

	FAMILY OF ONE	FAMILY OF TWO	FAMILY OF THREE	FAMILY OF FOUR
Alabama	N/A	N/A	N/A	N/A
Alaska	N/A	N/A	N/A	N/A
Arizona	N/A	N/A	N/A	N/A
Arkansas	$108	$217	$275	$333
California	600	750	934	1110
Colorado	N/A	N/A	N/A	N/A
Connecticut	452	601	738	867
Delaware	N/A	N/A	N/A	N/A
DC	391	412	524	640
Florida	300	300	383	458
Georgia	208	308	367	433
Hawaii	357	480	602	725
Idaho	N/A	N/A	N/A	N/A
Illinois	267	333	458	517
Indiana	N/A	N/A	N/A	N/A
Iowa	466	466	550	633
Kansas	368	475	480	506
Kentucky	217	267	308	383
Louisiana	100	192	258	317
Maine	400	441	591	741
Maryland	375	417	459	500
Massachusetts	483	650	775	891
Michigan	391	525	555	585
Minnesota	466	582	709	828
Mississippi	N/A	N/A	N/A	N/A
Missouri	N/A	N/A	N/A	N/A
Montana	368	383	408	433
Nebraska	392	392	492	584
Nevada	N/A	N/A	N/A	N/A
New Hampshire	382	554	575	597
New Jersey	350	433	566	658
New Mexico	N/A	N/A	N/A	N/A
New York	459	659	709	850
North Carolina	242	308	358	392
North Dakota	345	400	435	530
Ohio	N/A	N/A	N/A	N/A
Oklahoma	275	341	433	541
Oregon	385	491	575	701
Pennsylvania	408	425	450	542
Rhode Island	550	592	725	833
South Carolina	N/A	N/A	N/A	N/A
South Dakota	N/A	N/A	N/A	N/A
Tennessee	175	192	250	300
Texas	100	211	267	301
Utah	337	413	516	602
Vermont	733	733	875	975
Virginia	250	308	358	400
Washington	396	532	599	667
West Virginia	200	275	290	312
Wisconsin	471	592	689	823
Wyoming	N/A	N/A	N/A	N/A

Key: N/A = Not applicable - state has no Medically Needy program.
SEE NOTES ON NEXT PAGE.

SOURCE: NATIONAL GOVERNORS' ASSOCIATION, September 1989

TABLE 12

MEDICALLY NEEDY MONTHLY PROTECTED INCOME LEVELS
FAMILY SIZE ONE THROUGH FOUR - SEPTEMBER 1989

NOTES:

In a number of states, need and payment amounts vary depending on factors such as region, season (summer or winter) and what components are included in the standard (e.g., rental allowance). In all such cases, the region with the highest concentration of recipients and/or the highest seasonal rate is displayed. Detailed notes by state (where applicable) appear below.

CT - REGION B
KS - METROPOLITAN AREAS
LA - URBAN AREAS
MA - RENTAL ALLOWANCE INCLUDED
MI - ANNUALIZED SUMMER/WINTER AVERAGE
NY - NEW YORK CITY REGION
PA - PHILADELPHIA REGION
VT - CHITTENDEN COUNTY
VA - GROUP 2
WI - AREA 1

SOURCE: NATIONAL GOVERNORS' ASSOCIATION, September 1989

TABLE 13

MONTHLY INCOME ELIGIBILITY THRESHOLDS AND THEIR PERCENTAGE OF POVERTY - September 1989
(Families of Two)

	AFDC		PREGNANT WOMEN		SSI		QMB		MEDICALLY NEEDY	
State	INCOME	PERCENT	INCOME	PERCENT	INCOME*	PERCENT	INCOME	PERCENT	INCOME	PERCENT
AL	$88	13%	$668	100%	$553	83%	$568	85%	NA	NA
AK	$719	86%	$836	100%	$1,015	121%	$710	100%	NA	NA
AZ	$233	35%	$668	100%	$552	83%	$568	85%	NA	NA
AR	$162	24%	$668	100%	$553	83%	$568	85%	$217	32%
CA	$560	84%	$1,236	185%	$1,116	167%	$568	85%	$750	112%
CO	$331	50%	$501	75%	$837	125%	$568	85%	NA	NA
CT	$452	68%	$1,236	185%	$865	129%	$568	85%	$601	90%
DE	$247	37%	$668	100%	$553	83%	$568	85%	NA	NA
DC	$309	46%	$668	100%	$553	83%	$668	100%	$412	62%
FL	$220	33%	$1,003	150%	$553	83%	$668	100%	$300	45%
GA	$347	52%	$668	100%	$553	83%	$568	85%	$308	46%
HI	$480	62%	$1,421	185%	$562	73%	$768	100%	$480	62%
ID	$254	38%	$501	75%	$598	89%	$568	85%	NA	NA
IL	$250	37%	$668	100%	$553	83%	$535	80%	$333	50%
IN	$229	34%	$668	100%	$553	83%	$535	80%	NA	NA
IA	$347	52%	$1,236	185%	$553	83%	$568	85%	$466	70%
KS	$347	52%	$1,003	150%	$553	83%	$568	85%	$475	71%
KY	$460	69%	$835	125%	$553	83%	$568	85%	$267	40%
LA	$138	21%	$668	100%	$553	83%	$568	85%	$192	29%
ME	$470	70%	$1,236	185%	$568	85%	$568	85%	$441	66%
MD	$309	46%	$1,236	185%	$553	83%	$568	85%	$417	62%
MA	$486	73%	$1,236	185%	$755	113%	$668	100%	$650	97%
[illegible]	$466	70%	$1,236	185%	$598	89%	$568	85%	$525	79%
[illegible]N	$437	65%	$1,236	185%	$594	89%	$568	85%	$582	87%
MS	$293	44%	$1,236	185%	$553	83%	$568	85%	NA	NA
MO	$232	35%	$668	100%	$553	83%	$568	85%	NA	NA
MT	$286	43%	$668	100%	$553	83%	$568	85%	$383	57%
NE	$293	44%	$668	100%	$645	97%	$568	85%	$392	59%
NV	$270	40%	$501	75%	$627	94%	$668	100%	NA	NA
NH	$442	66%	$501	75%	$554	83%	$568	85%	$554	83%
NJ	$322	48%	$668	100%	$578	86%	$668	100%	$433	65%
NM	$210	31%	$668	100%	$553	83%	$568	85%	NA	NA
NY	$439	66%	$1,236	185%	$656	98%	$668	100%	$659	99%
NC	$231	35%	$668	100%	$553	83%	$535	80%	$308	46%
ND	$313	47%	$501	75%	$553	83%	$568	85%	$400	60%
OH	$263	39%	$668	100%	$553	83%	$535	80%	NA	NA
OK	$364	54%	$668	100%	$681	102%	$602	90%	$341	51%
OR	$369	55%	$568	85%	$553	83%	$568	85%	$491	73%
PA	$315	47%	$668	100%	$602	90%	$668	100%	$425	64%
RI	$440	66%	$1,236	185%	$668	100%	$568	85%	$592	89%
SC	$335	50%	$1,236	185%	$553	83%	$668	100%	NA	NA
SD	$333	50%	$668	100%	$568	85%	$568	85%	NA	NA
TN	$297	44%	$668	100%	$553	83%	$568	85%	$192	29%
TX	$158	24%	$869	130%	$553	83%	$568	85%	$211	32%
UT	$414	62%	$668	100%	$565	85%	$668	100%	$413	62%
VT	$547	82%	$1,236	185%	$666	100%	$575	86%	$733	110%
VA	$231	35%	$668	100%	$553	83%	$568	85%	$308	46%
WA	$397	59%	$1,236	185%	$575	86%	$568	85%	$532	80%
WV	$201	30%	$1,003	150%	$553	83%	$568	85%	$275	41%
WI**	$440	66%	$548	82%	$719	108%	$668	100%	$592	89%
[illegible]Y	$320	48%	$668	100%	$593	89%	$568	85%	NA	NA
AVERAGE	$335	50%	$848	126%	$610	91%	$593	88%	$435	65%

* Includes optional state supplement payments amounts.

** Wisconsin covers pregnant women up to 130%, but receives federal match only up to 82%.

SOURCE: National Governors' Association, September 1989.

STATE MEDICAID INPATIENT HOSPITAL REIMBURSEMENT AND COVERAGE

Introduction

Historically, as an individual service, hospital expenditures have represented the largest proportion of the Medicaid program. Hospital services have continually consumed slightly over one-quarter of Medicaid expenditures.

In fiscal year 1980 Medicaid inpatient hospital services cost state and federal government a total of $6.3 billion. By 1988 total state and federal inpatient hospital services were $12 billion for 3.7 million recipients. This amount represents approximately 25 percent of the total amount spent on Medicaid services.

Background

Medicaid reimbursement of inpatient services is guided by provisions of the Omnibus Budget Reconciliation Act of 1981 (OBRA '81). Said to have made the most substantial changes in the Medicaid program since its inception in 1965, OBRA '81 enabled states to move away from reasonable cost-based payment methods and set ceilings on rates of payment that are independent of what a particular hospital spends or of increases in the costs of goods and services used by the hospital. State payment for inpatient hospital services must be reasonable and adequate to meet the costs incurred by efficiently and economically operated facilities, meeting state and federal laws and regulations as well as quality and safety standards. The new law required state rates to be sufficient to assure that Medicaid patients have reasonable access to quality services.

In addition, OBRA '81 established a provision requiring states to take into account hospitals serving a disproportionate number of low income patients. Since OBRA '81, several pieces of legislation have been targeted at the calculation of hospital rates, specifically for disproportionate share hospitals. OBRA '86 prohibited limits on the amount of payment adjustments under the state Medicaid plan with respect to hospitals serving a disproportionate number of low income patients with special needs. Later, OBRA '87 was added requiring states to define disproportionate share hospitals and increase payment rates for inpatient services provided by these hospitals.

While coverage of inpatient hospital services is required by federal statute, states have authority over various aspects of the services, within federal statutory parameters. For example, states specify the amount, duration, and scope of hospital services sufficient to reasonably achieve their purpose. States may also impose limits focused on amount, duration, and scope. Limiting services also serves to constrain costs by preventing the program from paying for unnecessary care. (See "Program Changes Affecting The Medicaid Hospital Services," NGA, December 1987.)

In addition to service restrictions, states have implemented a variety of utilization controls. The most commonly used methods focus on monitoring to assure that patient admissions are medically necessary, and screening to ensure that the patient could not be appropriately cared for in an outpatient setting.

Finally, there are other services that can be provided in the hospital setting. These include: skilled nursing services, rehabilitation services, psychiatric services, and drug and alcohol treatment services. Each of these services carries its own definition and payment methods.

Data Summary

The following series of tables displays information on Medicaid inpatient payment method, coverage of bed type, as well as annual and summary characteristics of inpatient hospital expenditures and recipients.

Although states' Medicaid acute care inpatient reimbursement systems vary widely, for descriptive purposes, they have been classified into four broad categories. The first category, used by twenty states, sets prospective rates unadjusted by either diagnosis related groups (DRGs) or the actual costs or charges related to particular care. The second category is similar to the first except that the prospective rates are weighted by DRG for each individual case. Seventeen states set prospective rates adjusted for the DRG associated with the case. The third category of payment, used by ten states, calculates rates based on the lesser of: a prospective rate or a percentage of either costs or charges. Finally, four states reimburse hospitals based on a percentage of their costs or charges, typically using Medicare principles.

Prospective rate setting is the method preferred by the states. Typically this is done by using costs to establish a rate for a base year and then trending forward for future years using the inflation index or another index. Forty-seven states use some form of prospective rate-setting. Within this category, however, states base their payments on different criteria. Seventeen use DRGs, sixteen states reimburse on a per diem basis, and fourteen reimburse based on discharge.

Maryland is the only state that uses a system in which Medicaid is part of a pure all-payer payment system. In an all-payer system Medicaid pays hospitals through the same methodology, and in some cases at the same rate as other public and private payers. New York's and New Jersey's payment systems include other payers with Medicaid. In New Jersey and New York, unlike Maryland, Medicare does not participate in the all payer system.

Two states, California and Illinois, selectively contract for inpatient hospital services and payment. Under this method, made possible through use of federal waiver authority, hospitals bid for price or volume of services.

Rates can also be established for individual hospitals or for a group of hospitals. Some states group hospitals by the number of beds or by rural or urban distinction to form a peer group. In this case, prospective payment rates are based on the peer group's typical costs for treating Medicaid patients.

Thirty of the forty-seven states which have prospective rates compute averages for individual hospitals rather than compute an average for a peer group. Three states calculate payment based on a blend of hospital-specific rates and peer group rates. Other methods of calculating prospective rates include using historical or expected costs to establish a rate (two states) or computing a prospective payment for all general acute hospitals within the state (five states).

States may choose to cover various types of services in a hospital including; swing-beds, skilled nursing beds, rehabilitation beds, psychiatric beds, and alcohol and drug treatment beds. While the information we received on the number of facilities and the number of beds is somewhat limited, it appears from the variation in the number of beds allocated for such services that some states make more use of these options than others, based on their needs.

Swing-beds allow hospitals to be reimbursed for providing certain types of post-acute care, without designating beds exclusively to either acute or post-acute care. Given the popularity of swing-beds under Medicare, it is surprising that only thirty-two states reported coverage of swing-beds.

As the average length of stay continues to decline and the number of admissions also declines, hospitals are increasing the use of non-acute inpatient services such as skilled nursing facility (SNF) units, rehabilitation services, psychiatric services, and alcohol and drug treatment services. Thirty-five states reported coverage of SNF units within their general hospitals. The majority of states indicated that they cover rehabilitation (forty-five) and psychiatric units (forty-three) within general hospitals. However, the number of states indicating coverage of alcohol and drug units is lower (thirty-six). One likely reason for more widespread coverage of rehabilitation and psychiatric services compared with swing-beds and SNF units is that most states only cover rehabilitation and psychiatric services within institutions.

Finally, enclosed is a series of tables (II-3 - II-7) presenting data on inpatient hospital use and expenditures for 1985 through 1988. The data for this section were collected from the HCFA - 2082 report. Because some of these numbers may be estimates, this information should be used purely for descriptive purposes and should not be used to make comparisons.

However, generally Table II-3 shows that inpatient expenditures grew at an annual rate of about 11 percent between 1985-1989. On the other hand, the average cost for each recipient grew, on average, at a slower rate of about 6 percent. With overall expenditures growing almost twice as fast as the expenditures per recipient, this data suggests that Medicaid is covering larger numbers of hospital inpatients and spending increasingly more per inpatient visit.

For 1988, total Medicaid inpatient expenditures (table II-4) continue to represent approximately one quarter of the $48 billion that make up total Medicaid expenditures. These dollars provided coverage for approximately 3.7 million inpatient hospital recipients at an average cost of $3,048 per recipient. One-quarter of total Medicaid expenditures is consistent with the proportions spent in recent years. However, it does reflect a slight decrease in inpatient expenditures of earlier years, when inpatient expenditures consistently represented 30 percent of Medicaid expenditures. It is likely that this slight decrease in inpatient expenditures, as a percentage of total Medicaid expenditures, can be attributed to the gradual shift of many inpatient procedures to outpatient settings.

Conclusion

Although we hesitate to draw conclusions, for the reasons mentioned above, some trends in this data are apparent. Almost all states are using prospective payment systems to establish hospital rates. Within prospective systems, states vary their payment policies using per diem, per discharge and DRGs about equally. States are also experiencing growth in both Medicaid inpatient hospital expenditures and the number of recipients. While there may be some general statements about Medicaid inpatient hospital services, based on this data, the diversity across states is significant enough to temper any broad conclusions.

If you have any questions you may contact John Luehrs at (202) 624 - 7812 or Amanda Hock at (202) 624 - 5349.

TABLE II-1

MEDICAID HOSPITAL INPATIENT FACILITIES AND REIMBURSEMENT METHODS

State	Reimbursement Method			Medicaid Inpatient Facilities	
	Prospective Rates	Diagnoses Weighted	% of Costs or Charges	# of Beds	# of Facilities
Alabama	A (1)			19,922	119
Alaska	B			1,278	17
Arizona					
Arkansas	A			N/A	88
California	B (1,2)		#	107,200	559
Colorado	B	X		12,830	98
Connecticut	B			11,049	37
Delaware			X	N/A	N/A
District of Columbia	B			N/A	N/A
Florida	A (1)		#	55,715	243
Georgia	C			25,927	172
Hawaii	A			2,855	23
Idaho	A		#	2,876	44
Illinois	A (2)			60,000	28
Indiana	B		#	25,919	123
Iowa	B (3)	X		15,326	127
Kansas	B	X		N/A	N/A
Kentucky	A		#	17,586	108
Lousiana	B		#	N/A	N/A
Maine	B			5,372	44
Maryland	D			12,522	500
Massachusetts	B (4)			22,212	110
Michigan	B	X	#	43,230	213
Minnesota	C	X		19,546	163
Mississippi	A		#	12,748	109
Missouri	A			32,252	165
Montana	B	X		N/A	57
Nebraska	A			12,166	108
Nevada	B (5)			4,003	32
New Hampshire	B	X		N/A	N/A
New Jersey	B	X		30,934	89
New Mexico	B (1)		#	4,578	40
New York	B (3)			N/A	264
North Carolina	A			30,970	146
North Dakota	B	X		N/A	N/A
Ohio	B	X		44,721	194
Oklahoma	A			N/A	N/A
Oregon	B	X		8,960	71
Pennsylvania	B (3)	X		54,690	229
Rhode Island	A (8)			N/A	N/A
South Carolina	B (6)	X		12,107	112
South Dakota	B (1)	X		N/A	55
Tennessee	A			N/A	N/A
Texas	C	X		N/A	440
Utah	B (7)	X		4,613	42
Vermont	A			1,603	1[illegible]
Virginia	A		#	25,026	110
Washington	B	X		11,759	107
West Virginia			X	10,689	69
Wisconsin	B			N/A	N/A
Wyoming			X	1,781	30
TOTAL	47	17	13		

SOURCE: NGA, State Medicaid Information Center

TABLE II-1

KEY:

A = PER DIEM
B = PER DISCHARGE
C = PER ADMISSION
D = PER SERVICE

NOTES:

= IF A STATE IS MARKED IN BOTH COLUMN 1 AND 3, PAYMENT EQUALS THE LESSER OF THE TWO AMOUNTS.

1. HOSPITAL SPECIFIC UP TO PEER GROUP CEILING.
2. NEGOTIATED CONTRACTS (ONE OF SEVERAL ALTERNATIVE SYSTEMS IN CALIFORNIA.
3. BLEND OF HOSPITAL SPECIFIC AND PEER GROUP RATES.
4. HOSPITAL'S BUDGET ADJUSTED FOR ANY EXCESS CHARGES IN PREVIOUS YEAR.
5. PER DIEM RATE AFTER FIFTEENTH DAY.
6. HOSPITAL SPECIFIC PER DIEM RATES FOR INFREQUENT DRSs.
7. RURAL HOSPITALS PAID 95 PERCENT OF CHARGES.
8. BASED ON NEGOTIATED HOSPITAL BUDGETS.

SOURCE: NGA, State Medicaid Information Center

MEDICAID COVERAGE FOR VARIOUS BED TYPES WITHIN GENERAL ACUTE CARE HOSPITALS

	SWING-BEDS			SKILLED NURSING			REHABILITATION			PSYCHIATRIC			ALCOHOL/DRUGS		
	MEDICAID COVERAGE	# OF FACILITIES	# OF BEDS	MEDICAID COVERAGE	# OF FACILITIES	# OF BEDS	MEDICAID COVERAGE	# OF FACILITIES	# OF BEDS	MEDICAID COVERAGE	# OF FACILITIES	# OF BEDS	MEDICAID COVERAGE	# OF FACILITIES	# OF BEDS
AL	X	2	20	X			X (a)			X (a)	32	1202	X (a)	15	235
AK	X	9	24	X	7	125	X			X	3	77	X	2	34
AZ	X	N/A		X	N/A		X	N/A							
AR		N/A	N/A		N/A		X	N/A		X			X		
CA	X	N/A	N/A	X	N/A		X			X	N/A	N/A		N/A	N/A
CO				X			X			X	N/A	N/A	X	N/A	N/A
CT							X (a)			X (a)			X (a)		
DE							X			X			X		
DC				X			X			X					
FL	X	30		X (c)	45		X (a)			X (a)	N/A	N/A	X	N/A	N/A
GA	(e)			X			X			X	N/A	N/A	X	N/A	N/A
HI	X			X			X			X	N/A	N/A	X	N/A	N/A
ID	X	1	N/A	X	15		X	4			3	N/A	X		
IL				X											
IN		15		X	20		X	27		X	20	N/A	X	7	N/A
IA	X	71	2395	X	27	485	X	8	N/A	X	16	N/A	X	18	N/A
KS	X						X			X	N/A	N/A	X (a)		
KY	X (k)	17	152	X	16	379	X	6		X					
LA	X						X			X			X		
ME	X	2	12	X	9	166	X	5	52	X	8	139	X	3	148
MD	X			X	4	494	X	6	336	X	29	811	X		
MA							X	5	163	X	47	1257	X	3	115
MI		1	N/A	X	29	N/A	X	22	N/A	X	63	N/A	X	19	N/A
MN	X (c, j)	4		X			X			X			X		
MS	X	54	N/A	X	12	N/A	X			X			X		
MO	X (j)	N/A	N/A	X	N/A	N/A	X	N/A	N/A	X	N/A	N/A	X	N/A	N/A
MT	X			X	35	N/A	X	4	N/A	X	4	N/A	X	4	N/A
NE	X	65	2123	X	15	274	X	2	115		11	904	X	10	321
NV	X	7	145	X			X (a)			X (a)					
NH	X	N/A	N/A				X	N/A	N/A	X	N/A	N/A			
NJ				(m)			X	N/A	N/A	X	N/A	1531			
NM	X	10	165	X	2	47	X	N/A	N/A	X	6	N/A		N/A	N/A
NY	(n)			(n)	50		X			X			X		
NC	X	22	1100	X	28	996	X	554	554	X	40	1288	X	14	651
ND	X			X			X			X			X		

SOUR[illegible]ATIONAL GOVERNORS' ASSOCIATION, 1989

MEDICAID COVERAGE FOR VARIOUS BED TYPES WITHIN GENERAL ACUTE CARE HOSPITALS

	SWING-BEDS			SKILLED NURSING			REHABILITATION			PSYCHIATRIC			ALCOHOL/DRUGS		
	MEDICAID COVERAGE	# OF FACILITIES	# OF BEDS	MEDICAID COVERAGE	# OF FACILITIES	# OF BEDS	MEDICAID COVERAGE	# OF FACILITIES	# OF BEDS	MEDICAID COVERAGE	# OF FACILITIES	# OF BEDS	MEDICAID COVERAGE	# OF FACILITIES	# OF BEDS
OH					22	1138	X	21	470	X	76	2796	X (a)	43	1161
OK		6	54	X	9	360	X	25	232	X	11	310	X	21	217
OR	X (j, k)						X			X			X (a)		
PA					N/A	N/A	X	43	N/A	X	93	2949	X	8	233
RI	N/A			N/A			N/A			N/A			N/A		
SC	X	15	306	X	12	712		N/A	N/A		N/A	N/A		N/A	N/A
SD	X	39	N/A	X		N/A	X	2	N/A	X	3			2	
TN				X											
TX										X (a)	N/A	N/A	X (a)	N/A	N/A
UT	X	18	487	X	4	238	X (a)	3	N/A	X	7	N/A	X (a)		
VT	X	5	33	X	1	32	X	1	50	X	4	78	X	2	25
VA				X	12	375	X	9	485	X	N/A	N/A			
WA	X	20	N/A	X	11	365	X (a)	19	397	X	16	483	X (a)	N/A	N/A
WV				X	9	566		2	160		13	588			
WI							X (a)			X (a)			X (a)		
WY	X	13	163		2	43	X	2	N/A	X (a)	3	N/A	X (a)	2	N/A
Total	32			35			45			43			36		

KEY:

a. ACUTE-CARE COVERAGE ONLY.
b. MINIMUM EXPENDITURE THRESHOLDS
c. PARTICIPATION LIMITED TO SMALL HOSPITALS.
d. EXEMPT UP TO A MAXIMUM NUMBER OR PERCENTAGE OF HOSPITAL BEDS.
e. COVERAGE EFFECTIVE 1/1/90
f. ACCESSIBILITY VARIANCE.
g. ONLY NEW BEDS, NOT CONVERSIONS.
h. EXPEDITED CONVERSION PROCEDURE.
i. ONLY WHEN A NEW SERVICE.
j. LIMITED TO AREAS WITHOUT BEDS OF SIMILAR TYPE.
k. LIMITED TO A SET NUMBER PER HOSPITAL.
l. MORATORIUM ON NEW BEDS.
m. WHILE AWAITING NURSING HOME PLACEMENT.
n. NO, BUT COVERS A SIMILAR SERVICE.
o. CLASS OF HOSPITALS EXEMPT.
p. ALL NEW SERVICES.

NOTES:

N/A = NOT AVAILABLE

SOUR ATIONAL GOVERNORS' ASSOCIATION, 1989

TABLE II-3

INPATIENT HOSPITAL USE AND EXPENDITURES
(Excluding Mental Health and Outpatient Departments)

1985 - 1988
Average Compound Rate of Growth

State	% Growth of Inpatient Expend.	% Growth of Total Inpatient Recipients	% Growth of Average Per Recipient Expend.
Alabama	3.4	-7.4	11.6
Alaska	11.9	10.7	1.1
Arkansas	5.9	5.6	0.33
California	7.2	2.9	4.2
Colorado	18.2	12.4	5.1
Connecticut	1.7	-0.5	2.2
Delaware	14.2	-0.4	14.6
District of Columbia	3.3	8.6	-4.8
Florida	27.9	27.8	0.1
Georgia	9.8	8.8	0.9
Hawaii	2.2	-3.8	6.2
Idaho	19.9	6.9	12.2
Illinois	-1.7	-4	2.3
Indiana	20.2	1.9	7
Iowa	13.5	7.4	5.7
Kansas	17.9	-5.8	25.2
Kentucky	5.2	-0.3	5.6
Lousiana	-4.2	-9.1	5.2
Maine	18.4	0.92	17.3
Maryland	11.6	6.3	5.2
Massachusetts	8.1	2.2	5.8
Michigan	4	2.5	1.5
Minnesota	5.7	1.1	4.5
Mississippi	21.8	5.3	15.6
Missouri	7.1	2.2	4.9
Montana	15.9	13.3	2.3
Nebraska	15.1	5.2	9.4
Nevada	19.4	13.5	5.2
New Hampshire	12.1	1.2	10.8
New Jersey	15.4	-0.8	16.3
New Mexico	10.3	6.3	3.9
New York	8.2	5.9	2.2
North Carolina	16.1	19.5	5.1
North Dakota	6.6	-3.6	10.5
Ohio	3.6	1.4	2.1
Oklahoma	9.5	7.6	1.8
Oregon	10.8	8.4	2.3
Pennsylvania	5.9	-1.3	7.3
Rhode Island	18.3	0.8	5
South Carolina	14.2	7.1	6.7
South Dakota	6.4	3.3	3
Tennessee	15.6	3.9	11.3
Texas	15.8	12.5	2.9
Utah	17.37	9.39	7.25
Vermont	7.2	-2.7	10.3
Virginia	16	5.3	10.2
Washington	12.3	9.1	2.9
West Virginia	21.3	5.6	14.9
Wisconsin	-0.9	-1.5	0.57
Wyoming	18.6	7.5	10.3
Average	**10.92**	4.38	**6.48**

SOURCE: HCFA-2082 REPORT

TABLE II-4

STATE MEDICAID INPATIENT HOSPITAL EXPENDITURES FOR 1988*
(Excluding Mental Health and Outpatient Departments)

State	Inpatient Expenditure	Total Inpatient Recipients	Average Per Recipient Expend.	% Growth in Avg. Per Recipient Expend.
Alabama	$81,520,393	46,108	$1,768	-10.8
Alaska	$24,496,119	4,052	$6,045	4.1
Arkansas	$88,513,030	55,119	$1,606	-4.6
California	$1,861,818,981	514,960	$3,615	9.2
Colorado	$77,279,206	30,704	$2,517	-3
Connecticut	$120,447,360	38,960	$3,092	1.5
Delaware	$22,597,413	5,858	$3,858	0.5
District of Columbia	$122,419,624	24,543	$4,988	-16.5
Florida	$441,354,121	136,242	$3,239	6.3
Georgia	$280,333,830	124,841	$2,246	2.1
Hawaii	$35,968,687	11,289	$3,186	24.5
Idaho	$24,618,643	7,209	$3,415	32.8
Illinois	$555,418,764	174,496	$3,183	1.2
Indiana	$218,807,617	64,113	$3,413	6.3
Iowa	$112,342,693	38,506	$2,918	23.2
Kansas	$73,719,360	20,550	$3,587	49
Kentucky	$173,304,403	76,180	$2,275	8.5
Lousiana	$136,640,389	63,596	$2,149	13.4
Maine	$79,306,982	28,953	$2,739	-33.7
Maryland	$253,022,485	81,318	$3,112	4.9
Massachusetts	$492,240,463	114,974	$4,281	-8.6
Michigan	$497,262,583	147,224	$3,378	-4.7
Minnesota	$164,767,230	54,184	$3,041	-1.6
Mississippi	$108,884,485	71,333	$1,526	17.1
Missouri	$143,876,824	71,161	$2,022	4.6
Montana	$29,571,790	11,783	$2,510	7.3
Nebraska	$50,505,329	19,757	$2,556	5
Nevada	$25,822,812	6,793	$3,801	11.2
New Hampshire	$18,843,677	6,548	$2,878	0.41
New Jersey	$443,852,981	83,220	$5,333	33.6
New Mexico	$62,339,423	20,873	$2,987	10.9
New York	$2,232,282,165	387,434	$5,762	10.2
North Carolina	$252,517,068	97,789	$2,582	7.7
North Dakota	$23,631,729	8,705	$2,715	4.8
Ohio	$558,720,160	184,264	$3,032	5.1
Oklahoma	$162,840,396	58,114	$2,802	16.5
Oregon	$45,208,059	28,023	$1,613	29.8
Pennsylvania	$434,457,714	167,086	$2,600	11.3
Rhode Island	$101,224,131	15,532	$6,517	7.8
South Carolina	$100,201,736	77,369	$1,295	12.2
South Dakota	$23,756,490	8,645	$2,748	2
Tennessee	$182,946,659	100,416	$1,822	-15.3
Texas	$417,097,672	224,215	$1,860	3
Utah	$46,595,588	15,404	$3,025	5.9
Vermont	$19,379,472	7,001	$2,768	1.7
Virginia	$165,462,165	65,433	$2,529	13.8
Washington	$178,955,742	54,055	$3,311	26.2
West Virginia	$102,879,247	40,652	$2,531	-1
Wisconsin	$127,587,224	57,020	$2,238	-7.9
Wyoming	$12,298,303	3,649	$3,370	15.4
SUMMARY:	**$ TOTAL:**	**TOTAL:**	AVG $:	AVG GROWTH:
	$12,009,939,417	**3,756,253**	**$3,048**	**6.87**

* **All dollar amounts refer to both federal and state money.**

SOURCE: HCFA-2082 REPORT

TABLE II-5

*STATE MEDICAID INPATIENT HOSPITAL EXPENDITURES FOR 1987**
(Excluding Mental Health and Outpatient Departments)

State	Inpatient Expenditure	Total Inpatient Recipients	Average Per Recipient Expend.	% Growth in Avg. Per Recipient Expend.
Alabama	$69,169,961	34,887	$1,983	41.8
Alaska	$22,325,445	3,832	$5,826	-5.8
Arkansas	$81,313,254	48,288	$1,684	-12.7
California	$1,672,814,388	505,560	$3,309	4.9
Colorado	$60,816,232	23,431	$2,596	7.4
Connecticut	$113,466,135	37,261	$3,045	1.2
Delaware	$22,180,600	5,791	$3,830	35.7
District of Columbia	$128,518,770	21,497	$5,978	-11.6
Florida	$338,463,753	110,839	$3,054	13.1
Georgia	$231,287,185	105,178	$2,199	-3.9
Hawaii	$28,907,784	11,306	$2,557	-3.5
Idaho	$15,601,984	5,981	$2,609	2.7
Illinois	$551,733,461	171,220	$3,222	9.2
Indiana	$192,101,360	64,203	$2,992	0.26
Iowa	$87,929,169	37,153	$2,367	-2.3
Kansas	$54,804,533	22,770	$2,407	7.4
Kentucky	$160,873,387	76,773	$2,095	11.8
Lousiana	$161,299,237	85,142	$1,894	-0.78
Maine	$76,411,767	18,484	$4,134	9.6
Maryland	$232,315,876	78,373	$2,964	7.6
Massachusetts	$503,752,903	107,468	$4,687	2.8
Michigan	$567,107,125	159,893	$3,547	-2.7
Minnesota	$136,548,541	44,141	$3,093	7.3
Mississippi	$92,706,043	71,132	$1,303	22.4
Missouri	$130,904,860	67,726	$1,933	20.2
Montana	$27,748,946	11,862	$2,339	-2.7
Nebraska	$50,674,013	20,822	$2,434	21.7
Nevada	$22,284,486	6,519	$3,418	5.6
New Hampshire	$16,999,747	5,932	$2,866	11.1
New Jersey	$380,729,611	95,449	$3,989	7.4
New Mexico	$51,023,088	18,950	$2,693	2.6
New York	$2,103,152,603	402,418	$5,226	-14.9
North Carolina	$205,140,535	85,574	$2,397	4.9
North Dakota	$22,389,657	8,649	$2,589	48.3
Ohio	$608,520,728	210,892	$2,885	-5
Oklahoma	$139,072,114	57,834	$2,405	34.6
Oregon	$33,254,443	26,785	$1,242	-6.2
Pennsylvania	$409,486,604	175,421	$2,334	-1.7
Rhode Island	$91,055,819	15,067	$6,043	7.3
South Carolina	$109,629,751	74,347	$1,475	0.82
South Dakota	$23,231,466	8,626	$2,693	2.9
Tennessee	$193,565,535	89,935	$2,152	3
Texas	$381,820,180	211,511	$1,805	-2.5
Utah	$43,244,245	15,152	$2,854	2.9
Vermont	$19,319,383	7,101	$2,721	14.2
Virginia	$139,719,915	62,906	$2,221	10.9
Washington	$175,980,330	67,098	$2,623	3.6
West Virginia	$95,458,290	37,330	$2,557	19.5
Wisconsin	$143,267,220	58,938	$2,431	11.1
Wyoming	$16,480,290	5,643	$2,920	7.3
SUMMARY:	**$ TOTAL:**	**TOTAL:**	**AVG $:**	**AVG GROWTH:**
	$11,236,602,752	**3,699,090**	**$2,892**	**6.98**

*** All dollar amounts refer to both federal and state money.**

SOURCE: HCFA-2082 REPORT

TABLE II-6

*STATE MEDICAID INPATIENT HOSPITAL EXPENDITURES FOR 1986**
(Excluding Mental Health and Outpatient Departments)

State	Inpatient Expenditure	Total Inpatient Recipients	Average Per Recipient Expend.	% Growth in Avg. Per Recipient Expend.
Alabama	$80,157,879	57,323	$1,398	9.9
Alaska	$17,983,226	2,906	$6,188	6.1
Arkansas	$96,713,284	50,117	$1,930	21.1
California	$1,478,305,383	468,960	$3,152	1.3
Colorado	$31,578,820	13,067	$2,417	11.4
Connecticut	$123,634,155	41,078	$3,010	3.9
Delaware	$17,321,497	6,137	$2,822	10.2
District of Columbia	$111,866,765	16,523	$6,770	17
Florida	$262,311,448	97,168	$2,700	16.3
Georgia	$220,542,364	96,453	$2,287	4.7
Hawaii	$30,559,567	11,533	$2,650	-4.5
Idaho	$15,623,640	6,152	$2,540	4.9
Illinois	$558,080,434	189,298	$2,948	-0.97
Indiana	$181,046,160	60,656	$2,985	7.2
Iowa	$74,748,784	30,856	$2,423	2.6
Kansas	$36,549,540	16,309	$2,241	22.6
Kentucky	$140,350,149	74,930	$1,873	3.2
Lousiana	$167,518,223	87,767	$1,909	3.4
Maine	$75,831,116	20,113	$3,770	55
Maryland	$206,004,316	74,839	$2,753	2.9
Massachusetts	$506,027,233	111,074	$4,556	25.9
Michigan	$591,811,521	162,206	$3,649	13
Minnesota	$126,608,577	43,956	$2,880	8.1
Mississippi	$75,209,544	70,674	$1,064	7.8
Missouri	$115,465,019	71,797	$1,608	-8.3
Montana	$25,534,041	10,617	$2,405	2.5
Nebraska	$40,756,148	20,380	$2,000	2.5
Nevada	$20,917,673	6,467	$3,235	-0.8
New Hampshire	$15,557,936	6,033	$2,579	21.8
New Jersey	$316,974,220	85,346	$3,714	9.3
New Mexico	$48,095,094	18,328	$2,624	1.6
New York	$2,019,534,277	328,668	$6,145	13.6
North Carolina	$193,523,334	84,675	$2,285	2.6
North Dakota	$19,085,278	10,938	$1,745	13.3
Ohio	$572,571,308	188,505	$3,037	6.7
Oklahoma	$109,796,153	29,837	$3,680	38.6
Oregon	$34,496,851	26,032	$1,325	-7.1
Pennsylvania	$422,020,135	177,652	$2,376	12.8
Rhode Island	$79,940,556	14,207	$5,627	0.26
South Carolina	$107,914,309	73,777	$1,463	37.1
South Dakota	$21,404,814	8,185	$2,615	4.2
Tennessee	$182,520,165	82,198	$2,220	11.5
Texas	$342,499,882	184,952	$1,852	8.7
Utah	$34,081,285	12,299	$2,771	13
Vermont	$16,768,180	7,043	$2,381	15.3
Virginia	$122,312,010	61,085	$2,002	6
Washington	$128,897,019	47,338	$2,723	10.4
West Virginia	$73,405,906	34,314	$2,139	28.1
Wisconsin	$112,194,062	51,276	$2,188	0.5
Wyoming	$9,854,467	3,624	$2,719	8.1
SUMMARY:	**$ TOTAL:**	TOTAL:	AVG $:	AVG GROWTH:
	$10,412,503,747	**3,455,668**	**$2,807**	**10.11**

* **All dollar amounts refer to both federal and state money.**

SOURCE: HCFA-2082 REPORT

TABLE II-7

STATE MEDICAID INPATIENT HOSPITAL EXPENDITURES FOR 1985*
(Excluding Mental Health and Outpatient Expenditures)

State	Inpatient Expenditure	Total Inpatient Recipients	Average Per Recipient Expend.
Alabama	$73,847,525	58,095	$1,271
Alaska	$17,483,241	2,989	$5,849
Arkansas	$74,542,961	46,875	$1,590
California	$1,509,936,841	472,420	$3,196
Colorado	$46,821,625	21,600	$2,168
Connecticut	$114,533,761	39,536	$2,897
Delaware	$15,193,444	5,932	$2,561
District of Columbia	$110,802,341	19,153	$5,785
Florida	$210,814,201	65,286	$3,229
Georgia	$212,013,490	97,075	$2,184
Hawaii	$33,731,942	12,672	$2,662
Idaho	$14,290,682	5,905	$2,420
Illinois	$585,428,882	197,144	$2,970
Indiana	$168,607,996	60,556	$2,784
Iowa	$76,901,151	31,088	$2,474
Kansas	$44,914,590	24,587	$1,827
Kentucky	$148,756,604	76,908	$1,934
Lousiana	$156,490,747	84,711	$1,847
Maine	$47,767,873	28,168	$1,696
Maryland	$180,812,021	67,640	$2,673
Massachusetts	$389,914,137	107,816	$3,616
Michigan	$441,961,618	136,907	$3,228
Minnesota	$139,547,390	52,423	$2,662
Mississippi	$60,273,800	61,051	$987
Missouri	$117,026,742	66,707	$1,754
Montana	$18,998,044	8,101	$2,345
Nebraska	$33,141,303	16,994	$1,950
Nevada	$15,159,228	4,645	$3,264
New Hampshire	$13,369,683	6,319	$2,116
New Jersey	$289,018,338	85,131	$3,395
New Mexico	$46,393,668	17,396	$2,667
New York	$1,762,284,543	326,038	$5,405
North Carolina	$161,571,650	72,593	$2,226
North Dakota	$19,533,678	9,702	$2,013
Ohio	$503,233,256	176,836	$2,846
Oklahoma	$123,998,203	46,720	$2,654
Oregon	$33,213,121	22,007	$1,509
Pennsylvania	$365,568,839	173,574	$2,106
Rhode Island	$79,710,349	15,173	$5,253
South Carolina	$67,244,399	63,013	$1,067
South Dakota	$19,698,425	7,850	$2,509
Tennessee	$118,392,332	89,489	$1,323
Texas	$268,172,533	157,439	$1,703
Utah	$28,856,582	11,769	$2,452
Vermont	$15,711,394	7,610	$2,065
Virginia	$105,905,697	56,081	$1,888
Washington	$126,512,619	41,606	$3,041
West Virginia	$57,586,074	34,506	$1,669
Wisconsin	$131,292,836	59,672	$2,200
Wyoming	$7,374,384	2,934	$2,513
SUMMARY:	**$ TOTAL:**	**TOTAL:**	**AVG $:**
	$9,404,356,783	**3,356,442**	**$2,569**

*** All dollar amounts refer to both federal and state money.**

SOURCE: HCFA-2082 REPORT

THE WHITE HOUSE

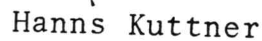
WASHINGTON

March 27, 1990

NOTE TO KEN YALE
DAN HEIMBACH
JOHN SCHALL

Mike Duncan of Public Liaison has arranged for Peter Libassi of The Travelers, representing the Connecticut Insurance Association and Carl Schramm of the Health Insurance Association of America to come by Friday at 10 am in my office to discuss the proposal to expand access to health insurance in Connecticut put forward by that state's insurance community.

Please join us if you can. Peggy Polk will circulate the material we receive from them in advance.



Hanns Kuttner

Information for
White House Meeting
March 30, 1990

Bruce W. Butler
Vice President and General Manager
Local Customer Accounts
The Travelers
SS# 471-40-9967
DOB 8/9/39

Frank Peter Libassi
Senior Vice President
Corporate Communications Dept.
The Travelers
SS# 126-22-7360
DOB 4/20/30

Carole T. Roberts
Second Vice President
Federal Government Affairs
The Travelers
SS# 077-36-7889
DOB 5/23/47

Carl J. Schramm
President
Health Insurance Association of America
SS# 078-40-3465
DOB 8/12/46

The Travelers

The Travelers Companies
One Tower Square
Hartford, CT 06183

F. Peter Libassi
Senior Vice President
Corporate Communications

January 30, 1990

Ms. Bobbie Kilberg
Deputy Assistant to
the President
Office of the Public Liaison
The White House, Room 128
Washington, D.C. 20500

Dear Ms. Kilberg:

Knowing of your interest in expanding access to health care, I want to bring to your attention a new initiative by the Insurance Association of Connecticut (IAC). This innovative program, recently presented to the Connecticut Blue Ribbon Commission on State Health Insurance, is designed to provide access to the financing of health care for small businesses (firms having fewer than 25 employees). Information about the proposal is attached.

Travelers, the largest commercial insurer in the small group market, helped craft and supports the IAC proposal. We believe it represents a responsible approach to the serious concerns expressed by our customers and by public policymakers. It entails fundamental changes in the way that we as insurers do business in the small group market. The plan would:

- Guarantee access and availability by offering a more affordable core benefits plan to small companies and by reinsuring against high risks.

- Bring stability to this market by limiting premium increases and by restricting termination of coverage.

- Allow employees to change jobs without losing coverage because of a pre-existing condition.

The IAC program is one piece of what must be a partnership between business and government. The private and public sectors, working in concert, have a unique opportunity to resolve the access dilemma without undermining an employer-based health care financing system that already provides 180 million Americans with access to care.

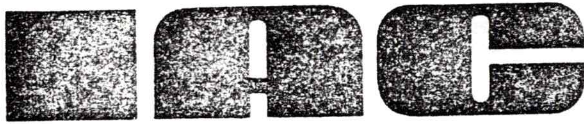
We would be pleased to brief you about the details of this proposal. At your convenience, Travelers representatives are available to meet with you to discuss the Connecticut plan as well as Travelers commitment to the small business market.

Sincerely,

F. Peter Libassi

Enclosure

FPL/lh



INSURANCE ASSOCIATION OF CONNECTICUT

SUITE 1304 • 60 WASHINGTON STREET, HARTFORD, CONN. 06106 • PHONE (203) 547-0610

PRESS RELEASE

For Release:
January 9, 1990
11:30 a.m.

CONTACT: E. Joseph Martin
Director of Information
Insurance Association of Connecticut
60 Washington Street, Suite 1304
Hartford, CT 06106
(203) 547-0610

IAC PRESIDENT LEROY UNVEILS INNOVATIVE PROPOSALS ON MEDICALLY UNINSURED

HARTFORD -- The Insurance Association of Connecticut (IAC) today unveiled a bold new proposal concerning medical insurance for the 272,000 Connecticut citizens who are uninsured -- a program never before advanced anywhere in the U.S.

H. Craig Leroy, president of the IAC, said the insurance industry's plan "would radically change how we do business in the small group health insurance marketplace for the better." He also asked for a cooperative public/private partnership to fill the needs of the poor and near poor. Leroy stated that, "This proposal demands a shared responsibility among government, business, the insurance industry and health care community."

Nationwide surveys show that two-thirds of the working uninsured are employed in companies with fewer than 25 employees. To provide affordable coverage to these employers, the plan would allow insurance companies to sell lower-cost benefit plans free of some of the benefits mandated by Connecticut law. "We have develcped several low-cost, pared-down plans that could be offered to the small employer community," Leroy said.

Those employers who purchase a pared-down policy would be granted a tax credit and such policies would be exempt from the state's two percent premium tax with the savings being passed on to the policyholder.

A reinsurance mechanism coupled with underwriting and rating restrictions would provide more affordable coverage to small employers, he explained. The reinsurance mechanism would also protect employee privacy.

Rating restrictions would eliminate the "traumatic" rate increases currently being levied on some small employers. These restrictions Leroy outlined would include:

-- A prohibition on all carriers from cancelling a small employer's coverage except for fraud, non-payment of premium and the like.

-- A restriction on the ability to impose pre-existing condition limitations under certain circumstances.

-- A requirement to mandate carriers to accept or reject entire groups.

-- A requirement that all small group insurers operate according to these rules.

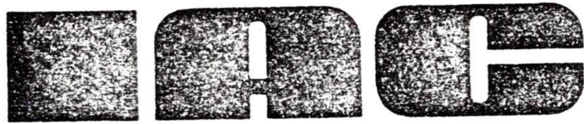
"We believe this plan would make insurance more available, make the pricing structure more predictable and stable, and small employers would be more fully protected from being cancelled outright or being priced out of the market due to adverse claims experience," Leroy said.

In addressing the coverage for the poor population, Leroy said insurance companies and the government "should jointly begin the process of discussing how Medicaid should help more low income individuals obtain Medicaid services." He said that the IAC would work cooperatively with the state government to devise new options for Medicaid to expand coverage to the poor and near poor.

Another important component for maintaining and expanding employer coverage and expanding the number of people covered by public sector plans is controlling health costs.

"Policymakers should encourage development of the private sector's cost-management techniques," he concluded.

lc



INSURANCE ASSOCIATION OF CONNECTICUT

SUITE 1304 • 60 WASHINGTON STREET, HARTFORD, CONN. 06106 • PHONE (203) 547-0610

IAC INITIATIVE ON STATE HEALTH INSURANCE

The IAC has been developing a comprehensive plan to address the problem of the health uninsured in Connecticut. The major elements of the IAC program are:

1. Basic, more affordable policies for small groups--make less expensive health insurance policies available to currently uninsured small groups (2 to 25 lives), where the majority of working uninsured are employed, and create financial incentives to encourage purchasing the policies, thereby helping to reduce the number of uninsured. The proposal includes:

A. Pared-down health insurance policy--the IAC has formed several model insurance plans, which vary in the degree to which preventive and catastrophic coverage is provided. The policies would be marketed by individual insurers, would eliminate or reduce certain mandates and would be made available to new employers and employers who had not insured their employees for at least two years. The program would be sunset after four years.

B. Tax credit--grant employers who are purchasing a pared-down policy for their employees a tax credit against any corporation business tax owed, provided the employer pays at least 50% of the premium. The credit would sunset after four years.

C. Premium tax waiver--exempt pared-down policies from 2% premium tax with the savings to be passed onto the policyholder. This will cost the state minimal amounts, since no premiums are currently being paid by such employers.

D. Legislative study of efficacy of pared-down policy--study the program after three years; submit recommendations to General Assembly as to continuation, elimination or modification of the program.

2. Medicaid--since the 1989 Budget Reconciliation Act provides funds for Medicaid demonstration projects targeting maternal and child-care benefits, the IAC will offer its member companies' expertise to the state to assist it in developing such projects for Connecticut, as these projects could be useful in addressing a sizeable segment of the problem of the health uninsured. IAC assistance will also be offered to explore the possibility of Medicaid "buy-in" and "buy-out" programs.

3. Market stability--increase the stability and accessibility of the small group health insurance market (2 to 25 lives) by making fundamental changes in industry practices regarding underwriting and rating and by establishing a statewide reinsurance mechanism. The characteristics of this proposal are:

A. Guaranteed Availability--All small employers would be guaranteed the right to purchase a plan of benefits without regard to the health condition of their employees or dependents. This program would be similar to the current Connecticut Health Reinsurance Association's program for purchase of health insurance, but would be especially designed for the small employer market.

B. Guaranteed Continuity of Coverage for Small Groups--Insurers would be precluded from discontinuing an employer's health benefits plan except for non-payment of premium, fraud, material change in risk or failure to meet participation requirements. Individuals who continue to meet eligibility requirements could not be terminated from group plans.

C. Pre-existing Health Conditions--Pre-existing condition limitations may be applied to the individual employee or his dependents when the employee changes jobs. The IAC proposal would prohibit application of pre-existing condition limitations in these situations in the small group market.

D. Premium Rates--In order to provide for a more stable and affordable market for the purchase of small group health insurance:

1. Regardless of the health condition or numbers of claims of any insureds in a small group, the annual increase in premium rates for the group could not exceed the total of the increase in the insurer's premium rates for a similar new group plus a specified amount for necessary rating flexibility.

2. Also, despite health conditions, premium rates for a small group could never be more than an amount, to be determined, higher than those of the insurer's lowest rating category for a similar employer with similar benefits.

E. Reinsurance Pool for the Small Employer Market--In order to provide for a more stable market and to encourage the insuring of groups that might not otherwise be underwritten, the proposal calls for establishment of a reinsurance pool for high risk individuals within the small group market with the following major provisions:

1. The pool would be available for use by small group insurers, who may put the group as a whole or individuals from the group in the pool, depending on who is considered to be of sufficient risk to warrant reinsuring that risk.

2. A reinsurance premium would be charged the insurer for each reinsured risk. Employers would pay some or all of the reinsurance premium, depending on the circumstances of reinsurance.

3. Losses from the mechanism would be covered by assessments against pool members. The IAC proposal anticipates that all insurers in the small group marketplace will be members of the pool, including all commercial insurance companies, health maintenance organizations, and any other organizations doing a small group insurance business in Connecticut.

4. Assessments paid by small group members will not exceed 5% of the total premium for small group health insurance in Connecticut, so as not to exacerbate the affordability concerns in the market. A premium tax offset or other broad-based financing mechanism will be provided for liability exceeding the 5% level.

5. The reinsurance mechanism is transparent to the beneficiary and to third parties in order to avoid discriminatory treatment and protect employee privacy. Employees who are placed in the reinsurance mechanism pay no more for coverage than other employees with the same employer.

F. Transition--rules will be established for a specified period of time to cover the initial application of rating restrictions to each insurer's existing book of business.

STATEMENT
TESTIMONY OF H. CRAIG LEROY
THE BLUE RIBBON COMMISSION ON STATE HEALTH INSURANCE
TUESDAY, JANUARY 9, 1990

The insurance industry is greatly concerned about the near 272,000 Connecticut citizens who do not enjoy the protection of health insurance. The industry has worked hard to develop creative solutions for extending health care benefits to uninsured groups and individuals. Our companies are committed to working with government to implement effective approaches for providing coverage to this population.

Indeed, we need a shared partnership between government, business, insurers, as well as health care providers if we are to step forward in Connecticut and address the issue of the medically uninsured. It is no one's sole responsibility but it is going to take everyone's willingness to do things differently if we are to make progress in Connecticut. As you will hear, the Connecticut insurance industry is willing to answer that challenge. We hope others are also willing.

The task of ensuring that all our citizens enjoy the protection of health insurance is complex. This complexity is largely a function of the diversity of the uninsured population; this diversity requires a combination of private and public solutions.

A positive, multi-faceted approach that addresses the people greatest in need and responds to the different portions of the uninsured population is necessary.

The IAC proposes a 6-point program of public and private sector partnership to respond positively to this challenge:

1. Creation of basic, no-frills insurance policies for the small group market (25 lives and less). These plans would focus on preventative and catastrophic coverages and eliminate or reduce certain mandated benefits. These policies would provide significant premium savings for the purchasing small employer.

2. Tax Credits for small employers who purchase the basic policy for their employees and who pay at least 50% of the premium;

3. Premium tax waiver for these basic policies to further reduce the cost to the policyholder;

4. Legislative study of the efficacy of the basic policy program outlined above after a three-year period so the Legislature can determine whether it works, should be modified or eliminated;

5. Expand the Medicaid program to ensure that all individuals below the poverty line are covered, consider Medicaid "buy-in" and "buy-out" programs, and work to develop demonstration projects targeting maternal and child-care benefits. The IAC and its member companies will be willing to assist in exploring these initiatives with the state;

6. Enhance the stability and accessibility of the small group health insurance market in Connecticut by establishing a statewide reinsurance mechanism and by making fundamental changes in industry practices regarding underwriting and rating.

I will now discuss each of these in more detail.

Expanding Coverage in the Small Employer Market

More has to be done, with efforts from both the public and private sectors, to provide small businesses with the opportunity to purchase affordable health coverage. Nationwide surveys show that two-thirds of the working uninsured are employed in companies with fewer than 25 employees. Also, surveys demonstrate that small businesses do provide health coverage to their workers once they grow or can afford it. Currently, health coverage is unaffordable

to many small employers. This is because the cost of health services continues to increase much more rapidly than overall inflation and the rate of utilization of these services continues to increase. Health insurance premiums must reflect these underlying cost trends.

We believe, however, there are actions that can be taken to provide more affordable health coverage for small employers, incentives that encourage small businesses to buy coverage for the first time, and a more stable market in which to purchase coverage.

More Affordable Coverage is Needed

Underlying affordability problems faced by small employers must be addressed. Currently, Connecticut's mandated benefit laws prevent insurers from offering lower cost benefit plans. The increase in the cost of coverage due to the state's mandated benefit laws is responsible for some businesses choosing not to purchase health coverage. Making affordable coverage available would allow employers and employees the flexibility to decide the type of healthcare they would like to purchase. Furthermore, small employers should be provided the very same freedom from state

mandated benefits laws now enjoyed by self-insured plans (which typically are used by larger employers). It is ironic that small employers, those least able to afford health coverage, are saddled with purchasing these costly mandated benefits.

Carriers should be permitted to sell to small employers low-cost benefit plans free of some of Connecticut's mandated benefits. We have developed several low cost prototype "pared-down" plans that could be offered to the small employer community. "Pared-down" coverage should be offered for a limited time to small employers not yet offering coverage as an incentive to have these employers begin offering coverage. A sunset provision and study of the effect of offering such policies should be included in any proposed legislation.

Tax Credits are Needed

We should grant employers who are purchasing a pared-down policy for their employees a tax credit. Pared down policies should also be exempt from the state 2% premium tax with the savings being passed to the policyholder. (This exemption would have little fiscal impact on the state since these would be new policies being sold.) Providing tax credits and a premium tax waiver for the purchase of a pared-down policy could have a significant impact on making health coverage more affordable.

<u>A More Stable and Predictable Marketplace that Guarantees Availability Is Needed</u>

A reinsurance mechanism, coupled with underwriting and rating restrictions for health coverage written in the small employer market, should be established. In the present marketplace, certain small employer groups may present a high or even uninsurable risk due to the presence of high risk individuals or the high risk nature of their business. For many of these businesses, the cost of health coverage is prohibitively expensive. The small employer reinsurance mechanism coupled with reasonable underwriting and rating restrictions would help provide more affordable coverage to small employers.

A not-for-profit reinsurance mechanism should be established and would serve to promote availability. It would allow insurers to "reinsure" high risks with the reinsurance mechanism in exchange for a reinsurance premium. Claims incurred by reinsured risks would be covered by the reinsurer. This would encourage insurers to accept risks that they might not normally accept since they are protected by the marketplace at large from the costs of accumulating a disproportionate number of high risks.

Employers would pay some or all of the reinsurance premium, depending on the circumstances of reinsurance. However, the process of reinsurance is intended to be invisible to the insureds within the groups in order to avoid discriminatory treatment and protect employee privacy. To accomplish these objectives, an employee will not be aware that he is being reinsured by an insurer. When a carrier has chosen to reinsure, they will continue to pay the claims (and/or utilize the same delivery system) for the nonreinsured and reinsured risks. The processes of reinsurance premium payment and reimbursement for reinsured risks are purely transactions between the carrier and the reinsurer.

Naturally, the reinsurer will incur losses. Insurers will generally only reinsure risks for which they expect the actual claims costs to exceed the premium for reinsurance. Therefore, the losses generated would be spread back equitably across the marketplace. However, to avoid exacerbating the affordability concerns of the small employer market, limitations on the amount of losses are necessary. Legislation creating the mechanism should not require the small business community to pay any pool losses which exceed 5% of the total premium for small business group health insurance in Connecticut. To that end, a premium tax offfset should be provided for participating insurers for any losses exceeding 5%. Otherwise, serious harm could be done to small business due to increased affordability problems.

In addition, reasonable underwriting and rating restrictions would also be imposed on carriers writing in the small employer market in order to provide needed stability to this marketplace. These restrictions include:

-Rate restrictions to eliminate the traumatic rate increases currently levied on some small employers. Medical costs continue to increase rapidly and premium rates will continue to reflect those increases. However, these rate limitations would inject some needed predictability and stability into the small employer market, thereby allowing small employers to plan and budget for health coverage costs with greater ease.

-A prohibition on all carriers from cancelling a small employer's coverage except for fraud, non-payment of premium and the like. Thus, cancelling a group for adverse claims experience would be prohibited.

-A restriction on all carriers on their ability to impose pre-existing condition limitations under certain circumstances.

-A requirement imposed on all carriers to accept or reject entire groups. Employers and insurers could not exclude any individual in the group who wanted coverage.

-A prohibition on all carriers from operating in the small group market unless they operated according to these rules.

The small employer reinsurance mechanism coupled with the underwriting and rating restrictions is intended to serve several goals. First, it would promote the availability of coverage to all small employers, including groups with high risk individuals. The reinsurance mechanism will provide the necessary safety net for those employers and employees who are currently experiencing difficulty obtaining health coverage due to existing medical conditions. Second, the reinsurance mechanism and the rating restrictions would interact to provide a more predictable and stable pricing structure for small employers, as well as making the coverage more affordable for groups with employees possessing existing serious medical conditions. The rate restrictions will also help alleviate tremendous premium increases some employers are currently experiencing. Lastly, by imposing the underwriting and rating restrictions (both initially and at renewal), small employers will be more fully protected from being cancelled outright or being priced out of the market due to adverse claims experience.

Let me emphasize what I have just described. This proposal would impose significant but reasonable underwriting and rating restrictions on carriers and it would radically change the way carriers operate in the small group market for the better. While these restrictions may increase costs for some groups, we believe it is a necessary response to the problems experienced in the small group market and it should provide a more stable market for small employers, thereby encouraging them to provide coverage to their workers.

Public Assistance for the Uninsured with Low Income

The proper role of government and a priority of any program for the uninsured must be to provide coverage to low income individuals through carefully targeted, improved, and expanded public assistance programs. Eligibility for public assistance programs should be broadened to ensure that all persons who fall below the poverty line are covered for health care services, irrespective of age, disability, family or employment status. If available funds prevent full coverage up to the poverty level, priority should be given to children before other populations. Priority should also be placed on primary care and preventive services. Governmental assistance to the poor and near poor could take several creative forms and could

involve public/private cooperative efforts. The suggested forms of public assistance outlined below are just that--suggestions. The IAC, representing major Connecticut insurers, offers the resources of our member companies to help state government examine current Medicaid programs and devise possible expansion. We are also aware of certain budget realities. However, we should jointly begin the process of discussing how Medicaid should evolve to help more low income individuals obtain medical services.

Medicaid Buy-In

Connecticut should evaluate creating a limited Medicaid "buy in" program. Individuals and families with income above the poverty line but below 150 percent of the federal poverty level should be eligible to purchase first-dollar coverage of a limited package of primary, preventive and related ambulatory care coverages through the state's Medicaid Program.

Such a limited benefit package meets the near-poor's need for access to basic primary care (so that illness does not become more severe and expensive through lack of treatment), while not significantly lessening employers' incentives to offer basic insurance protection.

The limited benefit package keeps costs of the buy-in coverage per se to a minimum, thus permitting very low premiums, constraining government costs, broadening participation, and reducing the chance of adverse selection.

Medicaid Buy-Out

We should also examine creating a Medicaid "buy-out" program.

Medicaid eligibles who are working should be encouraged to make use of employment-based health insurance, where it is available. To accomplish this goal, state Medicaid programs could be given the option of paying (and receiving federal matching funds which would take federal legislation) the employee's share (if any) of the private insurance premium, as well as other costs. Medicaid would continue to be available to cover deductibles and other benefits not covered under the employer plan; and Medicaid's contribution, for the employee's premium plus Medicaid's "wrap-around" coverage, would not be permitted to exceed the average cost of traditional Medicaid coverage. For both the "buy out" of Medicaid eligibles and the "buy out" of individuals transitioning off Medicaid, participating employers should be required to make the same premium contribution on behalf of Medicaid-eligible employees as they do for other employees.

Such a program would support the current public policy concept of encouraging low-income persons to work by easing the transition from public support to self support.

Health Care Management Initiatives

Controlling health care costs is an important component of maintaining and expanding employer coverage and expanding the number of people covered by public sector plans. Healthcare costs are being driven mainly by a number of factors including demographics, new technology and cost-shifting from the public sector. The private sector is, however, developing and implementing programs aimed at better management of health care costs. The goal of health care cost management is to restrain costs without reducing quality of care.

New and creative provider networks are also being developed to cost efficiently provide care. Both PPOs and HMOs are used for this purpose. New services such as utilization review which introduces an informed buyer into the health care services transaction are being implemented. The health care delivery system continues to evolve in response to concerns about the costs of health care and carriers continue to develop innovative cost management techniques.

Policymakers should encourage development of the private sector's cost-management techniques. Restrictions on the use of these techniques will cause an increase in a currently unaffordable product for many. In addition, the public sector could benefit from aggressively implementing these healthcare cost management techniques in their own health care programs.

Conclusion

I would like to conclude by reemphasizing my initial point. Addressing this issue of providing health insurance for all our citizens is complex. It demands a shared responsibility among government, business, the insurance industry, as well as the health care community. We in the insurance industry have offered today a proposal which would radically change how we do business in the small business health insurance marketplace. Nothing like this has been proposed elsewhere in our country. Yet, it is the responsibility of all involved in the health care system to shoulder part of the responsibility in addressing this issue. As the growth of health care costs continues to skyrocket, the ability of insurers to slow the increase in insurance premiums is limited. Only by working together can we create a solution in Connecticut which can be effective and, of which, we can all be proud.

101st CONGRESS
2d Session

H. R. 3932

To amend title XIX of the Social Security Act to improve access to basic health care services to needy children.

IN THE HOUSE OF REPRESENTATIVES

February 1, 1990

Mr. Slattery (for himself, Mr. Waxman, Mr. Miller of California, Mr. Scheuer, Mr. Walgren, Mr. Wyden, Mr. Sikorski, Mr. Bates, Mr. Bruce, Mrs. Collins, Mr. Towns, Mr. Markey, Mr. Boucher, Mr. Durbin, Mr. Berman, Mr. Williams, Mr. McDermott, Mr. Frank, Mr. Rangel, Mr. Fauntroy, Ms. Schneider, Mr. Payne of New Jersey, Ms. Pelosi, Mr. Wheat, Mr. Johnston of Florida, Mr. Foglietta, Mr. de Lugo, Mr. Crockett, Mr. Ackerman, and Mr. Hawkins) introduced the following bill; which was referred to the Committee on Energy and Commerce

---

A BILL

To amend title XIX of the Social Security Act to improve access to basic health care services to needy children.

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

3 ## TITLE I—SHORT TITLE

4 **SECTION 101. SHORT TITLE.**

5 This Act may be cited as the "Medicaid Child Health
6 Amendments of 1990".

(J. 39-080)

1 # TITLE II—CHILD HEALTH
2 # AMENDMENTS

3 **SEC. 201. PHASED-IN MANDATORY COVERAGE OF CHILDREN**
4 **UP TO 100 PERCENT OF POVERTY LEVEL.**

5 (a) IN GENERAL.—Section 1902 of the Social Security
6 Act (42 U.S.C. 1396a), as amended by section 6401(a) of the
7 Omnibus Budget Reconciliation Act of 1989, is amended—
8 (1) in subsection (a)(10)(A)(i)—
9 (A) by striking "or" at the end of subclause
10 (V),
11 (B) by striking the semicolon at the end of
12 subclause (VI) and inserting ", or", and
13 (C) by adding at the end the following new
14 subclause:
15 "(VII) who are described in sub-
16 paragraph (D) of subsection (l)(1) and
17 whose family income does not exceed
18 the income level the State is required to
19 establish under subsection (l)(2)(C) for
20 such a family;";
21 (2) in subsection (a)(10)(A)(ii)(IX), by striking "or
22 clause (i)(VI)" and inserting ", clause (i)(VI), or clause
23 (i)(VII)";
24 (3) in subsection (l)—

1 (A) by amending subparagraph (D) of para-
2 graph (1) to read as follows:
3 "(D) children born after September 30, 1983, who
4 have attained one year of age but have not attained 18
5 years of age,";
6 (B) by striking subparagraph (C) of para-
7 graph (2) and inserting the following:
8 "(C) For purposes of paragraph (1) with respect
9 to individuals described in subparagraph (D) of that
10 paragraph, the State shall establish an income level
11 which is equal to the 100 percent of the income official
12 poverty line described in subparagraph (A) applicable
13 to a family of the size involved.";
14 (C) in paragraph (3)—
15 (i) by inserting ", (a)(10)(A)(i)(VII),"
16 after "(a)(10)(A)(i)(VI)", and
17 (ii) in subparagraph (E), by striking
18 "the methodology employed" and inserting
19 "a methodology which is no more restrictive
20 than the methodology employed";
21 (D) in paragraph (4)(A), by inserting "or sub-
22 section (a)(10)(A)(i)(VII)" after "(a)(10)(A)(i)(VI)";
23 and

1 (E) in paragraph (4)(B), by striking "or
2 (a)(10)(A)(i)(VI)" after ", (a)(10)(A)(i)(VI), or
3 (a)(10)(A)(i)(VII)"; and
4 (4) in subsection (r)(2)(A), by inserting
5 "(a)(10)(A)(i)(VII)," after "(a)(10)(A)(i)(VI),".
6 (b) CONFORMING AMENDMENT TO QUALIFIED CHIL-
7 DREN.—Section 1905(n)(2) of such Act (42 U.S.C.
8 1396d(n)(2)) is amended by striking "age of 7 (or any age
9 designated by the State that exceeds 7 but does not exceed
10 8)" and inserting "age of 18".
11 (c) ADDITIONAL CONFORMING AMENDMENTS.—
12 (1) Section 1903(f)(4) of such Act (42 U.S.C.
13 1396b(f)(4)) is amended—
14 (A) by striking "1902(a)(10)(A)(i)(IV)," and
15 inserting "1902(a)(10)(A)(i)(III),
16 1902(a)(10)(A)(i)(IV), 1902(a)(10)(A)(i)(V),", and
17 (B) by inserting after "1902(a)(10)(A)(i)(VI),"
18 the following: "1902(a)(10)(A)(i)(VII),
19 1902(a)(1)(A)(ii)(I),".
20 (2) Subsections (a)(3)(C) and (b)(3)(C)(i) of section
21 1925 of such Act (42 U.S.C. 1396r–6), as amended by
22 section 6411(i)(3) of the Omnibus Budget Reconcilia-
23 tion Act of 1989, are each amended by inserting
24 "(i)(VII)," after "(i)(VI)".

1 (d) EFFECTIVE DATE.—(1) The amendments made by
2 this section apply (except as otherwise provided in this sub-
3 section) to payments under title XIX of the Social Security
4 Act for calendar quarters beginning on or after July 1, 1991,
5 without regard to whether or not final regulations to carry
6 out such amendments have been promulgated by such date.
7 (2)(A) In the case of a State plan for medical assistance
8 under title XIX of the Social Security Act which the Secre-
9 tary of Health and Human Services determines requires
10 State legislation (other than legislation authorizing or appro-
11 priating funds) in order for the plan to meet the additional
12 requirements imposed by the amendments made by this sec-
13 tion, the State plan shall not be regarded as failing to comply
14 with the requirements of such title solely on the basis of its
15 failure to meet these additional requirements before the first
16 day of the first calendar quarter beginning after the close of
17 the first regular session of the State legislature that begins
18 after the date of the enactment of this Act. For purposes of
19 the previous sentence, in the case of a State that has a 2-
20 year legislative session, each year of such session shall be
21 deemed to be a separate regular session of the State
22 legislature.
23 (B) In the case of the State of Texas, the State plan
24 shall not be regarded as failing to comply with the require-
25 ments of title XIX of the Social Security Act solely on the

1 basis of its failure to meet the additional requirements im-
2 posed by the amendments made by this section before Sep-
3 tember 1, 1991.

4 **SEC. 202. OPTIONAL COVERAGE OF CHILDREN UP TO AGE 6**
5 **WITH INCOME BELOW 185 PERCENT OF THE**
6 **POVERTY LEVEL.**

7 (a) IN GENERAL.—Section 1902 of the Social Security
8 Act, as amended by section 6401(a) of the Omnibus Budget
9 Reconciliation Act of 1989, is amended—

10 (1) in subsection (a)(10)(A)(i)(VI), by inserting
11 "minimum" before "income level", and

12 (2) in subsection (l)(2)(B), by striking "133 per-
13 cent" and inserting "a percentage (established by the
14 State, which is not less than 133 percent and not more
15 than 185 percent)".

16 (b) EFFECTIVE DATE.—The amendments made by sub-
17 section (a) shall apply to payments under title XIX of the
18 Social Security Act for calendar quarters beginning on or
19 after January 1, 1991, with respect to eligibility for medical
20 assistance on or after such date, without regard to whether
21 or not final regulations to carry out such amendments have
22 been promulgated by such date.

23 **SEC. 203. APPLICATIONS USING OUTREACH LOCATIONS.**

24 (a) IN GENERAL.—Section 1902(a) of the Social
25 Security Act (42 U.S.C. 1396a(a)), as amended by section

1 6406(a) of the Omnibus Budget Reconciliation Act of 1989,
2 is amended—
3 (1) by striking "and" at the end of paragraph
4 (52),
5 (2) by striking the period at the end of paragraph
6 (53) and inserting "; and", and
7 (3) by inserting after paragraph (53) the following
8 new paragraph:
9 "(54) provide for receipt and initial processing
10 of applications of individuals for medical assistance
11 under subsections (a)(10)(A)(i)(IV), (a)(10)(A)(i)(VI),
12 (a)(10)(A)(i)(VII), or (a)(10)(A)(ii)(IX)—
13 "(A) at locations which include locations
14 (such as hospitals or clinics providing covered
15 services to such individuals, without discrimina-
16 tion based on whether the hospital or clinic is
17 public or private) which are other than those used
18 for the receipt and processing of applications for
19 aid under part A of title IV, and
20 "(B) using applications which are other than
21 those used for applications for aid under such
22 part.".
23 (b) EFFECTIVE DATE.—The amendments made by sub-
24 section (a) apply to payments under title XIX of the Social
25 Security Act for calendar quarters beginning on or after July

1 1, 1991, without regard to whether or not final regulations to
2 carry out such amendments have been promulgated by such
3 date.

4 **SEC. 204. EXTENSION OF MEDICAID TRANSITION COVERAGE.**

5 (a) OPTIONAL ADDITIONAL 12-MONTH EXTENSION.—
6 Section 1925(b) of the Social Security Act (42 U.S.C.
7 1396s(b)) is amended—
8 (1) in the heading, by striking "6-MONTH";
9 (2) in paragraph (1), by striking "the succeeding
10 6-month period" and inserting "the succeeding period
11 of 6 months (or, at the State option as specified by the
12 State, of 9 months, 12 months, 15 months, or 18
13 months)";
14 (3) in paragraph (2)(A)(ii), by inserting "(and, if
15 applicable, 6th, 9th, 12th, and 15th month)" after "3rd
16 month";
17 (4) in paragraph (2)(B)(ii), by inserting "(and, if
18 applicable, 7th, 10th, 13th, and 16th month)" after
19 "4th month";
20 (5) in paragraph (3)(A), in the matter before
21 clause (i), by striking "6-month";
22 (6) in paragraph (3)(A)(iii), by striking "of the 6-
23 month period" and inserting "(or, if applicable, the
24 7th, 10th, 13th, or 16th month) of the period"; and

1 (7) in paragraph (5)(D)(i), by striking "of the 6-
2 month additional extension period" and inserting "(or,
3 if applicable, the 7th, 10th, 13th, or 16th month) of
4 the additional extension period".
5 (b) Repeal of Sunset Provision.—Subsection (f) of
6 section 1925 of such Act is repealed.
7 (c) Effective Dates.—The amendments made by
8 this section shall take effect on April 1, 1990.

9 **SEC. 205. EXTENSION OF PAYMENT PROVISIONS FOR MEDI-**
10 **CALLY NECESSARY SERVICES IN DISPROPOR-**
11 **TIONATE SHARE HOSPITALS TO CHILDREN**
12 **UNDER 18 YEARS OF AGE.**

13 (a) Coverage of Medically Necessary Services
14 for Children.—Section 1902(a)(10) of the Social Security
15 Act (42 U.S.C. 1396a(a)(10)) is amended, in the subdivision
16 (X) following subparagraph (E), by striking "under one year
17 of age" and inserting "under 18 years of age".
18 (b) Assuring Adequate Payment for Inpatient
19 Hospital Services for Children In Disproportion-
20 ate Share Hospitals.—Section 1923(a)(2) of such Act
21 (42 U.S.C. 1396r–4) is amended by adding at the end the
22 following new subparagraph:
23 "(D) If a State plan under this title provides for
24 payments for inpatient hospital services on a prospec-
25 tive basis (whether per diem, per case, or otherwise),

1 in order for the plan to be considered to have met such
2 requirement of section 1902(a)(13)(A) as of July 1,
3 1991, the State must submit to the Secretary by not
4 later than April 1, 1991, a State plan amendment that
5 provides, in the case of hospitals defined by the State
6 as disproportionate share hospitals under paragraph
7 (1)(A), for an outlier adjustment in payment amounts
8 for medically necessary inpatient hospital services pro-
9 vided on or after July 1, 1991, involving exceptionally
10 high costs or exceptionally long lengths of stay for in-
11 dividuals one year of age or older, but under 18 years
12 of age.".
13 (c) EFFECTIVE DATES.—(1)(A) The amendment made
14 by subsection (a) applies (except as provided under subpara-
15 graph (B)) to payments under title XIX of the Social Security
16 Act for calendar quarters beginning on or after July 1, 1991,
17 without regard to whether or not final regulations to carry
18 out such amendment have been promulgated by such date.
19 (B) In the case of a State plan for medical assistance
20 under title XIX of the Social Security Act which the Secre-
21 tary of Health and Human Services determines requires
22 State legislation (other than legislation authorizing or appro-
23 priating funds) in order for the plan to meet the additional
24 requirement imposed by the amendment made by subsection
25 (a), the State plan shall not be regarded as failing to comply

1 with the requirements of such title solely on the basis of its
2 failure to meet this additional requirement before the first day
3 of the first calendar quarter beginning after the close of the
4 first regular session of the State legislature that begins after
5 the date of the enactment of this Act. For purposes of the
6 previous sentence, in the case of a State that has a 2-year
7 legislative session, each year of such session shall be deemed
8 to be a separate regular session of the State legislature.
9 (2) The amendment made by subsection (b) shall take
10 effect on the date of the enactment of this Act.

11 **SEC. 206. REQUIRING "SECTION 209(B)" STATES TO PROVIDE**
12 **MEDICAL ASSISTANCE TO DISABLED CHILDREN**
13 **RECEIVING SSI BENEFITS.**

14 (a) IN GENERAL.—Section 1902(f) of the Social Securi-
15 ty Act (42 U.S.C. 1396a(f)) is amended—
16 (1) by inserting "paragraph (2) of this subsection
17 and" after ", except as provided in",
18 (2) by striking "(1)" and "(2)" and inserting
19 "(A)" and "(B)", respectively,
20 (3) by inserting "(1)" after "(f)", and
21 (4) by adding at the end the following new para-
22 graph:
23 "(2) A State shall provide medical assistance to any in-
24 dividual under 18 years of age with respect to whom supple-

1 mental security income benefits are payable under title
2 XVI.".
3 (b) EFFECTIVE DATE.—(1) The amendments made by
4 subsection (a) apply (except as provided under paragraph (2))
5 to payments under title XIX of the Social Security Act for
6 calendar quarters beginning on or after July 1, 1991, without
7 regard to whether or not final regulations to carry out such
8 amendments have been promulgated by such date.
9 (2) In the case of a State plan for medical assistance
10 under title XIX of the Social Security Act which the Secre-
11 tary of Health and Human Services determines requires
12 State legislation (other than legislation authorizing or appro-
13 priating funds) in order for the plan to meet the additional
14 requirement imposed by the amendments made by subsection
15 (a), the State plan shall not be regarded as failing to comply
16 with the requirements of such title solely on the basis of its
17 failure to meet this additional requirement before the first day
18 of the first calendar quarter beginning after the close of the
19 first regular session of the State legislature that begins after
20 the date of the enactment of this Act. For purposes of the
21 previous sentence, in the case of a State that has a 2-year
22 legislative session, each year of such session shall be deemed
23 to be a separate regular session of the State legislature.

1 **SEC. 207. MANDATORY CONTINUATION OF COVERAGE FOR**
2 **CHILDREN OTHERWISE QUALIFIED FOR BENE-**
3 **FITS UNTIL REDETERMINATION.**

4 (a) IN GENERAL.—Section 1902(e) of the Social Securi-
5 ty Act (42 U.S.C. 1396a(e)) is amended by adding at the end
6 the following new paragraph:
7 "(11) With respect to an individual who has not attained
8 the age of 18, who is receiving medical assistance under this
9 title, and who is determined to be no longer eligible for such
10 assistance, the State may not discontinue such assistance
11 until the State has determined that the individual is not eligi-
12 ble for assistance under this title on any basis.".
13 (b) CONFORMING AMENDMENT TO QUALITY CON-
14 TROL.—Section 1903(u)(1)(D) of such Act (42 U.S.C.
15 1396b(u)(1)(D)) is amended by adding at the end the follow-
16 ing new clause:
17 "(vi) In determining the amount of erroneous excess
18 payments for quarters beginning on or after July 1, 1991,
19 there shall not be included any erroneous payments which
20 are attributable to individuals described in section
21 1902(e)(11) who are determined to be no longer eligible for
22 assistance but whose assistance has not been discontinued
23 because a determination on other bases for such assistance
24 has not been made.".
25 (c) EFFECTIVE DATE.—The amendment made by sub-
26 section (a) shall become effective with respect to eligibility

1 determinations for medical assistance under title XIX of the
2 Social Security Act on or after July 1, 1991, without regard
3 to whether or not final regulations to carry out such amend-
4 ment have been promulgated by such date.

5 **SEC. 208. OPTIONAL MEDICAID COVERAGE FOR FOSTER CHIL-**
6 **DREN.**

7 (a) IN GENERAL.—Section 1902 of the Social Security
8 Act (42 U.S.C. 1396a) is amended—
9 (1) in subsection (a)(10)(A)(ii)—
10 (A) by striking "or" at the end of subclause
11 (X),
12 (B) by inserting "or" at the end of subclause
13 (XI), and
14 (C) by adding at the end the following new
15 subclause:
16 "(XII) who are described in sub-
17 section (s)(1);";
18 (2) in subsection (a)(17), by striking "and (m)(4)"
19 and inserting "(m)(4), and (s)(1)"; and
20 (3) by adding at the end the following new sub-
21 section:
22 "(s)(1) Individuals described in this paragraph are indi-
23 viduals for whom a public agency assumes full or partial fi-
24 nancial responsibility—
25 "(A) who have not attained the age of 18,

1 "(B) who reside in a foster home, group home, or
2 private institution, and
3 "(C) whose incomes do not exceed 100 percent of
4 the income official poverty line (as defined by the
5 Office of Management and Budget and revised annually
6 in accordance with section 673(2) of the Omnibus
7 Budget Reconciliation Act of 1981) applicable to a
8 family of one.
9 "(2) Notwithstanding subsection (a)(17), for individuals
10 who are eligible for medical assistance because of subsection
11 (a)(10)(A)(ii)(XII)—
12 "(A) no resource standard or methodology shall be
13 applied,
14 "(B) the income standard to be applied is the
15 income standard described in paragraph (1)(C), and
16 "(C) income for these individuals shall be deter-
17 mined in accordance with a methodology which is no
18 more restrictive than the methodology employed under
19 the State plan under part E of title IV.".
20 (b) EFFECTIVE DATE.—The amendments made by this
21 section shall become effective with respect to payments under
22 title XIX of the Social Security Act for calendar quarters
23 beginning on or after July 1, 1991, without regard to wheth-
24 er or not final regulations to carry out such amendments have
25 been promulgated by such date.

○

101ST CONGRESS
2D SESSION

S. 2032

To amend the Internal Revenue Code of 1986 to provide for a credit for health insurance expenses.

IN THE SENATE OF THE UNITED STATES

JANUARY 30 (legislative day, JANUARY 23), 1990

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

---

A BILL

To amend the Internal Revenue Code of 1986 to provide for a credit for health insurance expenses.

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. CREDIT FOR HEALTH INSURANCE EXPENSES.**
4 (a) IN GENERAL.—Subpart C of part IV of subchapter
5 A of chapter 1 of the Internal Revenue Code of 1986 (relat-
6 ing to refundable personal credits) is amended by inserting
7 after section 34 the following new section:
8 **"SEC. 34A. HEALTH INSURANCE EXPENSES.**
9 "(a) ALLOWANCE OF CREDIT.—

1 "(1) IN GENERAL.—In the case of an eligible in-
2 dividual, there shall be allowed as a credit against the
3 tax imposed by this subtitle for the taxable year an
4 amount equal to the applicable percentage of the quali-
5 fied health insurance expenses paid by such individual
6 during the taxable year.
7 "(2) APPLICABLE PERCENTAGE.—For purposes
8 of paragraph (1), the term 'applicable percentage'
9 means 60 percent reduced (but not below zero) by 10
10 percentage points for each $1,000 (or fraction thereof)
11 by which the taxpayer's adjusted gross income for the
12 taxable year exceeds the applicable dollar amount.
13 "(3) APPLICABLE DOLLAR AMOUNT.—For pur-
14 poses of this subsection, the term 'applicable dollar
15 amount' means—
16 "(A) in the case of a taxpayer filing a joint
17 return, $28,000,
18 "(B) in the case of any other taxpayer (other
19 than a married individual filing a separate return),
20 $18,000, and
21 "(C) in the case of a married individual filing
22 a separate return, zero.
23 For purposes of this subsection, the rule of section
24 219(g)(4) shall apply.

1 “(b) QUALIFIED HEALTH INSURANCE EXPENSES.—
2 For purposes of this section—
3 “(1) IN GENERAL.—The term ‘qualified health in-
4 surance expenses’ means amounts paid during the tax-
5 able year for insurance which constitutes medical care
6 (within the meaning of section 213(d)(1)(C)). For pur-
7 poses of the preceding sentence, the rules of section
8 213(d)(6) shall apply.
9 “(2) DOLLAR LIMIT ON QUALIFIED HEALTH IN-
10 SURANCE EXPENSES.—The amount of the qualified
11 health insurance expenses paid during any taxable year
12 which may be taken into account under subsection
13 (a)(1) shall not exceed $1,200 ($2,400 in the case of a
14 taxpayer filing a joint return).
15 “(3) ELECTION NOT TO TAKE CREDIT.—A tax-
16 payer may elect for any taxable year to have amounts
17 described in paragraph (1) not treated as qualified
18 health insurance expenses.
19 “(c) ELIGIBLE INDIVIDUAL.—For purposes of this sec-
20 tion, the term ‘eligible individual’ means, with respect to any
21 period, an individual who is not covered during such period
22 by a health plan maintained by an employer of such individ-
23 ual or such individual’s spouse.
24 “(d) SPECIAL RULES.—For purposes of this section—

1 "(1) COORDINATION WITH ADVANCE PAYMENT
2 AND MINIMUM TAX.—Rules similar to the rules of
3 subsections (g) and (h) of section 32 shall apply to any
4 credit to which this section applies.
5 "(2) MEDICARE-ELIGIBLE INDIVIDUALS.—No ex-
6 pense shall be treated as a qualified health insurance
7 expense if it is an amount paid for insurance for an in-
8 dividual for any period with respect to which such indi-
9 vidual is entitled (or, on application without the pay-
10 ment of an additional premium, would be entitled to)
11 benefits under part A of title XVIII of the Social
12 Security Act.
13 "(3) SUBSIDIZED EXPENSES.—No expense shall
14 be treated as a qualified health insurance expense to
15 the extent—
16 "(A) such expense is paid, reimbursed, or
17 subsidized (whether by being disregarded for pur-
18 poses of another program or otherwise) by the
19 Federal Government, a State or local govern-
20 ment, or any agency or instrumentality thereof,
21 and
22 "(B) the payment, reimbursement, or subsidy
23 of such expense is not includible in the gross
24 income of the recipient.

1 "(e) REGULATIONS.—The Secretary shall prescribe
2 such regulations as may be necessary to carry out the pur-
3 poses of this section."
4 (b) ADVANCE PAYMENT OF CREDIT.—
5 (1) IN GENERAL.—Chapter 25 of the Internal
6 Revenue Code of 1986 is amended by inserting after
7 section 3507 the following new section:
8 **"SEC. 3507A. ADVANCE PAYMENT OF HEALTH INSURANCE**
9 **EXPENSES CREDIT.**
10 "(a) GENERAL RULE.—Except as otherwise provided
11 in this section, every employer making payment of wages
12 with respect to whom a health insurance expenses eligibility
13 certificate is in effect shall, at the time of paying such wages,
14 make an additional payment equal to such employee's de-
15 pendent care advance amount.
16 "(b) HEALTH INSURANCE EXPENSES ELIGIBILITY
17 CERTIFICATE.—For purposes of this title, a health insurance
18 expenses eligibility certificate is a statement furnished by an
19 employee to the employer which—
20 "(1) certifies that the employee will be eligible to
21 receive the credit provided by section 34A for the tax-
22 able year,
23 "(2) certifies that the employee does not have a
24 health insurance expenses eligibility certificate in effect

1 for the calendar year with respect to the payment of
2 wages by another employer,
3 "(3) states whether or not the employee's spouse
4 has a health insurance expenses eligibility certificate in
5 effect,
6 "(4) estimates the amount of qualified health in-
7 surance expenses (as defined in section 34A(b)) for the
8 calendar year.
9 For purposes of this section, a certificate shall be treated as
10 being in effect with respect to a spouse if such a certificate
11 will be in effect on the first status determination date follow-
12 ing the date on which the employee furnishes the statement
13 in question.
14 "(c) HEALTH INSURANCE EXPENSES ADVANCE
15 AMOUNT.—
16 "(1) IN GENERAL.—For purposes of this title, the
17 term 'health insurance expenses advance amount'
18 means, with respect to any payroll period, the amount
19 determined—
20 "(A) on the basis of the employee's wages
21 from the employer for such period,
22 "(B) on the basis of the employee's estimated
23 qualified health insurance expenses included in the
24 health insurance expenses eligibility certificate,
25 and

1 "(C) in accordance with tables provided by
2 the Secretary.
3 "(2) ADVANCE AMOUNT TABLES.—The tables re-
4 ferred to in paragraph (1)(D) shall be similar in form to
5 the tables prescribed under section 3402 and, to the
6 maximum extent feasible, shall be coordinated with
7 such tables and the tables prescribed under section
8 3507(c).
9 "(d) OTHER RULES.—For purposes of this section,
10 rules similar to the rules of subsections (d) and (e) of section
11 3507 shall apply.
12 "(e) REGULATIONS.—The Secretary shall prescribe
13 such regulations as may be necessary to carry out the pur-
14 poses of this section."
15 (2) CONFORMING AMENDMENT.—The table of
16 sections for chapter 25 of such Code is amended by
17 adding after the item relating to section 3507 the fol-
18 lowing new item:

"Sec. 3507A. Advance payment of health insurance expenses credit."

19 (c) COORDINATION WITH DEDUCTIONS FOR HEALTH
20 INSURANCE EXPENSES.—
21 (1) SELF-EMPLOYED INDIVIDUALS.—Section
22 162(l) of the Internal Revenue Code of 1986 is amend-
23 ed by redesignating paragraph (6) as paragraph (7) and

1 by inserting after paragraph (5) the following new
2 paragraph:
3 "(6) COORDINATION WITH HEALTH INSURANCE
4 PREMIUM CREDIT.—Paragraph (1) shall not apply to
5 any amount taken into account in computing the
6 amount of the credit allowed under section 34A."
7 (2) MEDICAL, DENTAL, ETC., EXPENSES.—Sub-
8 section (e) of section 213 of such Code is amended by
9 inserting "or section 34A" after "section 21".
10 (d) CLERICAL AMENDMENT.—The table of sections for
11 subpart A of part IV of subchapter A of chapter 1 of the
12 Internal Revenue Code of 1986 is amended by inserting after
13 the item relating to section 34 the following new item:

"Sec. 34A. Health insurance expenses."

14 (e) EFFECTIVE DATE.—The amendments made by this
15 section shall apply to taxable years beginning after Decem-
16 ber 31, 1990.

○

II

101st CONGRESS
2d Session

S. 2050

To amend title XVIII of the Social Security Act to provide toll-free hotlines for individuals receiving benefits under such title and to provide increased protection against fraud and abuse with respect to the marketing and selling of medicare supplemental policies to such individuals, and for other purposes.

IN THE SENATE OF THE UNITED STATES

February 1 (legislative day, January 23), 1990

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

---

A BILL

To amend title XVIII of the Social Security Act to provide toll-free hotlines for individuals receiving benefits under such title and to provide increased protection against fraud and abuse with respect to the marketing and selling of medicare supplemental policies to such individuals, 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 "Medigap Fraud and
5 Abuse Prevention Act of 1990".

1 **SEC. 2. MEDIGAP FRAUD AND ABUSE PROTECTIONS IN-**
2 **CREASED.**

3 (a) CIVIL PENALTIES INCREASED.—Section 1882(d) of
4 the Social Security Act (42 U.S.C. 1395ss(d)) is amended by
5 striking "$5,000" each place it appears and inserting
6 "$25,000".

7 (b) PROTECTION AGAINST DUPLICATION OF POLICY
8 INCREASED.—Section 1882(d)(3)(A) of such Act (42 U.S.C.
9 1395ss(d)(3)(A)) is amended by striking "policy substantially
10 duplicates" and inserting "policy duplicates".

11 (c) MINIMUM BENEFIT TO PREMIUM RATIO IN-
12 CREASED.—Section 1882(c)(2) of such Act (42 U.S.C.
13 1395ss(c)(2)) is amended by striking "60" and inserting
14 "70".

15 (d) ENFORCEMENT OF BENEFIT TO PREMIUM RATIO
16 STRENGTHENED.—Section 1882(b)(1) of such Act (42
17 U.S.C. 1395ss(b)(1)) is amended—

18 (1) by striking "and" at the end of subparagraph
19 (D); and

20 (2) by adding "and" at the end of subparagraph
21 (E); and

22 (3) by adding at the end thereof the following new
23 subparagraph:

24 "(F) provides for strict enforcement of the
25 percentage requirements described in subsection

1 (c)(2) in place with respect to the actual ratio of
2 benefits provided to premiums collected,".
3 (e) IMPLEMENTATION OF PROCESS TO APPROVE PRE-
4 MIUM INCREASES.—Section 1882(b)(1) of such Act (42
5 U.S.C. 1395ss(b)(1)) as amended by subsection (d) of this
6 Act, is further amended—
7 (1) by striking "and" at the end of subparagraph
8 (E);
9 (2) by adding "and" at the end of subparagraph
10 (F); and
11 (3) by adding at the end thereof the following new
12 subparagraph:
13 "(G) provides for a process for approving or
14 disapproving proposed premium increases with re-
15 spect to such policies,".
16 **SEC. 3. ESTABLISHMENT OF MEDIGAP TOLL-FREE HOTLINES.**
17 (a) IN GENERAL.—
18 (1) GRANTS.—The Secretary of Health and
19 Human Services (hereinafter referred to as the "Secre-
20 tary") shall provide grants to States submitting appli-
21 cations to the Secretary which meet the requirements
22 of this section for the purpose of establishing within
23 such States a toll-free telephone hotline to provide in-
24 dividuals with information concerning medicare supple-
25 mental insurance.

1 (2) AMOUNT OF GRANT.—The amount of a grant
2 awarded to a State under this section shall be deter-
3 mined by the Secretary in the same manner as used by
4 the Commissioner on Aging for determining the
5 amount of allotments under section 304(a) of the Older
6 Americans Act of 1965 (42 U.S.C. 3035 et seq.).
7 (3) MATCHING REQUIREMENTS.—A State receiv-
8 ing a grant under this section shall provide State funds
9 for use in establishing a toll-free hotline in an amount
10 that is equal to the amount of the grant made under
11 this subsection to such State.
12 (b) TYPE OF INFORMATION.—Information to be
13 provided through the use of the toll-free hotlines established
14 under subsection (a) shall include—
15 (1) policy comparison information for all medicare
16 supplemental policies (as described in section
17 1882(g)(1) of the Social Security Act (42 U.S.C.
18 1395ss(g)(1))) and long-term care policies available to
19 individuals within the State;
20 (2) information that will assist individuals in filing
21 claims and obtaining benefits under titles XVIII and
22 XIX of the Social Security Act (42 U.S.C. 1395 et
23 seq. and 1396 et seq.);

1 (3) information that will assist individuals in filing
2 claims or obtaining benefits under a medicare supple-
3 mental policy;
4 (4) information concerning medicare supplemental
5 policy problem resolution, or appropriate referral of
6 such problems or complaints to the State insurance
7 commissioner or the State attorney general;
8 (5) information concerning the resources, informa-
9 tion, and procedures that are available within the State
10 to assist individuals with questions or complaints con-
11 cerning health insurance; and
12 (6) any other information determined appropriate
13 by the Secretary.
14 (c) TRAINING.—
15 (1) INDIVIDUALS ANSWERING HOTLINE.—The
16 Secretary shall promulgate regulations to insure that
17 individuals providing assistance through the use of the
18 toll-free hotlines established under subsection (a) are
19 adequately qualified to provide such assistance.
20 (2) VOLUNTEER ORGANIZATIONS.—States that
21 receive a grant under this title shall provide training,
22 educational materials, and technical assistance to vol-
23 unteer organizations that are willing and able to pro-
24 vide medicare supplemental policies and medical assist-

1 ance eligibility information and counseling to consum-
2 ers.
3 (3) COUNTY BENEFIT SPECIALISTS.—States that
4 receive a grant under this title shall conduct seminars
5 to provide training to county benefit specialists in local
6 welfare area agencies on aging concerning the toll-free
7 hotlines established under subsection (a) and the loca-
8 tion and functions of State aging agencies and offices.
9 (d) EDUCATIONAL BROCHURE.—Not later than 180
10 days after the date of enactment of this section, each State
11 that receives a grant under this title shall, through the State
12 commissioner of insurance, develop and disseminate a medi-
13 care supplemental policy educational brochure that shall
14 summerize the information described in subsection (b)(1).
15 Such brochure shall be distributed with each medicare sup-
16 plemental policy inquiry or application made to an insurance
17 carrier within the State. The State toll-free number described
18 in subsection (a) shall be clearly printed on the front page of
19 the brochure.
20 (e) AUTHORIZATION OF APPROPRIATIONS.—There are
21 authorized to be appropriated from the Federal Supplementa-
22 ry Medical Insurance Trust Fund to carry out this section,
23 $5,000,000 for each of the fiscal years 1991 through 1993.

1 **SEC. 4. GAO STUDY AND REPORT ON STATE ENFORCEMENT**
2 **OF FEDERAL MEDIGAP REQUIREMENTS AND**
3 **PENALTIES.**

4 (a) STUDY.—The General Accounting Office shall con-
5 duct a study on State efforts in enforcing the standards and
6 requirements set forth in section 1882(c) of the Social Securi-
7 ty Act with respect to the issuance and marketing of medi-
8 care supplemental policies within each State. The study shall
9 further evaluate efforts with regard to imposing civil or crimi-
10 nal penalties under section 1882(d) of the Social Security Act
11 with respect to persons found guilty of violating any of the
12 provisions described in such section. Such study shall further
13 evaluate the ratio of benefits to premiums collected with re-
14 spect to the supplemental policies described in section 1882,
15 and the effectiveness of State enforcement of such ratios.

16 (b) REPORT.—The General Accounting Office shall no
17 later than July 1, 1990, submit a report to Congress summa-
18 rizing the findings of the study described in subsection (a),
19 including legislative recommendations on strengthening and
20 improving the enforcement of the fraud and abuse provisions
21 provided for in section 1882 of the Social Security Act and
22 recommendations on improving enforcement of benefit to pre-
23 mium ratio requirements.

○

101ST CONGRESS
2D SESSION

H. R. 3931

To amend title XIX of the Social Security Act to reduce infant mortality through improvement of coverage of services to pregnant women and infants under the medicaid program.

IN THE HOUSE OF REPRESENTATIVES

FEBRUARY 1, 1990

Mrs. COLLINS (for herself, Mr. HYDE, Mr. WAXMAN, Mr. MILLER of California, Mr. SCHEUER, Mr. WALGREN, Mr. WYDEN, Mr. SIKORSKI, Mr. BATES, Mr. BRUCE, Mr. TOWNS, Mr. MARKEY, Mr. BOUCHER, Mr. DURBIN, Mr. BERMAN, Mr. MCDERMOTT, Mr. WILLIAMS, Mr. DE LUGO, Mr. CROCKETT, Mr. ACKERMAN, Mr. HAWKINS, Mr. FRANK, Mr. RANGEL, Mr. FAUNTROY, Ms. SCHNEIDER, Mr. PAYNE of New Jersey, Ms. PELOSI, Mr. WHEAT, Mr. JOHNSTON of Florida, and Mr. FOGLIETTA) introduced the following bill; which was referred to the Committee on Energy and Commerce

---

A BILL

To amend title XIX of the Social Security Act to reduce infant mortality through improvement of coverage of services to pregnant women and infants under the medicaid program.

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

3 ## TITLE I—SHORT TITLE

4 **SECTION 101. SHORT TITLE.**

5 This Act may be cited as the "Medicaid Infant Mortality
6 Amendments of 1990".

TITLE II—INFANT MORTALITY PROVISIONS

SEC. 201. PHASED-IN COVERAGE OF PREGNANT WOMEN AND INFANTS UP TO 185 PERCENT OF POVERTY LEVEL.

(a) IN GENERAL.—Section 1902(l)(2)(A) of the Social Security Act (42 U.S.C. 1396a(l)(2)(A)), as amended by section 6401(a) of the Omnibus Budget Reconciliation Act of 1989, is amended—

(1) in clause (ii)—

(A) in subclause (I), by striking "and" at the end of subclause (I),

(B) by striking the period at the end of subclause (II) and inserting a comma, and

(C) by adding at the end the following new subclauses:

"(III) July 1, 1991, 150 percent, or, if greater, the percentage provided under clause (v), and

"(IV) July 1, 1993, 185 percent."; and

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

"(v) In the case of a State which, as of the date of the enactment of this clause, has established under clause (i), or has enacted legislation authorizing, or appropriating funds, to provide for, a percentage (of the income official poverty line) that is greater than 150 percent, the percentage provided

1 under clause (ii) for medical assistance on or after July 1,
2 1991, shall not be less than—
3 "(I) the percentage specified by the State in an
4 amendment to its State plan (whether approved or not)
5 as of the date of the enactment of this clause, or
6 "(II) if no such percentage is specified as of the
7 date of the enactment of this clause, the percentage es-
8 tablished under the State's authorizing legislation or
9 provided for under the State's appropriations.".
10 (b) FLEXIBILITY IN INCOME METHODOLOGY AND DE-
11 DUCTION OF CHILD CARE IN COMPUTATION OF INCOME.—
12 Section 1902(l)(3)(E) of such Act (42 U.S.C. 1396a(l)(3)(E))
13 is amended by striking "(E)" and inserting the following:
14 "(E)(i) with respect to an individual described in
15 subparagraph (A) or (B) of paragraph (1), family
16 income shall be determined in accordance with a meth-
17 odology which is no more restrictive than the method-
18 ology employed under the State plan under part A or
19 E of title IV (except to the extent such methodology is
20 inconsistent with clause (D) of subsection (a)(17) and
21 except that there shall be disregarded costs for such
22 child care as is necessary for the employment of the
23 pregnant woman or the caretaker of the infant), and
24 costs incurred for medical care or for any other type of
25 remedial care shall not be taken into account, and

1 "(ii) with respect to an individual described in
2 paragraph (1)(C) or (1)(D),".
3 (c) PROHIBITING APPLICATION OF RESOURCE
4 TEST.—Section 1902(l)(3) of such Act (42 U.S.C.
5 1396a(l)(3)) is amended—
6 (1) by amending subparagraph (A) to read as
7 follows:
8 "(A)(i) no resource standard or methodology shall
9 be applied to individuals who are eligible for medical
10 assistance because of subsection (a)(10)(A)(i)(IV), and
11 (ii) application of a resource standard or methodology
12 for individuals who are eligible for medical assist-
13 ance because of subsection (a)(10)(A)(i)(VI) or
14 (a)(10)(A)(ii)(IX) shall be at the option of the State, but
15 any such resource standard or methodology may not be
16 more restrictive than the corresponding standard or
17 methodology that is applied under the State plan under
18 part A of title IV;",
19 (2) by striking subparagraphs (B) and (C), and
20 (3) by redesignating subparagraphs (D) and (E) as
21 subparagraphs (B) and (C), respectively.
22 (d) REPORT AND TRANSITION ON ERRORS IN ELIGI-
23 BILITY DETERMINATIONS.—
24 (1) REPORT.—The Secretary of Health and
25 Human Services shall report to Congress, by not later

1 than July 1, 1991, on error rates by States in deter-
2 mining eligibility of individuals described in subpara-
3 graph (A) or (B) of section 1902(l)(1) of the Social Se-
4 curity Act for medical assistance under plans approved
5 under title XIX of such Act. Such report may include
6 data for medical assistance provided before July 1,
7 1989.

8 (2) ERROR RATE TRANSITION.—There shall not
9 be taken into account, for purposes of section 1903(u)
10 of the Social Security Act, payments and expenditures
11 for medical assistance which—

12 (A) are attributable to medical assistance for
13 individuals described in subparagraph (A) or (B) of
14 section 1902(l)(1) of such Act, and

15 (B) are made on or after July 1, 1989, and
16 before the first calendar quarter that begins more
17 than 12 months after the date of submission of the
18 report under paragraph (1).

19 (e) EFFECTIVE DATES.—

20 (1) HIGHER INCOME STANDARDS.—Except as
21 provided in paragraph (3), the amendments made by
22 subsection (a) shall apply to payments under title XIX
23 of the Social Security Act for calendar quarters begin-
24 ning on or after July 1, 1991, with respect to eligibil-
25 ity for medical assistance on or after such date, with-

1 out regard to whether or not final regulations to carry
2 out such amendments have been promulgated by such
3 date.
4 (2) INCOME METHODOLOGY AND RESOURCE
5 STANDARD.—Except as provided in paragraph (3), the
6 amendments made by subsections (b) and (c) shall
7 apply to payments under title XIX of the Social Secu-
8 rity Act for calendar quarters beginning on or after
9 July 1, 1991, with respect to eligibility for medical as-
10 sistance on or after such date, without regard to
11 whether or not final regulations to carry out such
12 amendments have been promulgated by such date.
13 (3) EXCEPTION FOR CERTAIN STATES.—(A) In
14 the case of a State plan for medical assistance under
15 title XIX of the Social Security Act which the Secre-
16 tary of Health and Human Services determines re-
17 quires State legislation (other than legislation authoriz-
18 ing or appropriating funds) in order for the plan to
19 meet the additional requirements imposed by the
20 amendments made by this section, the State plan shall
21 not be regarded as failing to comply with the require-
22 ments of such title solely on the basis of its failure to
23 meet these additional requirements before the first day
24 of the first calendar quarter beginning after the close of
25 the first regular session of the State legislature that

1 begins after the date of the enactment of this Act. For
2 purposes of the previous sentence, in the case of a
3 State that has a 2-year legislative session, each year of
4 such session shall be deemed to be a separate regular
5 session of the State legislature.

6 (B) In the case of the State of Texas, the State
7 plan shall not be regarded as failing to comply with the
8 requirements of title XIX of the Social Security Act
9 solely on the basis of its failure to meet the additional
10 requirements imposed by the amendments made by this
11 section before September 1, 1991.

12 **SEC. 202. PRESUMPTIVE ELIGIBILITY.**

13 (a) EXTENSION OF PRESUMPTIVE ELIGIBILITY
14 PERIOD.—Section 1920 of the Social Security Act (42
15 U.S.C. 1396r–1) is amended—

16 (1) in subsection (b)(1)(B)—

17 (A) by adding "or" at the end of clause (i),

18 (B) by striking clause (ii), and

19 (C) by amending clause (iii) to read as
20 follows:

21 "(ii) in the case of a woman who does
22 not file an application by the last day of the
23 month following the month during which the
24 provider makes the determination referred to

1 in subparagraph (A), such last day; and";
2 and
3 (2) in subsections (c)(2)(B) and (c)(3), by striking
4 "within 14 calendar days after the date on which" and
5 inserting "by not later than the last day of the month
6 following the month during which".
7 (b) FLEXIBILITY IN APPLICATION.—Section 1920(c)(3)
8 of such Act (42 U.S.C. 1396r–1(c)(3)) is amended by insert-
9 ing before the period at the end the following: ", which appli-
10 cation may be the application used for the receipt of medical
11 assistance by individuals described in section 1902(l)(1)(A)".
12 (c) EFFECTIVE DATES.—
13 (1) The amendments made by subsection (a) apply
14 to payments under title XIX of the Social Security Act
15 for calendar quarters beginning on or after July 1,
16 1991, without regard to whether or not final regula-
17 tions to carry out such amendments have been promul-
18 gated by such date.
19 (2) The amendment made by subsection (b) shall
20 be effective as if included in the enactment of section
21 9407(b) of the Omnibus Budget Reconciliation Act of
22 1986.

1 **SEC. 203. OPTIONAL COVERAGE OF PRENATAL AND POSTPAR-**
2 **TUM HOME VISITATION SERVICES.**

3 (a) IN GENERAL.—Section 1905(a) of the Social Securi-
4 ty Act (42 U.S.C. 1396d(a)), as amended by section 6405(a)
5 of the Omnibus Budget Reconciliation Act of 1989, is
6 amended—

7 (1) by striking "and" at the end of paragraph
8 (21),

9 (2) by redesignating paragraph (22) as paragraph
10 (23), and

11 (3) by inserting after paragraph (20) the following
12 new paragraph:

13 "(22) prenatal home visitation services for high-
14 risk pregnant women, postpartum home visitation serv-
15 ices with respect to high-risk infants under 1 year of
16 age, or both (as specified by the State), as prescribed
17 by a physician; and".

18 (b) CONFORMING AMENDMENTS.—Section 1902 of
19 such Act (42 U.S.C. 1396a) is amended—

20 (1) in subsection (a)(10)(C)(iv), by striking "(20)"
21 and inserting "(22)", and

22 (2) in subsection (j), by striking "(21)" and insert-
23 ing "(23)".

24 (c) EFFECTIVE DATE.—The amendments made by this
25 section shall apply to services furnished on or after July 1,
26 1991, without regard to whether or not final regulations to

1 carry out such amendments have been promulgated by such
2 date.

3 **SEC. 204. ROLE IN PATERNITY DETERMINATIONS.**

4 (a) IN GENERAL.—Section 1912(a)(1)(B) of the Social
5 Security Act (42 U.S.C. 1396k(a)(1)(B)) is amended by in-
6 serting "the individual is described in section 1902(l)(1)(A)
7 or" after "unless (in either case)".

8 (b) EFFECTIVE DATE.—The amendment made by sub-
9 section (a) shall take effect on the date of the enactment of
10 this Act.

○

101st CONGRESS
2d Session

H. R. 3933

To amend title XIX of the Social Security Act to provide States the option of providing quality community care to the elderly under their medicaid programs.

IN THE HOUSE OF REPRESENTATIVES

February 1, 1990

Mr. Wyden (for himself, Mr. Waxman, Mr. Roybal, Mr. Rinaldo, Mr. Scheuer, Mr. Walgren, Mr. Sikorski, Mr. Bates, Mr. Bruce, Mrs. Collins, Mr. Towns, Mr. Markey, Mr. Eckart, Mr. Richardson, Mr. Boucher, Mr. Schumer, Mrs. Boxer, Mr. Durbin, Mr. Espy, Mr. Dwyer of New Jersey, Mr. Berman, Ms. Kaptur, Mr. Fauntroy, Mr. Levine of California, Mr. McDermott, Mr. Kostmayer, Mr. Mrazek, Ms. Pelosi, Mr. Foglietta, Mr. Morrison of Connecticut, Mr. Harris, Mr. Levin of Michigan, Mr. Hughes, Mr. Hertel, Mrs. Saiki, Mr. Rangel, Mr. Edwards of California, Mr. Ford of Tennessee, Mr. Fazio, Mr. Brown of California, Mr. Pallone, Mr. Rowland of Connecticut, Mr. Owens of New York, Mr. Payne of New Jersey, Mr. Clement, Mr. Mollohan, Mr. Engel, Mr. Matsui, Mr. Staggers, Mr. Wolpe, Mr. Gejdenson, Mr. de Lugo, Mr. Crockett, Mr. Ackerman, Mr. Hawkins, Mr. Hyde, Mr. Frank, Mr. Miller of California, Ms. Schneider, Mr. Wheat, Mr. Johnston of Florida, Mr. Williams, and Mr. Walsh) introduced the following bill; which was referred to the Committee on Energy and Commerce

---

A BILL

To amend title XIX of the Social Security Act to provide States the option of providing quality community care to the elderly under their medicaid programs.

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

TITLE I—SHORT TITLE

SECTION 101. SHORT TITLE.

This Act may be cited as the "Medicaid Frail Elderly Community Care Amendments of 1990".

TITLE II—FRAIL ELDERLY COMMUNITY CARE AMENDMENTS

SEC. 201. COMMUNITY CARE AS OPTIONAL, STATEWIDE SERVICE.

(a) PROVISION AS OPTIONAL, STATEWIDE SERVICE.—Section 1905(a) of the Social Security Act (42 U.S.C. 1396d(a)), as amended by section 6405(a) of the Omnibus Budget Reconciliation Act of 1989, is amended—

(1) by striking "and" at the end of paragraph (21),

(2) by redesignating paragraph (22) as paragraph (23), and

(3) by inserting after paragraph (21) the following new paragraph:

"(22) community care (as defined in section 1927(a)) for functionally disabled elderly individuals; and".

(b) COMMUNITY CARE FOR FUNCTIONALLY DISABLED ELDERLY INDIVIDUALS.—Title XIX of such Act, as amended by section 6402(b) of the Omnibus Budget Reconciliation Act of 1989, is amended—

1 (1) by redesignating section 1927 as section 1928,
2 and
3 (2) by inserting after section 1926 the following
4 new section:
5 "COMMUNITY CARE FOR FUNCTIONALLY DISABLED
6 ELDERLY INDIVIDUALS
7 "SEC. 1927. (a) COMMUNITY CARE DEFINED.—In this
8 title, the term 'community care' means one or more of the
9 following services furnished to an individual who has been
10 determined, after an assessment under subsection (c), to be a
11 functionally disabled elderly individual, and in accordance
12 with an individual community care plan (established and peri-
13 odically reviewed and revised by a qualified community care
14 case manager under subsection (d)):
15 "(1) Homemaker/home health aide services.
16 "(2) Chore services.
17 "(3) Personal care services.
18 "(4) Nursing care services (other than continuous
19 24-hour nursing care services) provided by, or under
20 the supervision of, a registered nurse.
21 "(5) Respite care.
22 "(6) Training for family members in managing the
23 individual.
24 "(7) Adult day health services.
25 "(8) In the case of an individual with chronic
26 mental illness, day treatment or other partial hospitali-

1 zation, psychosocial rehabilitation services, and clinic
2 services (whether or not furnished in a facility).
3 "(9) Such other home and community-based serv-
4 ices (other than room and board) as the Secretary may
5 approve.
6 With respect to services described in paragraphs (1) through
7 (4), the services must be provided in a place of residence used
8 as the individual's home.
9 "(b) FUNCTIONALLY DISABLED ELDERLY INDIVIDUAL
10 DEFINED.—
11 "(1) IN GENERAL.—In this title, the term 'func-
12 tionally disabled elderly individual' means an individual
13 who—
14 "(A) is 65 years of age or older;
15 "(B) is determined to be a functionally dis-
16 abled individual under subsection (c); and
17 "(C)(i) subject to section 1902(f) (as applied
18 consistent with section 1902(r)(2)), is described in
19 section 1902(a)(10)(A)(i), or
20 "(ii) at the option of the State, is described
21 in section 1902(a)(10)(C).
22 "(2) TREATMENT OF CERTAIN INDIVIDUALS COV-
23 ERED UNDER CERTAIN WAIVERS.—
24 "(A) HOME AND COMMUNITY-BASED WAIV-
25 ERS.—In the case of a State which—

1 "(i) at the time of its election to provide
2 coverage for community care under this sec-
3 tion has a waiver approved under section
4 1915(c) or 1915(d) with respect to individ-
5 uals 65 years of age or older, and
6 "(ii) subsequently discontinues such
7 waiver,
8 an individual who was eligible for benefits under
9 the waiver as of the date of its discontinuance and
10 who would, but for income or resources, be eligi-
11 ble for medical assistance for community care
12 under the plan shall, notwithstanding any other
13 provision of this title, be deemed a functionally
14 disabled elderly individual for so long as the indi-
15 vidual would have remained eligible for medical
16 assistance under such waiver.
17 "(B) OTHER WAIVERS.—In the case of a
18 State which, as of December 31, 1989, had in
19 effect a waiver under section 1115 that provides
20 under the State plan under this title for personal
21 care services for functionally disabled individuals,
22 the term 'functionally disabled elderly individual'
23 may include, at the option of the State, an indi-
24 vidual who—

1 "(i) is 65 years of age or older or is dis-
2 abled (as determined under the supplemental
3 security income program under title XVI);
4 "(ii) is determined to meet the test of
5 functional disability applied under the waiver
6 as of such date; and
7 "(iii) meets the resource requirement
8 and income standard that apply in the State
9 to individuals described in section
10 1902(a)(10)(A)(ii)(V).
11 "(3) USE OF PROJECTED INCOME.—In applying
12 section 1903(f)(1) in determining the eligibility of an in-
13 dividual (described in section 1902(a)(10)(C)) for medi-
14 cal assistance for community care, a State may, at its
15 option, provide for the determination of the individual's
16 anticipated medical expenses (to be deducted from
17 income) over a period of up to 6 months.
18 "(c) DETERMINATIONS OF FUNCTIONAL DISABIL-
19 ITY.—
20 "(1) IN GENERAL.—In this section, an individual
21 is 'functionally disabled' if the individual—
22 "(A) is unable to perform without substantial
23 assistance from another individual at least 2 of
24 the following 3 activities of daily living: toileting,
25 transferring, and eating; or

1 "(B) has a primary or secondary diagnosis of
2 Alzheimer's disease and is (i) unable to perform
3 without substantial human assistance (including
4 verbal reminding or physical cueing) or supervi-
5 sion at least 2 of the following 5 activities of daily
6 living: bathing, dressing, toileting, transferring,
7 and eating, or (ii) cognitively impaired so as to re-
8 quire substantial supervision from another individ-
9 ual because the individual engages in inappropri-
10 ate behaviors that pose serious health or safety
11 hazards to himself or herself or others.

12 "(2) ASSESSMENTS OF FUNCTIONAL DISABIL-
13 ITY.—

14 "(A) REQUESTS FOR ASSESSMENTS.—If a
15 State has elected to provide community care
16 under this section, upon the request of an individ-
17 ual who is 65 years of age or older and who
18 meets the requirements of subsection (b)(1)(C) (or
19 another person on such individual's behalf), the
20 State shall provide for a comprehensive functional
21 assessment under this subparagraph which—

22 "(i) is used to determine whether or not
23 the individual is functionally disabled,

1 "(ii) is based on a uniform minimum
2 data set specified by the Secretary under
3 subparagraph (C)(i), and
4 "(iii) uses an instrument which has been
5 specified by the State under subparagraph
6 (B).
7 No fee may be charged for such an assessment.
8 "(B) SPECIFICATION OF ASSESSMENT IN-
9 STRUMENT.—The State shall specify the instru-
10 ment to be used in the State in complying with
11 the requirement of subparagraph (A)(iii). Such in-
12 strument shall be—
13 "(i) one of the instruments identified
14 under subparagraph (C)(ii), or
15 "(ii) an instrument which the Secretary
16 has approved as being consistent with the
17 minimum data set of core elements, common
18 definitions, and utilization guidelines specified
19 by the Secretary in subparagraph (C)(i).
20 "(C) SPECIFICATION OF ASSESSMENT DATA
21 SET AND INSTRUMENTS.—The Secretary shall—
22 "(i) not later than July 1, 1991—
23 "(I) specify a minimum data set of
24 core elements and common definitions

1 for use in conducting the assessments
2 required under subparagraph (A), and
3 "(II) establish guidelines for use of
4 the data set; and
5 "(ii) by not later than July 1, 1991,
6 identify one or more instruments which are
7 consistent with the specification made under
8 subparagraph (A) and which a State may
9 specify under subparagraph (B) for use in
10 complying with the requirements of subpara-
11 graph (A).
12 "(D) PERIODIC REVIEW.—Each individual
13 who qualifies as a functionally disabled elderly in-
14 dividual shall have the individual's assessment pe-
15 riodically reviewed and revised not less often than
16 once every 12 months.
17 "(E) CONDUCT OF ASSESSMENT BY INTER-
18 DISCIPLINARY TEAMS.—
19 "(i) IN GENERAL.—An assessment
20 under subparagraph (A) and a review under
21 subparagraph (D) must be conducted by an
22 interdisciplinary team designated by the
23 State.
24 "(ii) DELEGATION.—The Secretary
25 shall permit a State to provide for assess-

1 ments and reviews through teams under con-
2 tracts—
3 "(I) with State or local agencies,
4 or
5 "(II) with nonprofit or public orga-
6 nizations which do not provide commu-
7 nity care or nursing facility services and
8 do not have a direct or indirect owner-
9 ship or control interest in, or direct or
10 indirect affiliation or relationship with,
11 an entity that provides, community care
12 or nursing facility services.
13 "(F) CONTENTS OF ASSESSMENT.—The
14 interdisciplinary team must—
15 "(i) identify in each such assessment or
16 review each client's functional disabilities
17 and need for community care (based on
18 social, cognitive, and other relevant factors),
19 and
20 "(ii) based on such assessment or
21 review, determine whether the individual is
22 (or continues to be) functionally disabled.
23 The results of such an assessment or review shall
24 be used in establishing, reviewing, and revising
25 the individual's ICCP under subsection (d)(1).

1 "(G) APPEAL PROCEDURES.—Each State
2 which elects to provide community care under this
3 section must have in effect an appeals process for
4 individuals adversely affected by determinations
5 under subparagraph (F).

6 "(d) INDIVIDUAL COMMUNITY CARE PLAN (ICCP).—

7 "(1) INDIVIDUAL COMMUNITY CARE PLAN DE-
8 FINED.—In this section, the terms 'individual commu-
9 nity care plan' and 'ICCP' mean, with respect to a
10 functionally disabled elderly individual, a written plan
11 which—

12 "(A)(i) is established by a qualified communi-
13 ty care case manager in face-to-face consultation
14 with (and with notice to) the individual and based
15 upon a visit to the individual in the individual's
16 residence and the most recent comprehensive
17 functional assessment of such individual conducted
18 under subsection (c)(2);

19 "(ii) is periodically reviewed and (as appro-
20 priate) revised by such a manager in face-to-face
21 consultation with (and with notice to) the individ-
22 ual and based upon a visit to the individual in the
23 individual's residence and the most recent compre-
24 hensive functional assessment of such individual
25 conducted under subsection (c)(2);

1 "(B) reflects, consistent with subparagraph
2 (C), the needs and preferences of the individual
3 and, to the extent feasible, allows for and pro-
4 motes the direction and oversight of community
5 care by the individual;
6 "(C) specifies, within any amount, duration,
7 and scope limitations imposed on community care
8 provided under the State plan, the community
9 care to be provided to such individual under the
10 plan;
11 "(D) does not include community care for
12 which payment is made by the individual or on
13 the individual's behalf; and
14 "(E) may specify services (other than those
15 to be provided to the individual under the plan)
16 required by such individual.
17 Nothing in this section shall be construed as authoriz-
18 ing an ICCP or the State to restrict the specific per-
19 sons or individuals (who are competent to provide com-
20 munity care under the State plan) who will provide the
21 community care described in subparagraph (C).
22 "(2) QUALIFIED COMMUNITY CARE CASE MAN-
23 AGER DEFINED.—In this section, the term 'qualified
24 community care case manager' means a nonprofit or
25 public agency or organization which—

1 "(A) has experience in establishing, and in
2 periodically reviewing and revising, assessments
3 or individual community care plans and in the
4 provision of case management services to the el-
5 derly;
6 "(B) is responsible (i) for assuring that com-
7 munity care covered under the State plan and
8 specified in the ICCP is being provided and (ii) for
9 visiting each individual receiving such care at the
10 individual's residence not less often than once
11 every 90 days;
12 "(C) in the case of a non-public organization,
13 does not provide community care or nursing facili-
14 ty services and does not have a direct or indirect
15 ownership or control interest in, or direct or indi-
16 rect affiliation or relationship with, an entity that
17 provides, community care or nursing facility
18 services;
19 "(D) has procedures for assuring the quality
20 of case management services it provides; and
21 "(E) meets such other standards, established
22 by the Secretary, as assure that—
23 "(i) such a manager is competent to
24 perform case management functions,

1 "(ii) individuals whose community care
2 they manage are not at risk of financial ex-
3 ploitation due to such a manager, and
4 "(iii) meets such other standards as the
5 State may establish.
6 "(3) APPEAL PROCEDURES.—Each State which
7 elects to provide community care under this section
8 must have in effect an appeals process for individuals
9 who disagree with the ICCP established under this
10 subsection.
11 "(e) CEILING ON PAYMENT AMOUNTS AND MAINTE-
12 NANCE OF EFFORT.—
13 "(1) CEILING ON PAYMENT AMOUNTS.—Pay-
14 ments may not be made under section 1903(a) to a
15 State for community care provided under this section
16 in a quarter to the extent that the medical assistance
17 for such care in the quarter exceeds 30 percent of the
18 product of—
19 "(A) the average number of individuals in
20 the quarter receiving such care under this section,
21 "(B) the average per diem rate of payment
22 which the Secretary has determined (before the
23 beginning of the quarter) will be payable under
24 title XVIII (without regard to coinsurance) for

1 extended care services to be provided in the State
2 during such quarter, and
3 "(C) the number of days in such quarter.
4 "(2) MAINTENANCE OF EFFORT.—
5 "(A) ANNUAL REPORTS.—As a condition for
6 the receipt of payment under section 1903(a) with
7 respect to medical assistance provided by a State
8 for community care (other than under a waiver
9 under section 1915(c) and other than home health
10 care services described in section 1905(a)(7) and
11 personal care services (specified under regulations
12 under section 1905(a)(23)) to functionally disabled
13 elderly individuals, the State shall report to the
14 Secretary, with respect to each Federal fiscal
15 year (beginning with fiscal year 1990) and in a
16 format developed or approved by the Secretary,
17 the amount of non-Federal funds obligated by the
18 State (including funds obligated by localities in the
19 State) with respect to the provision of community
20 care (other than under such a waiver or such
21 services) to functionally disabled elderly individ-
22 uals in that fiscal year.
23 "(B) REDUCTION IN PAYMENT IF FAILURE
24 TO MAINTAIN EFFORT.—In applying section
25 1903(a)(1) with respect to the total amount ex-

1 pended by a State for calendar quarters in a fiscal
2 year (beginning with fiscal year 1991) for commu-
3 nity care to the functionally disabled elderly indi-
4 viduals (other than under a waiver under section
5 1915(c) and other than home health care services
6 described in section 1905(a)(7) and personal care
7 services (specified under regulations under section
8 1905(a)(23)), such expenditures shall be reduced
9 by the amount reported under subparagraph (A)
10 with respect to fiscal year 1990.
11 "(3) DIRECT PAYMENT TO PROVIDERS OF COM-
12 MUNITY CARE.—Nothing in this title shall be con-
13 strued as authorizing a State to permit payment for
14 community care to be made through a qualified com-
15 munity care case manager.
16 "(f) MINIMUM REQUIREMENTS FOR COMMUNITY
17 CARE.—
18 "(1) IN GENERAL.—Community care provided
19 under this section must meet such requirements for in-
20 dividuals' rights and quality as are published or devel-
21 oped by the Secretary under subsection (j). Such re-
22 quirements shall include—
23 "(A) the requirement that individuals provid-
24 ing community care are competent to provide
25 such care,

1 "(B) guidelines for such minimum compensa-
2 tion for individuals providing such care as will
3 assure the availability and continuity of competent
4 individuals to provide such care for functionally
5 disabled individuals who have functional disabil-
6 ities of varying levels of severity, and
7 "(C) the rights specified in paragraph (2).
8 Nothing in this section shall be construed as preventing
9 competent individuals (other than members of the
10 family of an individual) from providing, and being paid
11 directly for, community care.
12 "(2) SPECIFIED RIGHTS.—The rights specified in
13 this paragraph are as follows:
14 "(A) FREE CHOICE.—The right to be fully
15 informed in advance about care and treatment, to
16 be fully informed in advance of any changes in
17 care or treatment that may affect the individual's
18 well-being, and (except with respect to an individ-
19 ual adjudged incompetent) to participate in plan-
20 ning care and treatment or changes in care and
21 treatment.
22 "(B) FREE FROM RESTRAINTS.—The right
23 to be free from physical or mental abuse, corporal
24 punishment, involuntary seclusion, and any physi-
25 cal or chemical restraints imposed for purposes of

1 discipline or convenience and not required to treat
2 the individual's medical symptoms. Restraints may
3 only be imposed—
4 "(i) to ensure the physical safety of the
5 individual or other individuals, and
6 "(ii) only upon the written order of a
7 physician that specifies the duration and cir-
8 cumstances under which the restraints are to
9 be used (except in emergency circumstances
10 specified by the Secretary until such an order
11 could reasonably be obtained).
12 "(C) PRIVACY.—The right to privacy with
13 regard to accommodations, medical treatment,
14 written and telephonic communications, visits, and
15 meetings of family and friends and of groups.
16 "(D) CONFIDENTIALITY.—The right to con-
17 fidentiality of personal and clinical records.
18 "(E) GRIEVANCES.—The right to voice
19 grievances with respect to treatment or care that
20 is (or fails to be) furnished, without discrimination
21 or reprisal (or threat of discrimination or reprisal)
22 for voicing the grievances and the right to prompt
23 efforts by the provider to resolve grievances the
24 individual may have, including those with respect
25 to the behavior of other individuals.

1 "(F) OTHER RIGHTS.—Any other right es-
2 tablished by the Secretary.
3 "(g) MINIMUM REQUIREMENTS FOR COMMUNITY
4 CARE SETTINGS.—
5 "(1) COMMUNITY CARE SETTING DEFINED.—In
6 this section, the term 'community care setting'
7 means—
8 "(A) a nonresidential setting, or
9 "(B) a residential setting (including a foster
10 home, board-and-care facility, or other group
11 living arrangement, but not including a setting to
12 the extent it is a nursing facility) in which more
13 than 2 unrelated adults reside and in which per-
14 sonal services (other than merely board) are pro-
15 vided in conjunction with residing in the setting,
16 in which community care under this section is pro-
17 vided.
18 "(2) MINIMUM REQUIREMENTS.—A community
19 care setting in which community care is provided under
20 this section must meet the following requirements:
21 "(A) SECRETARIAL REQUIREMENTS.—A
22 setting must meet such requirements as are pub-
23 lished or developed by the Secretary under sub-
24 section (j).

1 "(B) SPECIFIED RIGHTS, RIGHTS OF INCOM-
2 PETENT RESIDENTS, USE OF PSYCHOPHARMACO-
3 LOGIC DRUGS, ACCESS AND VISITATION RIGHTS,
4 PROTECTION OF RESIDENT FUNDS.—A setting
5 must meet the requirements of subparagraphs (A),
6 (C), and (D) of paragraph (1), paragraph (3), and
7 paragraph (6) of section 1919(c), to the extent ap-
8 plicable to such a setting.

9 "(C) NOTICE OF RIGHTS.—A setting must
10 inform each individual receiving community care
11 under this section in the setting, orally and in
12 writing at the time the individual first receives
13 community care in the setting, of the individual's
14 legal rights with respect to such a setting and the
15 care provided in the setting.

16 "(D) LICENSING.—A setting must be li-
17 censed under applicable State and local law.

18 "(E) LIFE SAFETY CODE.—A setting must
19 meet such provisions of such edition (as specified
20 by the Secretary in regulation) of the Life Safety
21 Code of the National Fire Protection Association
22 as are applicable and appropriate to the commu-
23 nity care setting; except that—

24 "(i) the Secretary may waive, for such
25 periods as he deems appropriate, specific

1 provisions of such Code which if rigidly ap-
2 plied would result in unreasonable hardship
3 upon a setting, but only if such waiver would
4 not adversely affect the health and safety of
5 clients or personnel, and

6 "(ii) the provisions of such Code shall
7 not apply in any State if the Secretary finds
8 that in such State there is in effect a fire and
9 safety code, imposed by State law, which
10 adequately protects clients of and personnel
11 in community care settings.

12 "(F) SANITARY AND INSPECTION CONTROL
13 AND MAINTENANCE OF PHYSICAL ENVIRON-
14 MENT.—A setting must—

15 "(i) establish and maintain infection con-
16 trol standards designed to provide a safe,
17 sanitary, and comfortable environment in
18 which residents reside and to help prevent
19 the development and transmission of disease
20 and infection, and

21 "(ii) be maintained in a manner to pro-
22 tect the health and safety of residents, per-
23 sonnel, and the general public.

1 "(3) DISCLOSURE OF OWNERSHIP AND CONTROL
2 INTERESTS AND EXCLUSION OF REPEATED VIOLA-
3 TORS.—A community care setting—
4 "(A) must disclose persons with an owner-
5 ship or control interest (including such persons as
6 defined in section 1124(a)(3)) in the setting, and
7 "(B) may not have, as a person with an
8 ownership or control interest in the setting, any
9 individual or person who has been excluded from
10 participation in the program under this title or
11 who has had such an ownership or control interest
12 in one or more community care settings which
13 have been found repeatedly to be substandard or
14 to have failed to meet the requirements of para-
15 graph (2).
16 "(h) SURVEY AND CERTIFICATION PROCESS.—
17 "(1) CERTIFICATIONS.—
18 "(A) RESPONSIBILITIES OF THE STATE.—
19 "(i) IN GENERAL.—Under each State
20 plan under this title, the State shall be re-
21 sponsible for certifying the compliance of
22 providers of community care and community
23 care settings with the applicable require-
24 ments of subsections (f) and (g).

1 "(ii) CONSTRUCTION.—The failure of
2 the Secretary to issue regulations to carry
3 out this subsection shall not relieve a State
4 of its responsibility under this subsection.
5 "(B) RESPONSIBILITIES OF THE SECRE-
6 TARY.—The Secretary shall be responsible for
7 certifying the compliance of State providers of
8 community care, and of State community care set-
9 tings in which such care is provided, with the re-
10 quirements of subsections (f) and (g).
11 "(C) FREQUENCY OF CERTIFICATIONS.—
12 Certification of providers and settings under this
13 subsection shall occur no less frequently than once
14 every 12 months.
15 "(2) REVIEWS OF PROVIDERS.—
16 "(A) IN GENERAL.—The certification under
17 this subsection with respect to a provider of com-
18 munity care must be based on a periodic review of
19 the provider's performance in providing the care
20 required under ICPP's in accordance with the re-
21 quirements of subsection (f). Such periodic review
22 shall be conducted, not less often than annually,
23 by an agency (other than the single State agency
24 described in section 1902(a)(5)) and shall be based
25 on information that includes the views of qualified

1 community care case managers whose clients
2 have received community care from such provid-
3 ers and from a sample of individuals receiving
4 community care from such providers.

5 "(B) SPECIAL REVIEWS OF COMPLIANCE.—
6 If the Secretary has reason to question the com-
7 pliance of a provider of community care with any
8 of the requirements of subsection (f), the Secretary
9 may conduct a review of the provider and, on the
10 basis of that review, make independent and bind-
11 ing determinations concerning the extent to which
12 the provider meets such requirements.

13 "(3) SURVEYS OF COMMUNITY CARE SET-
14 TINGS.—

15 "(A) IN GENERAL.—The certification under
16 this subsection with respect to a community care
17 setting must be based on a survey. Such survey
18 for such a setting must be conducted without prior
19 notice to the setting. Any individual who notifies
20 (or causes to be notified) a community care setting
21 of the time or date on which such a survey is
22 scheduled to be conducted is subject to a civil
23 money penalty of not to exceed $2,000. The pro-
24 visions of section 1128A (other than subsections
25 (a) and (b)) shall apply to a civil money penalty

1 under the previous sentence in the same manner
2 as such provisions apply to a penalty or proceed-
3 ing under section 1128A(a). The Secretary shall
4 review each State's procedures for scheduling and
5 conducting such surveys to assure that the State
6 has taken all reasonable steps to avoid giving
7 notice of such a survey through the scheduling
8 procedures and the conduct of the surveys them-
9 selves.

10 "(B) SURVEY PROTOCOL.—Surveys under
11 this paragraph shall be conducted based upon a
12 protocol which the Secretary has provided for
13 under subsection (j).

14 "(C) PROHIBITION OF CONFLICT OF INTER-
15 EST IN SURVEY TEAM MEMBERSHIP.—A State
16 and the Secretary may not use as a member of a
17 survey team under this paragraph an individual
18 who is serving (or has served within the previous
19 2 years) as a member of the staff of, or as a con-
20 sultant to, the community care setting being sur-
21 veyed (or the person responsible for such setting)
22 respecting compliance with the requirements of
23 subsection (g) or who has a personal or familial
24 financial interest in the setting being surveyed.

1 "(D) VALIDATION SURVEYS OF COMMUNITY
2 CARE SETTINGS.—The Secretary shall conduct
3 onsite surveys of a representative sample of com-
4 munity care settings in each State, within 2
5 months of the date of surveys conducted under
6 subparagraph (A) by the State, in a sufficient
7 number to allow inferences about the adequacies
8 of each State's surveys conducted under subpara-
9 graph (A). In conducting such surveys, the Secre-
10 tary shall use the same survey protocols as the
11 State is required to use under subparagraph (B).
12 If the State has determined that an individual set-
13 ting meets the requirements of subsection (g), but
14 the Secretary determines that the setting does not
15 meet such requirements, the Secretary's determi-
16 nation as to the setting's noncompliance with such
17 requirements is binding and supersedes that of the
18 State survey.
19 "(E) SPECIAL SURVEYS OF COMPLIANCE.—
20 If the Secretary has reason to question the com-
21 pliance of a community care setting with any of
22 the requirements of subsection (g), the Secretary
23 may conduct a survey of the setting and, on the
24 basis of that survey, make independent and bind-

1 ing determinations concerning the extent to which
2 the setting meets such requirements.
3 "(4) INVESTIGATION OF COMPLAINTS AND MONI-
4 TORING OF PROVIDERS AND SETTINGS.—Each State
5 and the Secretary shall maintain procedures and ade-
6 quate staff to investigate complaints of violations of ap-
7 plicable requirements imposed on providers of commu-
8 nity care or on community care settings under subsec-
9 tions (f) and (g).
10 "(5) INVESTIGATION OF ALLEGATIONS OF INDI-
11 VIDUAL NEGLECT AND ABUSE AND MISAPPROPRIA-
12 TION OF INDIVIDUAL PROPERTY AND PUBLIC DISCLO-
13 SURE OF FINDINGS.—The State shall provide, through
14 the agency responsible for surveys and certification of
15 providers of community care and community care set-
16 tings under this subsection, for a process for the re-
17 ceipt, review, and investigation of allegations of indi-
18 vidual neglect and abuse (including injuries of unknown
19 source) by individuals providing such care or in such
20 setting and of misappropriation of individual property
21 by such individuals. The State shall, after notice to the
22 individual involved and a reasonable opportunity for
23 hearing for the individual to rebut allegations, make a
24 finding as to the accuracy of the allegations. If the
25 State finds that an individual has neglected or abused

1 an individual receiving community care or misappropri-
2 ated such individual's property, the State shall notify
3 the individual against whom the finding is made. A
4 State shall not make a finding that a person has ne-
5 glected an individual receiving community care if the
6 person demonstrates that such neglect was caused by
7 factors beyond the control of the person. The State
8 shall provide for public disclosure of findings under this
9 paragraph upon request and for inclusion, in any such
10 disclosure of such findings, of any brief statement (or of
11 a clear and accurate summary thereof) of the individual
12 disputing such findings.
13 "(6) DISCLOSURE OF RESULTS OF INSPECTIONS
14 AND ACTIVITIES.—
15 "(A) PUBLIC INFORMATION.—Each State,
16 and the Secretary, shall make available to the
17 public—
18 "(i) information respecting all surveys,
19 reviews, and certifications made under this
20 subsection respecting providers of community
21 care and community care settings, including
22 statements of deficiencies,
23 "(ii) copies of cost reports (if any) of
24 such providers and settings filed under this
25 title,

1 "(iii) copies of statements of ownership
2 under section 1124, and
3 "(iv) information disclosed under section
4 1126.
5 "(B) NOTICES OF SUBSTANDARD CARE.—If
6 a State finds that—
7 "(i) a provider of community care has
8 provided care of substandard quality with re-
9 spect to an individual, the State shall make a
10 reasonable effort to notify promptly (I) an
11 immediate family member of each such indi-
12 vidual and (II) individuals receiving commu-
13 nity care from that provider under this title,
14 or
15 "(ii) a community care setting is sub-
16 standard, the State shall make a reasonable
17 effort to notify promptly (I) individuals re-
18 ceiving community care in that setting, and
19 (II) immediate family members of such indi-
20 viduals.
21 "(C) ACCESS TO FRAUD CONTROL UNITS.—
22 Each State shall provide its State medicaid fraud
23 and abuse control unit (established under section
24 1903(q)) with access to all information of the

1 State agency responsible for surveys, reviews, and
2 certifications under this subsection.
3 "(i) ENFORCEMENT PROCESS FOR PROVIDERS OF
4 COMMUNITY CARE.—
5 "(1) STATE AUTHORITY.—
6 "(A) IN GENERAL.—If a State finds, on the
7 basis of a review under subsection (h)(2) or other-
8 wise, that a provider of community care no longer
9 meets the requirements of this section and further
10 finds that the provider's deficiencies—
11 "(i) immediately jeopardize the health
12 or safety of individuals receiving its services,
13 the State shall take immediate action to
14 remove the jeopardy and correct the deficien-
15 cies or terminate the provider's participation
16 under the State plan and may, in addition,
17 provide for a civil money penalty, or
18 "(ii) do not immediately jeopardize the
19 health or safety of such individuals, the State
20 may—
21 "(I) terminate the provider's par-
22 ticipation under the State plan,
23 "(II) provide for a civil money
24 penalty, or
25 "(III) do both.

1 Nothing in this subparagraph shall be construed
2 as restricting the remedies available to a State to
3 remedy a provider's deficiencies. If the State finds
4 that a provider meets such requirements but, as of
5 a previous period, did not meet such require-
6 ments, the State may provide for a civil money
7 penalty under subparagraph (B) for the period
8 during which it finds that the provider was not in
9 compliance with such requirements.

10 "(B) CIVIL MONEY PENALTY.—

11 "(i) IN GENERAL.—Each State shall es-
12 tablish by law (whether statute or regulation)
13 at least the following remedy: A civil money
14 penalty assessed and collected, with interest,
15 for each day in which the provider is or was
16 out of compliance with a requirement of this
17 section. Funds collected by a State as a
18 result of imposition of such a penalty (or as a
19 result of the imposition by the State of a
20 civil money penalty under subsection
21 (h)(3)(A)) may be applied to reimbursement of
22 individuals for personal funds lost due to a
23 failure of community care providers to meet
24 the requirements of this section. The State
25 also shall specify criteria, as to when and

1 how this remedy is to be applied and the
2 amounts of any penalties. Such criteria shall
3 be designed so as to minimize the time be-
4 tween the identification of violations and
5 final imposition of the penalties and shall
6 provide for the imposition of incrementally
7 more severe penalties for repeated or uncor-
8 rected deficiencies.

9 "(ii) DEADLINE AND GUIDANCE.—Each
10 State which elects to provide community
11 care under this section must establish the
12 civil money penalty remedy described in
13 clause (i) applicable to all providers of com-
14 munity care covered under this section. The
15 Secretary shall provide, through regulations
16 or otherwise by not later than July 1, 1991,
17 guidance to States in establishing such
18 remedy; but the failure of the Secretary to
19 provide such guidance shall not relieve a
20 State of the responsibility for establishing
21 such remedy.

22 "(2) SECRETARIAL AUTHORITY.—

23 "(A) FOR STATE PROVIDERS.—With respect
24 to a State provider of community care, the Secre-
25 tary shall have the authority and duties of a State

1 under this subsection, except that the civil money
2 penalty remedy described in subparagraph (C)
3 shall be substituted for the civil money remedy
4 described in paragraph (1)(B)(i).

5 "(B) OTHER PROVIDERS.—With respect to
6 any other provider of community care in a State,
7 if the Secretary finds that a provider no longer
8 meets a requirement of this section and further
9 finds that the provider's deficiencies—

10 "(i) immediately jeopardize the health
11 or safety of individuals receiving its services,
12 the Secretary shall take immediate action to
13 remove the jeopardy and correct the deficien-
14 cies or terminate the provider's participation
15 under the State plan and may, in addition,
16 provide for a civil money penalty under sub-
17 paragraph (C), or

18 "(ii) do not immediately jeopardize the
19 health or safety of such individuals, the Sec-
20 retary may—

21 "(I) terminate the provider's par-
22 ticipation under the State plan,

23 "(II) provide for a civil money
24 penalty under subparagraph (C), or

25 "(III) do both.

1 If the Secretary finds that a provider meets such
2 requirements but, as of a previous period, did not
3 meet such requirements, the Secretary may pro-
4 vide for a civil money penalty under subparagraph
5 (C) for the period during which the Secretary
6 finds that the provider was not in compliance with
7 such requirements.

8 "(C) CIVIL MONEY PENALTY.—If the Secre-
9 tary finds on the basis of a review under subsec-
10 tion (h)(2) or otherwise that a community care
11 provider no longer meets the requirements of this
12 section, the Secretary shall impose a civil money
13 penalty in an amount not to exceed $10,000 for
14 each day of noncompliance. The provisions of sec-
15 tion 1128A (other than subsections (a) and (b))
16 shall apply to a civil money penalty under the
17 previous sentence in the same manner as such
18 provisions apply to a penalty or proceeding under
19 section 1128A(a). The Secretary shall specify cri-
20 teria, as to when and how this remedy is to be
21 applied and the amounts of any penalties. Such
22 criteria shall be designed so as to minimize the
23 time between the identification of violations and
24 final imposition of the penalties and shall provide

1 for the imposition of incrementally more severe
2 penalties for repeated or uncorrected deficiencies.
3 "(j) SECRETARIAL RESPONSIBILITIES.—
4 "(1) PUBLICATION OF INTERIM REQUIRE-
5 MENTS.—
6 "(A) IN GENERAL.—The Secretary shall
7 publish, by July 1, 1991, a regulation (that shall
8 be effective on an interim basis pending the pro-
9 mulgation of final regulations) that sets forth in-
10 terim requirements, consistent with subparagraph
11 (B), for the provision of community care and for
12 community care settings, including—
13 "(i) the requirements of subsection (c)(2)
14 (relating to comprehensive functional assess-
15 ments, including the use of assessment in-
16 struments), of subsection (d)(2)(E) (relating to
17 qualifications for qualified community care
18 case managers), of subsection (f) (relating to
19 minimum requirements for community care),
20 and of subsection (g) (relating to minimum
21 requirements for community care settings),
22 and
23 "(ii) survey protocols (for use under sub-
24 section (h)(3)(A)) which relate to such re-
25 quirements.

1 "(B) MINIMUM PROTECTIONS.—Interim re-
2 quirements under subparagraph (A) and final re-
3 quirements under paragraph (2) shall assure,
4 through methods other than reliance on State li-
5 censure processes, that individuals receiving com-
6 munity care are protected from neglect, physical
7 and sexual abuse, financial exploitation, inappro-
8 priate involuntary restraint, and the provision of
9 health care services by individuals in community
10 care settings who are not competent to provide
11 such care.
12 "(2) DEVELOPMENT OF FINAL REQUIRE-
13 MENTS.—The Secretary shall develop, by not later
14 than October 1, 1992—
15 "(A) final requirements, consistent with para-
16 graph (1)(B), respecting the provision of appropri-
17 ate, quality community care and respecting com-
18 munity care settings under this section, and in-
19 cluding at least the requirements referred to in
20 paragraph (1)(A)(i), and
21 "(B) survey protocols and methods for evalu-
22 ating and assuring the quality of community care
23 settings.
24 The Secretary may, from time to time, revise such re-
25 quirements, protocols, and methods.

1 "(3) CONSTRUCTION.—Nothing in this subsection
2 shall be construed as authorizing the Secretary to de-
3 velop standards respecting the quality of community
4 care and standards respecting community care settings
5 beyond the scope of the interim and final requirements
6 specified under paragraphs (1) and (2).
7 "(4) NO DELEGATION TO STATES.—The Secre-
8 tary's authority under this subsection shall not be dele-
9 gated to States.
10 "(5) NO PREVENTION OF MORE STRINGENT RE-
11 QUIREMENTS BY STATES.—Nothing in this section
12 shall be construed as preventing States from imposing
13 requirements that are more stringent than the require-
14 ments published or developed by the Secretary under
15 this subsection.
16 "(k) APPLICABILITY IN STATES OPERATING UNDER
17 DEMONSTRATION PROJECTS.—In the case of any State
18 which is providing medical assistance under a waiver granted
19 under section 1115(a) with respect to community care, the
20 Secretary shall require the State to meet the requirements of
21 this section in the same manner as the State would be re-
22 quired to meet such requirements if the State had in effect a
23 plan approved under this title and had elected to cover com-
24 munity care under this section.".
25 (c) PAYMENT FOR COMMUNITY CARE.—

1 (1) Reasonable and adequate payment
2 rates.—Section 1902 of such Act (42 U.S.C. 1396a)
3 is amended—
4 (A) in subsection (a)(13)—
5 (i) by striking "and" at the end of sub-
6 paragraph (D),
7 (ii) by inserting "and" at the end of
8 subparagraph (E), and
9 (iii) by adding at the end the following
10 new subparagraph:
11 "(F) for payment for community care (as de-
12 fined in section 1927(a) and provided under such
13 section) through rates which are reasonable and
14 adequate (and which may not be established on a
15 capitation basis or any other risk basis) to meet
16 the costs of providing care, efficiently and eco-
17 nomically, in conformity with applicable State and
18 Federal laws, regulations, and quality and safety
19 standards (including those described in section
20 1927(f)(1)(B));"; and
21 (B) in subsection (h), by inserting before the
22 period at the end the following: "or to limit the
23 amount of payment that may be made under a
24 plan under this title for community care".

1 (2) DENIAL OF PAYMENT FOR CIVIL MONEY PEN-
2 ALTIES, ETC.—Section 1903(i)(8) of such Act (42
3 U.S.C. 1396b(i)(8)) is amended by inserting "(A)" after
4 "medical assistance" and by inserting before the semi-
5 colon the following: ", or (B) for community care to
6 reimburse (or otherwise compensate) a provider of such
7 care for payment of a civil money penalty imposed
8 under this title or title XI or for legal expenses in de-
9 fense of an exclusion or civil money penalty under this
10 title or title XI if there is no reasonable legal ground
11 for the provider's case".
12 (3) DENIAL OF PAYMENT FOR SUBSTANDARD
13 COMMUNITY CARE AND COMMUNITY CARE FURNISHED
14 BY FAMILY MEMBERS OR OTHERWISE PAID FOR.—
15 Section 1903(i) of such Act is further amended—
16 (A) by striking "or" at the end of paragraph
17 (8),
18 (B) by striking the period at the end of para-
19 graph (9) and inserting "; or",
20 (C) by inserting after paragraph (9) the fol-
21 lowing new paragraph:
22 "(10) for community care under sections
23 1905(a)(22) and 1927—

1 "(A) which does not meet the applicable re-
2 quirements published or developed under section
3 1927(j),
4 "(B) which is furnished in a community care
5 setting—
6 "(i) if a survey under section
7 1927(h)(3)(A) indicates that such setting is
8 substandard,
9 "(ii) on or after January 1, 1993, with
10 respect to which the State has not applied
11 the protocols and methods developed under
12 section 1927(j)(2)(B), or
13 "(iii) that does not meet the applicable
14 requirements of paragraphs (2) and (3) of
15 section 1927(g),
16 "(C) which is provided to a functionally dis-
17 abled elderly individual by members of the family
18 of such individual, or
19 "(D) to the extent payment is made for such
20 care other than under this title.", and
21 (D) by adding at the end the following:
22 "Clauses (i) and (iii) of paragraph (10)(B) shall not apply
23 once, and only once, in the case of a setting found to be
24 substandard or not to meet applicable requirements if the set-

1 ting is changed within 3 months of the finding to no longer be
2 substandard and to meet applicable requirements.''.
3 (d) CONFORMING AMENDMENTS.—
4 (1) Section 1902(j) of such Act (42 U.S.C.
5 1396a(j)) is amended by striking ''(21)'' and inserting
6 ''(23)''.
7 (2) Section 1902(a)(10)(C)(iv) of such Act (42
8 U.S.C. 1396a(a)(10)(C)(iv)) is amended by striking
9 ''(20)'' and inserting ''(22)''.
10 (3) Section 1903(a)(2)(A) of such Act (42 U.S.C.
11 1396b(a)(2)(A)) is amended by inserting ''and are not
12 attributable to community care for functionally disabled
13 elderly individuals'' before the semicolon at the end.
14 (4) Section 9523(a) of the Consolidated Omnibus
15 Budget Reconciliation Act of 1985, as amended by
16 section 4115(d) of the Omnibus Budget Reconciliation
17 Act of 1987 (added by section 411(k)(9) of the Medi-
18 care Catastrophic Coverage Act of 1988) and by sec-
19 tion 6408(b) of the Omnibus Budget Reconciliation Act
20 of 1989, is amended by striking ''July 1, 1990'' and
21 inserting ''July 1, 1991''.
22 (e) EFFECTIVE DATES.—
23 (1) Except as provided in this subsection, the
24 amendments made by this section shall apply to com-
25 munity care furnished on or after July 1, 1991, with-

1 out regard to whether or not final regulations to carry
2 out such amendments have been promulgated by such
3 date.

4 (2)(A) The amendments made by subsection (c)(1)
5 shall apply to community care furnished on or after
6 July 1, 1991, or, if later, 30 days after the date of
7 publication of regulations effective on an interim basis
8 under section 1927(j)(1) of the Social Security Act.

9 (B) The amendment made by subsection (c)(2)
10 shall apply to civil money penalties imposed after the
11 date of the enactment of this Act.

12 (f) WAIVER OF PAPERWORK REDUCTION, ETC.—
13 Chapter 35 of title 44, United States Code, and Executive
14 Order 12291 shall not apply to information and regulations
15 required for purposes of carrying out this section and imple-
16 menting the amendments made by this section.

○

HIAA

Health Insurance Association of America

HEALTH CARE FINANCING

FOR ALL AMERICANS

Private Market Reform & Public Responsibility

HEALTH CARE FINANCING

FOR ALL AMERICANS

Private Market Reform & Public Responsibility

1991

Health Care Financing for All Americans: A Synopsis

The Health Insurance Association of America (HIAA) has formulated a proposal to provide access to health care coverage for all Americans. HIAA's proposal focuses on expanding coverage through the workplace and expanding public coverage for the poor and the near poor. Its essential elements follow.

Reform of the Small-Employer Market

Reforms are needed to ensure the availability and reliability of private health insurance in the small-employer market. The aim of small-employer market reforms is to assure private coverage on a continuing basis for small employers and to assure that individual high-risk employees are not denied coverage. If an employer changes insurers or an employee changes jobs, new preexisting condition restrictions would not be imposed. Limits would apply to variations in premiums and premium increases.

Private Reinsurance

A private reinsurance mechanism for the small-employer health benefit market needs to be authorized. This would allow insurers to implement market reforms by permitting insurers to spread losses for high-risk individuals equitably across the market. Under the HIAA proposal, no employer would have to pay more than 150 percent of the relevant market averages for basic coverage.

State Pools for the Medically Uninsurable

State pools for medically uninsurable individuals who are not part of an employer group need to be established. Losses should be financed by state general revenues or other broad-based funding. If a state does not act, the U.S. Department of Health and Human Services (HHS) should be authorized to set up a federally funded pool in that state to pay for losses. The funds for the pool would come from funds that HHS would otherwise spend in that state.

Affordable Coverage

Insurers should be allowed to offer more affordable coverage to small employer groups. Insurers should be permitted to market lower-cost prototype plans; and insured employer plans should receive exemptions from costly state provider and service coverage mandates (such exemptions are given to self-insured plans).

Targeted Tax Assistance

Tax assistance must be targeted so that small employers and their financially vulnerable employees can afford health insurance coverage. For example, the self-employed would find coverage more affordable if, instead of receiving a 25 percent deduction for the cost of health benefits, they received 100 percent, as do other employers (as long as they provide equal coverage for their employees). Financially vulnerable groups should receive new tax subsidies; such subsidies should be directed toward financially fragile employers and low-income employed individuals.

Expanded Public Coverage for the Poor and Near Poor

HIAA recommends expanding Medicaid to cover all those below the federal poverty level, regardless of family structure, age or employment status. Medicaid's link to welfare categorical restrictions should be eliminated. As an important first step, HIAA supports the recent enactment of phased-in coverage for poor children. The Medicaid "spend-down" program should be extended to all states and eligibility thresholds should be set to prevent impoverishment by medical expenses.

Low-income individuals above the poverty level should be allowed to "buy into" an income-related package of primary and preventive health care services. Also, the recent federal Medicaid "buy-out" requirement (which eventuated from HIAA's original proposal to authorize such state actions) should be implemented. States should pay the employee share of available employer group insurance where the average employee's premium costs are less than what the same benefit would cost on an average per capita basis under direct Medicaid financing. This will maximize state savings and avoid adverse selection between the public and private sectors.

Cost Containment

Moving forward with cost-containment efforts to make health care more affordable has become a national imperative. HIAA recommends promoting the development of managed care systems (HMOs, PPOs, point-of-service plans, and the like) that rationalize and integrate health delivery and financing; HIAA also supports such managed care mechanisms as utilization review and quality assurance. Government must be encouraged to create a climate hospitable to the growth of managed care, and to refrain from creating barriers to utilization review and other key cost-containment strategies.

Better methods for assessing the cost-effectiveness of new technologies and procedures are also needed, as are increased efforts to formulate medical practice guidelines and protocols. (The latter would encourage efficiency in physicians' practice styles.) Another way to control costs is to provide financial incentives for consumers, so that they will be cost-conscious when they select health plan alternatives, health care providers, and medical services. Efforts also must be made to reduce the incidence of malpractice and to reform the malpractice system, making it more efficient and assuring that victims are reasonably compensated.

Health Care Financing for All Americans

Introduction

Today, more than 30 million Americans have neither public nor private health care coverage. These Americans often have greater problems gaining access to the health care system than do those who have coverage. They may forgo necessary care or delay getting treatment until their problems worsen — and become more costly.

These individuals represent the widening gap in our nation's health care financing system. HIAA believes that policy makers must devise ways to close the gap. More precisely, government action is needed to provide the legislative and fiscal base that will enable a combination of public and private providers of health care coverage to meet the health care financing needs of all Americans.

The HIAA proposal takes into account the important policy implications of the relationship between income, the workplace, and health care coverage. The vast majority of Americans with adequate incomes have health coverage. Ninety percent of all nonelderly Americans with in-

comes of over three times the federal poverty level have some form of coverage. Approximately 150 million nonelderly in this country obtain health coverage through an employment-based plan.

Yet most individuals without health care coverage are in families with some involvement in the work force. In fact, 66 percent of the uninsured are full-time workers or are dependents of full-time workers. Another 14 percent either work half-time (18 to 34 hours a week) or belong to families with one or more part-time working members. (*Current Population Survey,* U.S. Dept. of Health and Human Services, March 1988 tabulations.)

Efforts to make coverage more available and more affordable should take into account the fact that most Americans receive their health care coverage through employment. A realistic approach is to focus on improving the ability of financially vulnerable employers to offer health insurance to their often low-income employees. In addition, low-income employees need direct government assistance so that they can afford their share of premiums.

To be cost effective, expansion strategies should build on existing coverage and target public coverage to the poor and near poor. Extending public coverage to higher income individuals will lead inevitably to unnecessary tax increases to support substitution of public coverage for private coverage.

HIAA also believes that efforts to expand the nation's health care financing system must be complemented by responsible cost-containment measures. HIAA's policy on cost containment includes an emphasis on the development of managed health care systems. It also calls for greater scrutiny of one of the major causes of high costs — the use of new, often unproven, technologies and procedures. HIAA also strongly supports wellness and prevention activities, as well as economic incentives for the consumer to be "cost conscious" in the use of medical resources and in choosing a health plan.

Proposal

Reform of the Small-Employer Market

Those who are concerned with assuring the availability and reliability of health insurance coverage are paying increasing attention to the small-employer health benefit market. This is largely because a high proportion of workers without health care coverage — fully two-thirds — work for a business establishment with 25 or fewer employees at that establishment's location; but only one in three firms with fewer than 10 employees offers health benefits. (Figures 1 and 2.)

Increasingly, small employers seek relief from rising health care costs by an aggressive search for the lowest possible price for health care coverage. Those with healthy employees are more likely to seek, and to obtain, coverage at prices that reflect their low risk.

In turn, more and more insurers have found that to be price competitive for these low risk employers, they are less able to spread the costs of groups with employees at high risk of incurring large medical expenses broadly across the lower risk groups. This has led to a growing number of higher risk employers that cannot find coverage at an affordable price. Moreover, those employer groups that are at lower risk today, and thus initially obtain a lower premium, are likely to have employees who will develop expensive medical conditions. Those employers may then face large premium increases.

In general, then, small employers have greater difficulty than large employers in affording and sometimes even obtaining health coverage. Fur-

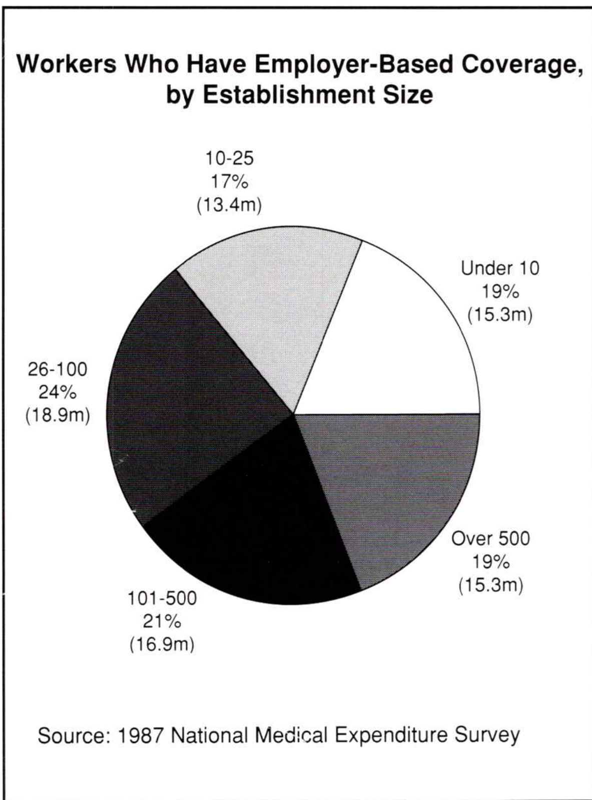


Figure 1

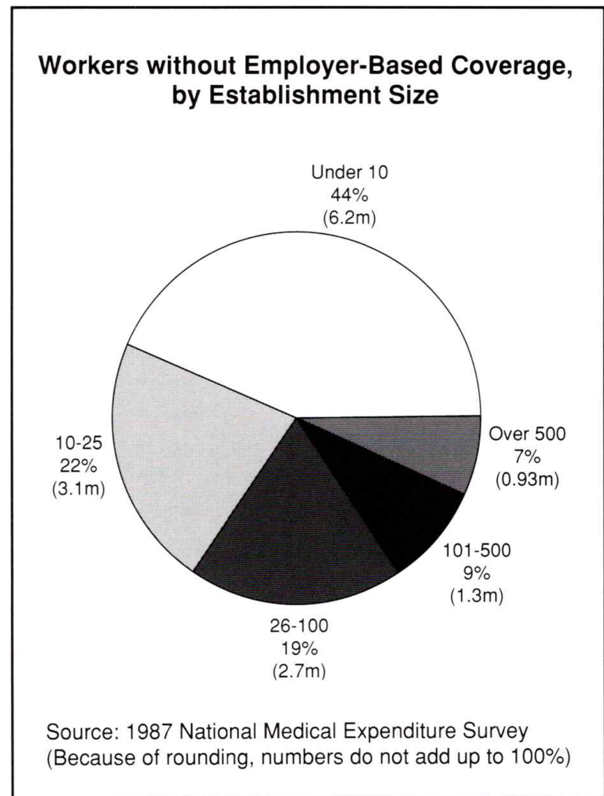


Figure 2

thermore, the greater frequency with which small employers change carriers and their workers change jobs exposes these individuals to greater risk of being left out of the system. Finally, small employers are highly sensitive to very large, unanticipated premium increases and may fail to obtain, or to retain, coverage in a marketplace where individual employer experience is highly unpredictable.

Substantial reforms are needed if health insurers are to serve the broader interests of small employers and their employees. Many recommendations are under discussion. But not all are of equal value.

One ill-advised proposal is to institute a flat "community rate" for all small employers. This would increase rates for the populations least able to pay, and younger workers (who on average earn less than older workers) would end up subsidizing older, higher income workers. Subsidies could occur on a regional scale, too, because some community rating schemes fail to permit rate adjustment by geographic area: these would force lower cost, more efficient and often lower-income localities to subsidize higher cost, less efficient localities that often have higher per capita incomes. Community rating gives carriers little if any latitude to fine-tune their rates, thereby increasing the risk of insolvency.

There are far better avenues to reforming the small-employer health benefits market than community rating schemes. The best approach is a multi-faceted blend of private and public strategies that take into account the complexity and realities of health care financing. Accordingly, HIAA has developed a comprehensive set of legislative reforms that can be implemented while allowing a viable private marketplace.

HIAA recommends market reforms and reinsurance mechanisms to ensure fair access to, and continuity of coverage for, small employers and their employees. When enacted by the states, these reforms will introduce a greater degree of predictability and stability to the small-employer health benefit marketplace.

- *Guaranteed Availability.* All small-employer groups would be able to obtain private health insurance regardless of the health risk they present. A significant number of carriers in a state (defined by their small-employer market share) would be required to guarantee to issue health care coverage to any legitimate small-employer group. HIAA is willing to consider variations on this approach (in a given state) to enhance consumer choice.

- *Coverage of Whole Groups.* Coverage would be made available to entire employer groups; no small employer nor any insurer would be able to exclude from the group's coverage individuals who present high medical risks.

- *Renewability of Coverage.* At renewal time, employer groups and/or individuals in these groups would be assured that their coverage would not be canceled because of deteriorating health.

- *Continuity of Coverage.* Once a person is covered in the employer market and has satisfied an initial plan's preexisting condition restrictions, he or she would not have to meet those requirements again when changing jobs or when the employer changes carriers.

- *Premium Pricing Limits.* Insurance carriers would be required to limit how much their rates could vary for groups similar in geography, demographic composition and plan design.

More specifically, a carrier's premiums for similar groups could not vary by more than 35 percent from the carrier's midpoint rate (halfway between the lowest and highest rate). There would also be a 15 percent limitation on how much a carrier could vary rates by industry. Finally, carriers would have to limit a group's year-to-year premium increases to no more than 15 percent above the carrier's "trend" (the year-to-year increase in the lowest new business rate). Separate "trends" should be allowed for managed care and non-managed care to reflect health care cost/efficiency differences in these structures.

In order for these reforms to succeed, the implementing legislation will have to pertain to all competitors in the small-employer market. If any one company or segment of the market pursues such reforms independently, without rules for marketplace behavior spelled out in legislation, it might invite financial ruin. It is therefore important that states have the clear authority to impose these rules on all competitors in the small-employer marketplace. Within the scope of these rules, insurers would be allowed to use individual risk assessment and classification initially to assess risk, to set rates, and to determine for which individuals to purchase reinsurance.

Private Reinsurance

A private marketwide reinsurance system would make possible the reform of the small-employer market. Reinsurance means to "insure again." Under reinsurance, an insurance company, called the ceding or direct-writing insurer, purchases insurance from the reinsurer to cover all or part of the loss against which it protects its policy-

holder. The reinsurer is, in a sense, a silent partner of the original insurer. Reinsurance enables an insurer to accept a greater variety of risks. By sharing these risks with a reinsurer, the ceding insurer obtains an adequate spread within which the law of averages can operate.

Reinsurance will allow individual insurers (or other small-employer health plan entities) to implement reforms without facing high financial losses. Reinsurance will allow carriers to assure small-employer groups presenting a high health risk access to a basic set of benefits at a rate no higher than 50 percent above the applicable average market premium. For groups already covered by an insurance carrier, the premium pricing limits described above would pertain, and would in many cases limit a high-risk employer's rates to a level below the guaranteed marketwide maximum level of 50 percent above average.

Under this approach, a significant number of carriers in a state's small-employee health benefit market (defined by small-employer premium) would be required to guarantee to issue health coverage to any legitimate small-employer group applicant. Not all carriers would be required to guarantee to issue coverage, but they would be strongly encouraged to do so through better reinsurance terms for guaranteed issue carriers. Guaranteed issue carriers could reinsure entire high-risk small-employer groups at a reinsurance premium price of 150 percent of average market costs or reinsure high-risk individuals within groups at 500 percent of average market costs. (Individual reinsurance would include a $5,000 deductible.)

To reduce the volume of reinsured claims, reinsurance would be on a three-year basis. (If reinsurance were permitted annually, carriers could declare more groups or individuals high-risk and utilize reinsurance more often, increasing reinsurance losses to unacceptable levels.) Nonguaranteed issue carriers would be permitted only to reinsure new entrants to existing groups through individual reinsurance. This reflects the fact that under the "whole group" rule, all carriers would have to make coverage available to any new employees entering a group they already insure.

The reinsurer would cover the costs associated with reinsured cases. The process of reinsurance is invisible to employers and employees and is purely a transaction between the ceding insurer and the reinsurer.

In the aggregate, the cost of reinsured persons will exceed the reinsurance premiums; this is because reinsurance would be aimed at employer groups and employees known to be high risk, and because the premium price would be limited in order to encourage carriers to accept high risk applicants. Under this proposal, the reinsurer's losses would be spread equitably across all competitors in the private marketplace —both the guaranteed issue and nonguaranteed issue carriers.

Losses would be covered first through contributions from all carriers in the small-employer market. If losses were significantly higher than expected, a second "safety valve" of broad-based financing would be made available.

HIAA will aggressively pursue reinsurance and related small-employer market reform at the state level. HIAA will also recommend federal legislation to give states the authority, where necessary, to assure compliance with the market reforms outlined here and to finance the reinsurance system.

With HIAA's recommended market changes in place, the small employer will stand to benefit greatly from the rapidly evolving cost-management capacity. These reforms will encourage competition based more on efficiency and less

on selection. Competitors would no longer be allowed to draw business away from more efficient health benefit plans by offering temporarily low prices that rise sharply once an employee gets sick. Insurers that reduce inefficient operating expenses and that offer cost-effective financing systems and delivery systems will gain a larger share of what is an extremely price-sensitive market.

State Pools for Uninsurable Individuals

Even with increased employer-based coverage and with Medicaid expansions (see below), medically uninsurable individuals who are not part of an insured employer group would remain without coverage. High-risk pools should be established in the states so that coverage would become available to such individuals. Pool losses should be funded by general revenues or similar sources, which spread the cost broadly across society. (As of December 1990, 25 states had enacted broad-based pools for uninsurable individuals.)

Allow Insurers to Offer More Affordable Benefit Plans to Small-Employer Groups

Over the years, the list of state laws mandating benefits and providers has grown dramatically. There are about 800 such laws nationwide — and they mandate coverage of such disparate services and provider categories as chiropractic and podiatry, acupuncture, expansive inpatient mental health services (even where most cost effective alternatives exist), in vitro fertilization, and pastoral counseling. The cumulative effect of this hodgepodge of state laws is to increase the cost of health insurance, particularly for small employers who are most in need of affordable basic benefits and who are too small to self-insure and thus escape these mandates as larger employers often do.

One reason that mandated benefit laws increase the cost of coverage is that multi-state insurers must monitor and comply with so many different state rules and regulations. Insurers are precluded from developing lower-cost prototype plans that would be marketable across state lines. Instead, they are often forced to offer only "Cadillac" plans based on a multitude of mandates from many states.

Many of these benefits, are expensive in their own right. Taken together, mandated benefits in many states provide a package that many small employers simply cannot afford.

A 1989 study (conducted by Gail Jensen, then a health care economist with the University of Illinois, and now at the University of North Carolina) concluded that 16 percent of small employers not now providing health insurance would offer benefits in the absence of state mandates.

State-mandated benefit laws do not apply equally to all employer-sponsored health plans. The Employee Retirement Income Security Act of 1974 (ERISA) exempts self-insured plans from state mandated benefit laws and other forms of state insurance regulations. In general, only large employers have the financial resources or the risk-spreading base to self-insure; self-insurance allows multi-state employers not only to save administrative costs through plan uniformity but to pick and choose those benefits that are most desirable and cost effective. Employers too small to self-insure do not have this flexibility, and they are thus less likely to offer health insurance at all.

In 1985, the U.S. Supreme Court ruled that to put employee health benefit plans on the same footing as self-insured plans required congressional action. Moreover, in recent years, there also has been a proliferation of state actions that obstruct or hinder private-sector managed care efforts that would make health care coverage more affordable. These state bills are aimed at

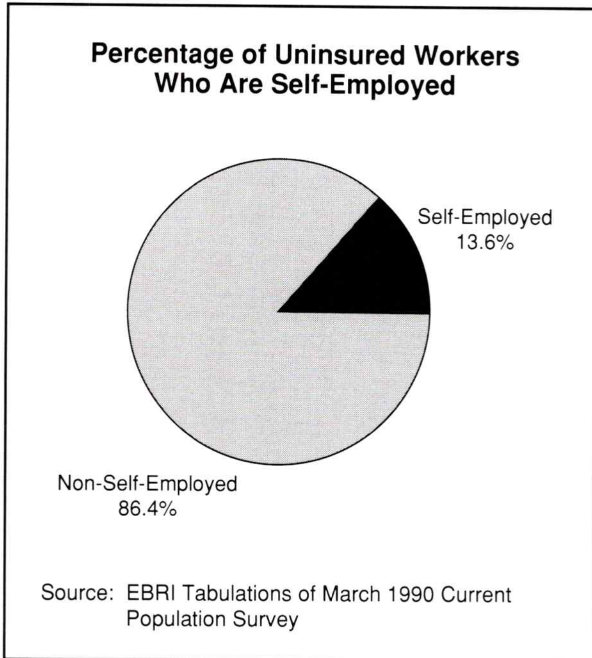


Figure 3

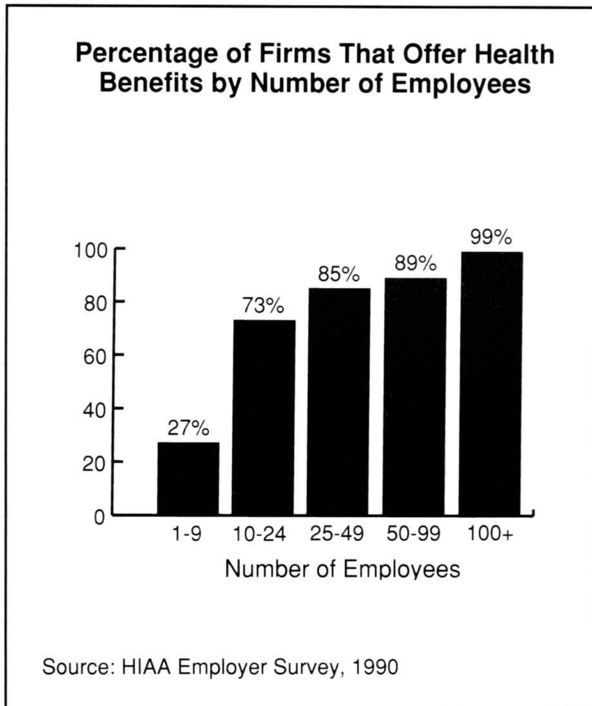


Figure 4

limiting contractual arrangements with cost-effective provider networks, as well as preventing or limiting insurers' ability to carry out effective utilization review programs. Again, small employers should be able to benefit from the same cost-management approaches as do larger employers.

Targeted Tax Assistance for Small Employers and Their Financially Vulnerable Employees

Small businesses tend to be younger, financially less stable and employ a lower wage work force. Thus, health benefits often represent a greater financial burden to small businesses, who are far less likely to offer them than are other employers. A 1989 HIAA survey found that only 27 percent of firms with fewer than 10 employees offer health benefits. Conversely, over 90 percent of firms with more than 25 employees offer health benefits. (Figures 3 and 4.)

Eleven percent of uninsured workers are self-employed. They are uninsured in part because self-employed workers receive only a 25 percent income tax deduction for the cost of health benefits. Other (incorporated) businesses receive a full 100 percent deduction.

The financial vulnerability of small employers and uninsured workers, as well as government fiscal realities, suggest that additional tax assistance should be carefully targeted to those populations most in need. For instance, government should direct new tax subsidies to assist employers and individuals with inadequate financial resources in purchasing private coverage. Sliding scale subsidies should be targeted, for example, to small employers paying average wages of less than $18,000 annually. The subsidy rate for such employers should increase as the percent of total payroll going to hospital and medical benefits increases. A temporarily higher subsidy could be given to firms offering benefits for the first time.

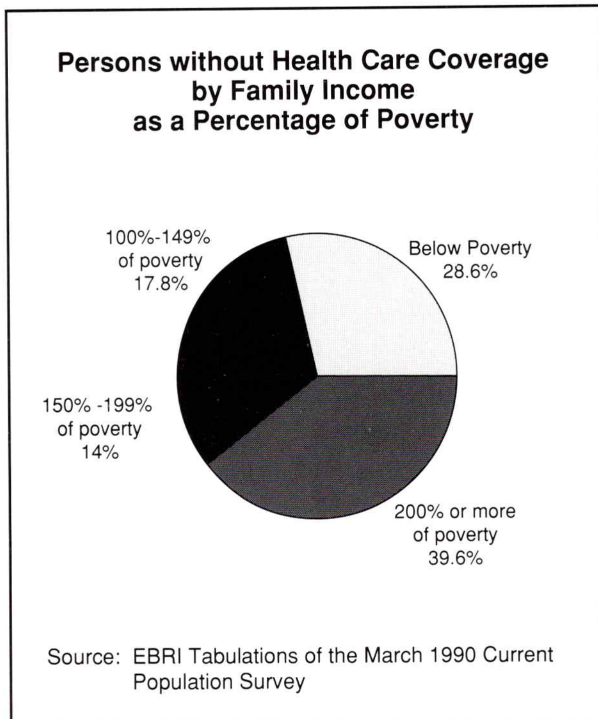


Figure 5

Subsidies should be targeted to low-income individuals and families. A refundable tax credit equaling 50 percent of the employee share of premium cost could be made available for taxpayers at or below the poverty level. Above poverty, the percentage credit would decrease as income rises and phase out completely at twice poverty. Advance payment of the tax credit through the employer should be made for employees with little or no income tax liability; and, government should extend to the self-employed the 100 percent tax deduction enjoyed by other employers (as long as they provide equal coverage for their employees, if they have any).

Expand Public Coverage for the Poor and Near Poor

Close to 29 percent of the uninsured have family incomes below the federal poverty level ($10,560 for a family of three in 1990). Another 18 percent have incomes between one and one-and-a-half times the federal poverty level. (Figure 5.) The current federal/state Medicaid program covers only four out of ten poor Americans. Many states do not have a medically needy program, and Medicaid income eligibility thresholds for the nonelderly generally fall far below the poverty level.

Because the poor and many of the near poor do not have the means to purchase coverage on their own, the health care financing responsibility for these populations rests largely with the government.

HIAA proposes that the Medicaid program be extended to cover all poor Americans regardless of age, family structure or employment status. To carry out this recommendation fully, Medicaid eligibility will have to be independent of such cash assistance programs as Aid to Families with Dependent Children (AFDC). Moreover, fiscal constraints suggest first priority should be phasing in coverage to all poor children under age 18. For poor workers who have access to employer-based private coverage, HIAA supports appropriate state implementation of recent federal legislation on a "buy-out" of employed individuals and their families from the Medicaid program. States should pay the poor employees' premium contributions and cost sharing (co-pays and deductibles) associated with available employer plans when Medicaid outlays would be reduced on an average per capita basis. This will help ease individuals' transition into economic self-reliance and often improve access to medical care.

Near-poor individuals who have family incomes between one and one-and-a-half times the federal poverty level should be allowed to "buy into" a package of primary and preventive care services only. Premiums would be based on a sliding scale related to their income. This would target government assistance to the primary and preventive services the near poor most often forgo

and for which employer-sponsored plans' cost-sharing sometimes presents a financial obstacle.

To assure that no American falls beneath the poverty level as a consequence of medical expenses, all states should deduct medical expenses from income when determining eligibility for Medicaid. "Medically needy" or "spend-down" programs (and many states have already adopted such programs) constitute a last-resort financial safety net covering a full range of health services.

Raising eligibility standards for Medicaid to 100 percent of the federal poverty level will give an estimated 9.5 million to 11 million uninsured Americans access to Medicaid coverage. (The Medicaid program currently pays for the care of over 21 million people annually.) These reforms would increase Medicaid costs by only about 25 percent while increasing the population served by the program by about 70 percent. This is because three-quarters of Medicaid spending now goes for long-term care and other services for the elderly and disabled. Medicaid coverage for poor uninsured populations is far less expensive on a per capita basis.

Contain Health Care Costs

Efforts to improve access will be thwarted, at least to some extent, if no way is found to curb the escalation of health care costs. As the cost of care continues to rise, employers who are on the margin with respect to decisions to offer coverage will find coverage unaffordable. Solving the cost problem is a prerequisite to solving the access problem.

Although there are no simple solutions to the cost problem, a key component of any effective cost containment strategy is the further development of managed care systems that integrate financing and delivery — HMOs, PPOs, point-of-service plans, and the like. Since physicians make most of the key decisions that determine the cost of treatment, it is imperative to make sure that patients get care from physicians (and other providers) who use resources efficiently. Managed care systems build on that premise by selecting panels of providers for their networks who meet specified criteria and who agree to be monitored to assure that they continue to provide high-quality cost-effective care. Patients are then given financial incentives to choose these providers as their caregivers. By integrating the financing and delivery of care, managed care improves quality while constraining costs.

A second major element in effective cost containment must be improved knowledge about what constitutes cost-effective care. New technologies that promise better care are introduced into medical practice, often at great cost, before anyone has made a careful assessment of their cost-effectiveness or even appropriateness for certain treatments. Insurers, government, and all who pay for medical services have a stake in developing better mechanisms and procedures for that assessment.

Related to the need for better knowledge about technologies is the need for better information about what constitutes good medical practice. (One symptom of this need is that in many areas of medicine there is broad variation in the treatment of patients with similar conditions.) Increased efforts should be directed to filling the knowledge gap by establishing mechanisms and financing to develop medical practice guidelines and protocols that define the range of acceptable medical practice for particular conditions. This task will require a substantial commitment of resources from both government and the private sector. These kinds of advances in medical knowledge will help to improve utilization review activities by providing standards that are accepted by both physicians and, very likely, the courts as well.

Government has a vital role to play in the

battle against cost escalation, particularly with respect to technology assessment, protocol development, and the collection and analysis of data that can be used to develop more accurate measures of cost, use, and medical outcomes. Also necessary is a legal climate that is hospitable to the growth of managed care. Government should refrain from limiting insurers' ability to employ appropriate utilization review techniques and should not outlaw managed care plans that require patients to pay significantly more when they opt to get care from non-network providers (thus generating significantly higher costs).

Government can help reduce administrative costs by cooperating with industry-wide efforts to utilize common claims forms and expand electronic collection, analysis, and payment of claims. Finally, government has to take the lead in malpractice reform. Such reform includes reducing the incidence of malpractice by encouraging better risk management activities by providers, taking steps to assure that only competent providers treat patients, and making legislative changes in the malpractice system so that awards are appropriate and adjudication does not absorb an excessive percentage of the costs of righting the wrongs done to patients.

Health Insurance Association of America
1025 Connecticut Avenue, N.W.
Washington, D.C. 20036–3998

PP191

Statement by the AFL-CIO Executive Council

on

Health Care

February 20, 1990
Bal Harbour, Flordia

Our nation is now at a crossroads on health care. Because of cutbacks in public programs, jobs that offer no benefits and efforts by employers to shift health care costs to workers, 50 million Americans have health care coverage that is inadequate to meet their needs and another 37 million have no protection at all.

The United States spends $2 billion a day, or 11 percent of its gross national product, on health care. As insurance premiums increase 18 to 30 percent a year, basic health care has moved well beyond the reach of a growing number of working families. This increase also places heavy pressure on employer labor costs. There is no end in sight to this trend.

The AFL-CIO through a grassroots health reform campaign is assisting affiliates in defending health benefits against employer attacks and is sending a strong message to Congress that bold and innovative action is urged to address this grave problem.

The AFL-CIO stands ready to explore a variety of alternatives, so long as the overall objective is the enactment of health care legislation that deals with the issues of cost, access and quality based on the following ten principles:

* **Universality** -- Through federal legislation, make health care a right for all Americans regardless of age, sex, race, health status, employment or income.

* **Public Accountability** -- Assure that the program is administered by an independent entity. Provide opportunity for the participation of labor, management, consumers and the health care community in the development and implementation of the national health care program.

* **Affordability and Accessibility** -- Require that health care be provided in a manner which assures that services are affordable and out-of-pocket charges do not limit access.

* **Comprehensiveness** -- Assure all Americans a federally-mandated set of comprehensive health care benefits. Develop a national program to provide access to services for long-term and chronic health conditions.

* **Equitable and Progressive Financing** -- Require all employers to contribute to the cost of health care benefits for employees, including part-time workers and their dependents. Re-channel federal and state revenue sources and, to the extent necessary, explore other sources of revenue, including tax-based financing. Link employee contributions with ability to pay.

* **Fairness** -- Assure that the unemployed, the poor and their dependents have affordable access to health care services.

* **Portability** -- Guarantee all Americans, regardless of where they live, access to the same mandated package of benefits.

* **Cost Containment** -- Require the development of mechanisms to contain rising health care costs for all payors. Establish guidelines that prohibit physicians and other providers from charging patients more than they are paid under the program. Substantially reduce paper work and red tape in the system and develop health care information systems that will provide consumers, purchasers and providers adequate data on the cost and quality of health care services. Develop a process to manage the expansion or updating of existing health care facilities, as well as the acquisition and proliferation of new health care technology.

* **Quality Assurance** -- Develop appropriate mechanisms to encourage the delivery of high quality services and an equitable and cost-effective system for handling medical malpractice. Better coordinate existing medical research and commit the resources necessary to achieve the nation's health care objectives.

* **Public/Private Administration** -- Establish national standards for the program at the federal level. Pooled funds should be available at the federal, state or regional level for the purchase of affordable, community-rated coverage administered through insurers or other third parties.

###

FACT SHEET

on

AFL-CIO PRINCIPLES FOR

NATIONAL HEALTH CARE REFORM

Improving Quality and Administration

- An entity should be established to administer the national health care program. It should involve the participation of workers, employers, consumers and the health care community.

- The national health care program should encourage the development of alternative delivery systems. The national administrative entity should develop standards for such systems.

- This body should coordinate the development and dissemination of guidelines for medical practice. Having practice pattern guidelines available could begin the process of resolving the malpractice crisis.

- The national administrative entity should take steps to reduce paperwork and red tape in the system.

- This body should develop standard claim forms to be used in the national health care program. This would help reduce excessive administrative costs currently in the system.

- This body should develop guidelines for the development of health information systems so that consumers, purchasers and providers can have the information necessary to assess the quality and cost of services provided under the program.

- The national administrative entity should make an assessment of the adequacy of the level of existing medical research, as well as the relative distribution of these funds for specific diseases and conditions.

Improving Access to Care

- Health care services should be a right for all Americans, regardless of age, sex, race, income, health status, employment or geographic location.

- All Americans should have access to a comprehensive federally mandated benefit package.

- This should include hospital care, physicians services, diagnostic tests and preventive care.
- These benefits would be the minimum package of services that could be provided by state Medicaid programs. States should be allowed to supplement the federal package for the low income, Medicaid population. These individuals have special health care needs that they cannot afford to address without the support of public programs.

- For the non-Medicaid population states should not be allowed to mandate that any benefits, in addition to the federally mandated package, be provided.

- Through collective bargaining, unions could negotiate with employers to obtain additional benefits or reduce any out-of-pocket costs.

- All Americans should continue to have access to basic benefits when traveling out of their home state or region.

- A national program must be developed to provide all citizens protection against the high cost of long-term and chronic health conditions.

- Access to services should not be impeded by out-of-pocket charges required at point of service.

- Employers should be required to contribute to the cost of health care coverage for all of their workers and their dependents.

- Individuals could be required to participate in the financing of coverage based on their ability to pay.

- The federal government, states or regions should establish pools through which affordable community-rated coverage would be made widely available.

- The pools could be administered by insurance companies or other third parties that would function as intermediaries in the system.

- Private and public employers and multi-employer plans should be given the option of buying into the pools.

- States could buy into the pools for the Medicaid population.

- Retirees not yet eligible for Medicare and other individuals could buy into the pools, with or without an employer contribution, based on their ability to pay.

Containing Costs

- The national health care program should include a system for containing costs for all payors.
- A national health care expenditure target should be developed to assure that health care spending remains within pre-determined limits. Targets also should be developed for states or regions.
- Various cost containment mechanisms should be incorporated into the program, such as physicians' fee schedules and limits on hospital charges.
- States or regions should be given the option of using cost containment techniques developed at the federal level or adopting other alternatives under predetermined federal standards.
- Balance billing, or the practice by providers of charging patients more than the rate paid to providers, should be prohibited.
- A system for controlling capital expenditures in hospitals, physicians offices and outpatient centers should be developed and implemented on a state or regional basis.
- Technology assessment should be better coordinated at the federal level. There should be wide dissemination of information about the efficiency and efficacy of new technology.
- Health care information systems that provide adequate information to consumers and providers must be developed.

101st CONGRESS
2d Session

S. 2163

To amend the Public Health Service Act to establish a lifecare long-term care program, and for other purposes.

IN THE SENATE OF THE UNITED STATES

February 22 (legislative day, January 23), 1990

Mr. Kennedy (for himself, Mr. Simon, and Mr. Inouye) introduced the following bill; which was read twice and referred to the Committee on Labor and Human Resources

---

A BILL

To amend the Public Health Service Act to establish a lifecare long-term care 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; TABLE OF CONTENTS.**
4 (a) Short Title.—This Act may be cited as the "Life-
5 care Long-Term Care Protection Act".
6 (b) Table of Contents.—The table of contents is as
7 follows:

Sec. 1. Short title; table of contents.
Sec. 2. Lifecare long-term care protection program.

"TITLE XXVI—LIFECARE LONG-TERM CARE PROTECTION PROGRAM

"Part A—General Provisions

"Sec. 2601. Definitions.
"Sec. 2602. Long-term care agencies.
"Sec. 2603. Contribution of State funds.

"Part B—Coverage of Home and Community-Based Care Services

"Sec. 2611. Benefits.
"Sec. 2612. Eligibility.
"Sec. 2613. Respite care.
"Sec. 2614. Qualified service providers.
"Sec. 2615. Payment for services.
"Sec. 2616. Home and Community-Based Advisory Council.
"Sec. 2617. Quality assurance boards and community advisory boards.
"Sec. 2618. Home and community-based care quality assurance.
"Sec. 2619. Certification.
"Sec. 2620. Reimbursement.

"Part C—Coverage of First 6 Months of Nursing Home Care

"Sec. 2621. Benefits.
"Sec. 2622. Eligibility.
"Sec. 2623. Limitations on payment.
"Sec. 2624. Reimbursement.
"Sec. 2625. Relationship to other entitlement programs.

"Part D—Insurance Coverage for Nursing Home Care That Exceeds 6 Months

"Sec. 2631. Establishment of Federal Long-Term Care Insurance Program.
"Sec. 2632. Eligibility.
"Sec. 2633. Premium rates.
"Sec. 2634. Benefits.
"Sec. 2635. Qualified service providers.
"Sec. 2636. Reimbursement.

"Part E—Training and Research

"Sec. 2641. Grants for training for home and community-based care for the elderly.
"Sec. 2642. Grants for home health aides.
"Sec. 2643. Grants for model consumer training programs.
"Sec. 2644. Centers for long-term care planning and technical assistance.

"Part F—Demonstration Projects

"Sec. 2651. Demonstration projects for seriously mentally ill individuals.
"Sec. 2652. Demonstration projects for working age individuals with severe functional limitations.
"Sec. 2653. General authority.".
Sec. 3. Conforming amendments.
Sec. 4. Effective date.

1 **SEC. 2. LIFECARE LONG-TERM CARE PROTECTION PROGRAM.**

2 The Public Health Service Act is amended—

3 (1) by redesignating title XXVI (42 U.S.C.
4 300aaa et seq.) as title XXVII;

5 (2) by redesignating sections 2601 through 2614
6 (42 U.S.C. 300aaa through 300aaa-13) as sections
7 2701 through 2714, respectively; and

8 (3) by inserting after title XXV the following new
9 title:

10 "TITLE XXVI—LIFECARE LONG-
11 TERM CARE PROTECTION PRO-
12 GRAM

13 "PART A—GENERAL PROVISIONS

14 **"SEC. 2601. DEFINITIONS.**

15 "As used in this title:

16 "(1) ACTIVITY OF DAILY LIVING.—The term 'ac-
17 tivity of daily living' includes:

18 "(A) BATHING.—Getting water and cleans-
19 ing the whole body, including turning on the
20 water for a bath, shower, or sponge bath, getting
21 to, in, and out of a tub or shower, and washing
22 and drying oneself;

23 "(B) DRESSING.—Getting clothes from clos-
24 ets and drawers and then getting dressed, includ-
25 ing putting on braces or other devices and fasten-
26 ing buttons, zippers, snaps, or other closures, se-

1 lecting appropriate attire, and dressing in the
2 proper order;
3 "(C) TOILETING.—Going to a bathroom for
4 bowel and bladder function, transferring on and
5 off the toilet, cleaning after elimination, and ar-
6 ranging clothes;
7 "(D) TRANSFERRING.—Moving in and out of
8 bed and in and out of a chair or wheelchair; or
9 "(E) EATING.—Transferring food from a
10 plate or its equivalent into the body, including
11 cutting food so as to make possible safe ingestion.
12 "(2) ADULT DAY HEALTH CARE.—The term
13 'adult day health care' means a community-based
14 group program designed to—
15 "(A) meet the need for adult day health care
16 for functionally impaired individuals in a struc-
17 tured, comprehensive program; and
18 "(B) provide a variety of health and social
19 services furnished by an adult day health care
20 center in an ambulatory group care setting during
21 any part of a day, but on a less than 24-hour
22 basis, to an individual described in section 2612.
23 "(3) ADULT DAY HEALTH CARE CENTER.—
24 "(A) IN GENERAL.—The term 'adult day
25 health care center' means a public agency or pri-

1 vate organization (or a subdivision thereof), with
2 an identifiable administrative unit headed by a Di-
3 rector, that meets such standards for personnel,
4 program, physical characteristics of the facility,
5 recordkeeping, and such other aspects of the func-
6 tion of such center as the Secretary considers nec-
7 essary or desirable for the health, safety, and ef-
8 fective treatment of patients and establishes by
9 regulation.

10 "(B) PROFESSIONAL ORGANIZATION STAND-
11 ARDS.—In promulgating such regulations, the
12 Secretary shall carefully consider certification
13 standards established by the National Council on
14 Aging and its professional membership unit, the
15 National Institute for Adult Day Care.

16 "(C) PERSONNEL.—Such standards shall in-
17 clude the participation in the provision of the
18 services of the center of a multidisciplinary group
19 of personnel that includes at least—

20 "(i) one physician or nurse practitioner,
21 which could be the individual's own physi-
22 cian or nurse practitioner;

23 "(ii) one registered professional nurse;

24 "(iii) one social worker;

1 "(iv) individuals with skills representing
2 physical, recreational, or occupational ther-
3 apy or speech-language pathology; and
4 "(v) a dietitian.
5 "Such personnel may be employed directly by the
6 center or on a consultant basis, as specified by the
7 Secretary by regulation.
8 "(D) STATE CERTIFICATION.—To be con-
9 sidered an adult health care center under this
10 title, a center shall be certified by a State, pursu-
11 ant to regulations issued by the Secretary.
12 "(4) CARE PLAN.—
13 "(A) IN GENERAL.—The term 'care plan'
14 means a plan that has been developed by a Case
15 Management Agency, or a home care or home
16 health agency working under contract with the
17 Case Management Agency to provide case man-
18 agement services. Such a care plan shall be based
19 on the results of a comprehensive needs assess-
20 ment of an eligible individual conducted by a case
21 management team in cooperation with the individ-
22 ual, the family of the individual, or other informal
23 caregivers, and in consultation with such other
24 health professionals as the case management team
25 considers appropriate for the needs of the individ-

1 ual. A care plan developed by a home care or
2 home health agency is subject to review and ap-
3 proval by the Case Management Agency. Any
4 entity performing case management services for
5 individuals determined eligible for services under
6 this title shall not be allowed to self-refer for
7 services included in the care plan of such individ-
8 ual.

9 "(B) CONTENTS.—The plan shall—

10 "(i) include a definition of specific out-
11 come goals on which improvement, reduced
12 rate of decline, maintenance, or improved
13 quality of life for the individual is expected;
14 and

15 "(ii) identify the specific mix of services
16 necessary to meet the outcome goals allotted
17 to the patient and reimbursable under this
18 title as determined by the procedure de-
19 scribed in section 2602.

20 "(5) CASE MANAGEMENT SERVICES.—

21 "(A) IN GENERAL.—The term 'case manage-
22 ment services' means services performed by a
23 case management team that include—

24 "(i) conducting a comprehensive needs
25 assessment in cooperation with an individual

1 and the family of an individual and in consul-
2 tation with such other health professionals
3 (including a physical therapist, occupational
4 therapist, nurse practitioner, certified dieti-
5 tian, or physician) as the case management
6 team considers appropriate for the needs of
7 the individual to assess the physical, social,
8 cognitive, and environmental status of the in-
9 dividual;
10 "(ii) developing, implementing, and
11 modifying (when necessary) the care plan of
12 an individual;
13 "(iii) coordinating the services provided
14 under the care plan;
15 "(iv) monitoring the care plan to ensure
16 the quality, quantity, timeliness, and effec-
17 tiveness of the services;
18 "(v) monitoring the progress of an indi-
19 vidual toward achievement of the goals spec-
20 ified in the care plan; and
21 "(vi) reviewing and revising, as neces-
22 sary, the care plan at least once every three
23 months or earlier in the event that the condi-
24 tion of the individual changes.

1 "(B) REQUIREMENT.—Individuals providing
2 case management services to children and the dis-
3 abled under this Act shall demonstrate their expe-
4 rience with the special needs of these populations.
5 "(6) CASE MANAGEMENT TEAM.—The term
6 'case management team' means a registered profession-
7 al nurse and a qualified social worker (who is licensed
8 or certified, if applicable, in the State in which the in-
9 dividual is providing services), working in consultation
10 with other health professionals as needed, who are em-
11 ployed by a Case Management Agency or by a certi-
12 fied home health agency, home care agency, or other
13 private nonprofit organization under contract with the
14 agency to provide case management services pursuant
15 to the requirements of this title and standards pre-
16 scribed by the Secretary by regulation. Such nurse and
17 social worker shall meet standards of education, train-
18 ing, and experience established by the Secretary by
19 regulation to qualify to provide case management serv-
20 ices under this title. The case management team for
21 any person determined eligible for services under this
22 part, as defined under section 2612(a)(2)(B)(ii), shall
23 also include a physician.
24 "(7) COMPREHENSIVE NEEDS ASSESSMENT.—
25 The term 'comprehensive needs assessment' means a

1 comprehensive interdisciplinary assessment of the
2 status and needs of an individual that is conducted by a
3 case management team. The assessment shall address
4 functional status (including activities of daily living), in-
5 strumental activities of daily living (such as housekeep-
6 ing, shopping, transportation, meal preparation, and
7 taking medication), medically defined conditions, drug
8 regimen, nutrition status, mental status, living arrange-
9 ment, and availability of caregiver support.
10 "(8) HEAVY CHORE SERVICES.—The term 'heavy
11 chore services' means heavy cleaning and minor home
12 repair. Chore services may not be used to perform ac-
13 tivities that are the responsibility of a housing author-
14 ity or landlord, or both. Heavy chore services shall be
15 provided by personnel not requiring special training but
16 who work under supervision of the case management
17 agency or other qualified provider. Heavy chore serv-
18 ices include those services determined by a case man-
19 ager to be necessary to protect the health and safety of
20 an individual such as washing floors and walls, wood-
21 cutting, changing storm windows, replacing window
22 panes, door and window locks, installing minor home
23 adaptations, snow shoveling, weatherization, and such
24 other needed heavy chore services as are specified by a
25 case manager.

1 "(9) HOME AND COMMUNITY-BASED CARE SERV-
2 ICES.—The term 'home and community-based care
3 services' means items and services provided to an indi-
4 vidual—
5 "(A) under a written plan of care for furnish-
6 ing such items and services to the individual;
7 "(B) except as provided clauses (iv), (v), and
8 (xii) of subparagraph (C), on a visiting basis in a
9 place of residence of the individual and in other
10 facilities (but not including a nursing home); and
11 "(C) that include—
12 "(i) homemaker services;
13 "(ii) home health aide services;
14 "(iii) heavy chore services;
15 "(iv) adult day health care provided at
16 an adult day health care center;
17 "(v) respite care;
18 "(vi) home mobility aids and minor ad-
19 aptations to the home of the individual that
20 promote independence (such as installation of
21 an emergency alarm system, railings, ramps,
22 and special toilets) that are approved by the
23 case manager and included in the care plan
24 of the individual;

1 "(vii) nursing care provided by or under
2 the supervision of a registered professional
3 nurse;
4 "(viii) medical social work services;
5 "(ix) physical, occupational, or speech
6 therapy or rehabilitative services to preserve
7 and restore functional capability or to pre-
8 vent functional deterioration;
9 "(x) transportation to and from health
10 or social services;
11 "(xi) nutrition and dietary counseling
12 provided by or under the supervision of a
13 qualified dietitian; and
14 "(xii) any of the items and services re-
15 ferred to in clauses (i) through (xi)—
16 "(I) that are provided on an outpa-
17 tient basis, under arrangements made
18 by the case manager, at a hospital or
19 nursing facility, or at a rehabilitation
20 center that meets such standards as
21 may be prescribed in regulation; and
22 "(II) the furnishing of which
23 cannot readily be made available to the
24 individual in such place of residence, or
25 can be provided more economically or

1 effectively in such hospital, facility, or
2 center.
3 "(10) HOME CARE AGENCY.—The term 'home
4 care agency' means an agency in any State that has
5 been certified by the State to provide home care serv-
6 ices pursuant to regulations of the Secretary. Such
7 services include homemaker services, heavy chore serv-
8 ices, and respite services.
9 "(11) HOME HEALTH AGENCY.—The term 'home
10 health agency' means an agency in any State that has
11 been certified by the Secretary to provide home health
12 services. Such services shall include home health aide
13 services, homemaker services, nursing services, respite
14 services, medical social work services, and occupation-
15 al, physical, speech therapy, and nutrition and dietary
16 counseling.
17 "(12) HOME HEALTH AIDE SERVICES.—
18 "(A) IN GENERAL.—The term 'home health
19 aide services' means the services provided by a
20 home health aide who meets such educational,
21 training, and any other requirements as the Secre-
22 tary shall establish by regulation and who is em-
23 ployed by a home health or home care agency or
24 whose services are provided under a contract

1 with, or subcontract on behalf of, a Case Manage-
2 ment Agency.
3 "(B) SERVICES.—Such services shall in-
4 clude—
5 "(i) providing personal care in following
6 the instructions of the case management
7 team of an individual under the supervision
8 of a registered professional nurse or, if ap-
9 propriate, a physical, speech, or occupational
10 therapist;
11 "(ii) assisting the individual with activi-
12 ties of daily living;
13 "(iii) assisting the individual with the
14 taking of medications ordered by a physician,
15 that are ordinarily self-administered;
16 "(iv) assisting and reinforcing the indi-
17 vidual with necessary self-help skills; and
18 "(v) reporting to the registered profes-
19 sional nurse supervisor any change in the
20 condition or family situation of the individual.
21 "(13) HOMEMAKER SERVICES.—
22 "(A) IN GENERAL.—The term 'homemaker
23 services' means services provided by a homemak-
24 er who meets such educational, training, and any
25 other requirements as the Secretary shall establish

1 by regulation and who is employed by a home
2 health or home care agency or who are working
3 under contract with, or subcontract on behalf of, a
4 Case Management Agency.
5 "(B) SERVICES.—Homemaker services may
6 include—
7 "(i) organizing the homemaking activity
8 of the household with the active participation
9 of an individual, if possible, and other re-
10 sponsible family members;
11 "(ii) coordinating efforts of other family
12 members in planning and carrying out the
13 duties necessary for the normal functioning
14 of the household;
15 "(iii) performing routine housekeeping
16 tasks, planning and preparing meals, doing
17 the marketing and simple errands, and taking
18 care of light laundry;
19 "(iv) assisting the individual with per-
20 sonal care services including performing ac-
21 tivities of daily living; and
22 "(v) performing such incidental house-
23 hold services as are essential to the care of
24 an individual at home, such as reporting to a
25 registered professional nurse supervisor

1 changes in the condition or family situation
2 of the individual and following a written case
3 plan established by a case management
4 team.

5 "(14) NURSING FACILITY.—

6 "(A) IN GENERAL.—The term 'nursing facil-
7 ity' means an institution that meets such require-
8 ments as the Secretary shall prescribe by regula-
9 tion to ensure the safe and efficient provision of
10 nursing home services under this title.

11 "(B) REQUIREMENTS.—

12 "(i) REGISTERED PROFESSIONAL
13 NURSE.—All nursing facilities shall maintain
14 at least one registered professional nurse on
15 duty at all times. The Secretary may provide
16 limited waivers of such requirement if—

17 "(I) the facility demonstrates to
18 the satisfaction of the Secretary that it
19 has been unable, despite diligent efforts
20 (including offering wages at the commu-
21 nity prevailing rate) to recruit and
22 retain appropriate personnel;

23 "(II) the Secretary determines that
24 a waiver of the requirement will not en-

1 danger the health, safety, or well being
2 of residents of the facility;
3 "(III) the facility meets any other
4 requirements that the Secretary may es-
5 tablish for the approval of such a
6 waiver; and
7 "(IV) such waiver is not for a
8 period in excess of 6 months, but such
9 may be renewed on a limited basis for
10 additional periods not to exceed 6
11 months.
12 "(ii) REGISTERED PROFESSIONAL
13 SOCIAL WORKER.—All nursing facilities
14 shall maintain at least one full-time regis-
15 tered professional social worker to direct its
16 social services program.
17 "(15) RESPITE CARE.—The term 'respite care'
18 means a temporary break provided to an individual
19 who supplies regular care to a dependent relative or
20 friend. For purposes of this title, the break may not
21 exceed 30 days or 720 hours, in a calendar year. The
22 term includes institutional or noninstitutional patient
23 supervisory services to temporarily relieve the care-
24 giver of an eligible individual as determined by a Care

1 Management Agency and included in the care plan of
2 the individual.
3 "(17) SPELL OF ILLNESS.—The term 'spell of ill-
4 ness' means a period of consecutive days beginning
5 with the first day on which an individual is furnished a
6 covered service and ending with the close of the first 6
7 consecutive months thereafter during which the individ-
8 ual is not an inpatient of a hospital or a nursing
9 facility.

10 **"SEC. 2602. LONG-TERM CARE AGENCIES.**

11 "(a) LONG-TERM CARE SCREENING AGENCY.—
12 "(1) ESTABLISHMENT.—The Secretary shall con-
13 tract with entities to act as Long-Term Care Screening
14 Agencies (hereinafter referred to in this title as the
15 'Screening Agency') for each designated area of a
16 State. It shall be the responsibility of such agency to
17 assess the eligibility of individuals residing in the geo-
18 graphic jurisdiction of the agency, for services provided
19 under this Act according to the requirements of this
20 Act and regulations prescribed by the Secretary.
21 "(2) ELIGIBILITY.—The Screening Agency shall
22 determine the eligibility of an individual based on the
23 results of a preliminary telephone or written question-
24 naire (completed by the applicant, by the caregiver of
25 the applicant, or by the legal guardian or representa-

1 tive of the applicant) that shall be validated through
2 the use of a screening tool administered in person by a
3 physician, nurse practitioner, or registered professional
4 nurse, to each applicant determined eligible through
5 initial telephone or written questionnaire interviews not
6 later than 15 days from the date on which such indi-
7 vidual initially applied for services under this part.

8 "(3) QUESTIONNAIRES AND SCREENING
9 TOOLS.—

10 "(A) IN GENERAL.—The Secretary shall es-
11 tablish a telephone or written questionnaire and a
12 screening tool to be used by the Screening
13 Agency to determine the eligibility of an individ-
14 ual for services under this title consistent with re-
15 quirements of this title and standards established
16 by the Secretary by regulation.

17 "(B) QUESTIONNAIRES.—The questionnaire
18 shall include questions about the functional im-
19 pairment, mental status, and living arrangement
20 of an individual and other criteria that the Secre-
21 tary shall prescribe by regulation.

22 "(C) SCREENING TOOLS.—The screening
23 tool should measure functional impairment caused
24 by physical or cognitive conditions as well as in-
25 formation concerning cognition disability, behav-

1 ioral problems (such as wandering or abusive and
2 aggressive behavior), the living arrangement of an
3 individual, availability of caregivers, and any
4 other criteria that the Secretary shall prescribe by
5 regulation. The screening tool shall be adminis-
6 tered in person.

7 "(4) NOTIFICATION.—Not later than 15 days
8 after the date on which an individual initially applied
9 for services under this part (by phone or written ques-
10 tionnaire), the Screening Agency shall notify such indi-
11 vidual that such individual is not eligible for benefits,
12 or that such individuals must schedule an in-person
13 screening to determine final eligibility for benefits
14 under this title. The Screening Agency shall notify
15 such individual of its final decision not later than 2
16 working days after the in-person screening.

17 "(5) IN-PERSON SCREENING.—An individual (or
18 the legal guardian or representative of such individual)
19 whose application for long-term care benefits under
20 this Act is denied on the basis of information provided
21 through a telephone or written questionnaire, shall be
22 notified of such individual's right to an in-person
23 screening by a nurse or appropriate health care profes-
24 sionals.

1 "(6) APPEALS.—The Secretary shall establish a
2 mechanism for hearings and appeals in cases in which
3 individuals contest the eligibility findings of the Screen-
4 ing Agency.

5 "(7) FUNDING LEVEL.—The Screening Agency
6 shall be responsible for determining the estimated fund-
7 ing level that shall be allotted for individuals eligible
8 for home and community-based care, pursuant to
9 standards established under section 2615(e) and regula-
10 tions of the Secretary.

11 "(b) LONG-TERM CARE CASE MANAGEMENT
12 AGENCY.—

13 "(1) ESTABLISHMENT.—The Secretary shall con-
14 tract with a State or, in any case in which a State de-
15 clines to contract with the Secretary, a private non-
16 profit organization, to establish and administer a Long-
17 Term Care Case Management Agency (hereinafter re-
18 ferred to in this title as 'Case Management Agency')
19 for each designated area of a State. Such agency shall
20 demonstrate expertise in the delivery of health and
21 social services to the chronically ill and disabled pursu-
22 ant to requirements established in this title and such
23 standards as the Secretary may establish by regulation
24 (including standards for training and qualification of
25 personnel, financial responsibility, and governance).

1 "(2) DUTIES.—A Case Management Agency shall
2 provide case management services for eligible individ-
3 uals directly or through contracts with home care or
4 home health agencies that meet the requirements of
5 this title and standards prescribed by the Secretary by
6 regulation for providing case management services.
7 "(3) CARE PLAN.—The Case Management
8 Agency shall develop a care plan for each individual
9 determined to be eligible by a Screening Agency. In
10 developing a care plan for an individual, the Case
11 Management Agency shall design a plan that meets the
12 service needs of the individual, consistent with the re-
13 sources available to the agency.
14 "(4) FUNDING.—
15 "(A) IN GENERAL.—The actual level of
16 funding allotted to an eligible individual by the
17 Case Management Agency to cover services in-
18 cluded in the individual's care plan may fall above
19 or below the estimated annualized level allotted to
20 the individual by the Screening Agency based on
21 the detailed assessment and plan of care provided
22 by the Case Management Agency.
23 "(B) LIMITATION.—The Case Management
24 Agency shall allocate the resources available from
25 the Screening Agency (as described in section

1 2615(a)) to ensure that the total expenditures for
2 home and community-based care for individuals
3 eligible for services covered under this title resid-
4 ing within the geographic jurisdiction of the
5 agency do not exceed the total amount available
6 monthly to the Case Management Agency, pursu-
7 ant to this section, for home and community-based
8 services. The Case Management Agency shall es-
9 tablish specific financial controls (including author-
10 izing the amount, scope, and duration of services
11 to be provided to an individual) to carry out this
12 subparagraph.
13 "(c) REGISTRY.—A Case Management Agency shall
14 maintain a registry of qualified providers of home and com-
15 munity-based and nursing home care in the State and shall
16 assist individuals in choosing qualified providers to carry out
17 the care plan. An individual eligible for services under this
18 title shall be free to choose from the registry the home care
19 agency, home health agency, or other qualified provider of
20 services to carry out the care plan of such individual. The
21 Case Management Agency shall assist the individual in locat-
22 ing alternative providers if the individual becomes dissatisfied
23 with the provider initially chosen.
24 "(d) MONITORING.—A State shall, along with the Sec-
25 retary, monitor the performance of all designated Case Man-

1 agement Agencies and assure the fiscal stability of such
2 agencies. A State shall act as the financial guarantor of each
3 agency.

4 **"SEC. 2603. CONTRIBUTION OF STATE FUNDS.**

5 "(a) ESTIMATE.—The Secretary shall estimate the
6 amount that a State would have spent during each calendar
7 year for individuals eligible for long-term care services under
8 each Federal-State entitlement program in the absence of the
9 program established by this title. Such estimate shall be up-
10 dated annually based on the projected increases in the cost of
11 carrying out this title.

12 "(b) CONTRIBUTION.—For residents of a State to be
13 eligible to participate in the program established by this title
14 during a calendar year, the State shall contribute the amount
15 estimated under subsection (a) to the Secretary to share in
16 the costs of providing services to such State residents under
17 the program established by this title for such calendar year.

18 **"PART B—COVERAGE OF HOME AND COMMUNITY-**
19 **BASED CARE SERVICES**

20 **"SEC. 2611. BENEFITS.**

21 "An individual who meets the eligibility criteria pre-
22 scribed in section 2612 shall be eligible under the program
23 established by this part for coverage for home and communi-
24 ty-based care services that are—

1 "(1) determined to be necessary by a Case Man-
2 agement Agency;
3 "(2) described in the care plan of the individual;
4 "(3) services for which the individual is eligible;
5 and
6 "(4) consistent with the need for care of the indi-
7 vidual, regulations issued by the Secretary, and stand-
8 ards established under this part.

9 **"SEC. 2612. ELIGIBILITY.**

10 "(a) IN GENERAL.—An individual shall be eligible for
11 benefits under this part only if the individual—
12 "(1)(A) is—
13 "(i) 65 years of age or older; or
14 "(ii) eligible for benefits under part A of title
15 XVIII of the Social Security Act (42 U.S.C.
16 1395 et seq.) as the result of a disability; and
17 "(B) has been determined by a Screening Agency
18 through a screening process (conducted in accordance
19 with section 2602) to be—
20 "(i) completely dependent (does not partici-
21 pate) in at least one age-appropriate activity of
22 daily living or unable to perform two or more
23 age-appropriate activities of daily living without
24 human assistance or supervision; or

1 "(ii) so cognitively impaired (due to adult
2 onset or acquired chronic organic disease of the
3 brain, occurring in clear consciousness, and in-
4 cluding those individuals who would meet such
5 criteria except for the presence of a transient de-
6 lirium in such individuals) as to require substantial
7 supervision from another individual because such
8 impaired individual engages in inappropriate be-
9 havior that poses a substantial health and safety
10 hazard to such impaired individual or to others; or
11 "(2)(A) is under 19 years of age; and
12 "(B) has been determined by a Screening Agency
13 through a screening process (conducted in accordance
14 with section 2602)—
15 "(i) to be unable to perform two or more
16 age-appropriate activities of daily living without
17 human assistance or supervision; or
18 "(ii) to require both a medical devise to com-
19 pensate for the loss of a vital body function that is
20 necessary to avert death or major loss of bodily
21 functional capacity and substantial and ongoing
22 nursing care to avert death or further disability;
23 or
24 "(3)(A) would be eligible for benefits under title
25 XVIII of the Social Security Act (42 U.S.C. 1395 et

1 seq.) on the basis of a disability except for the required
2 24-month waiting period;
3 "(B) has been determined by a Screening Agency
4 through a screening process (conducted in accordance
5 with section 2602) to be completely dependent (does
6 not participate) in at least one age-appropriate activity
7 of daily living or unable to perform two or more age-
8 appropriate activities of daily living without human as-
9 sistance or supervision; and
10 "(C) has a medical prognosis that such individ-
11 ual's life expectancy is 12 months or less.
12 "(b) APPLICATION.—An individual shall be eligible for
13 benefits under this part only if—
14 "(1) the individual has filed an application for, and
15 is in need of, benefits covered under this part;
16 "(2) the legal guardian of the individual has filed
17 an application on behalf of an individual who is in need
18 of benefits covered under this part; or
19 "(3) the representative of an individual who is
20 cognitively impaired, who has no legal guardian, and
21 who is in need of benefits covered under this part, files
22 an application on behalf of the individual.
23 **"SEC. 2613. RESPITE CARE.**
24 "(a) ELIGIBILITY.—An individual shall be eligible for
25 respite care benefits under this part if—

1 "(1)(A) the individual meets the requirements es-
2 tablished in section 2612;
3 "(B) the individual is dependent on a daily basis
4 on a primary caregiver and is assisting the individual
5 without monetary compensation in the performance of
6 at least two age-appropriate activities of daily living;
7 and
8 "(C) without such assistance the individual could
9 not perform such activities of daily living; or
10 "(2) the individual has dementia or other cognitive
11 impairments, as determined by a Screening Agency.
12 "(b) DETERMINATION OF NEED.—The determination
13 of the need of an individual for respite care shall be made by
14 the Case Management Agency. An analysis of such need
15 shall be included in the care plan of the individual.
16 "(c) SERVICES.—Respite care services under this sec-
17 tion may include home and community-based services or
18 nursing home services described in section 2621(b).
19 "(d) PERIOD OF COVERAGE.—Coverage for such serv-
20 ices shall be for short periods of time of not to exceed 30 days
21 or 720 hours during a given calendar year.
22 "(e) REIMBURSEMENT RATES.—Reimbursement rates
23 for respite care services covered under this section shall be
24 the same as rates established elsewhere in this part for home
25 and community-based services and nursing home services.

1 "SEC. 2614. QUALIFIED SERVICE PROVIDERS.

2 "(a) IN GENERAL.—Services provided to eligible indi-
3 viduals pursuant to a plan of care under this part shall be
4 provided by qualified service providers.

5 "(b) TYPES.—A qualified service provider shall in-
6 clude—

7 "(1) a home care agency certified by the State;

8 "(2) a home health agency certified by the Secre-
9 tary;

10 "(3) an adult day health care center certified by
11 the State; and

12 "(4) other certified or licensed provider of specific
13 services including a registered professional nurse, quali-
14 fied social worker, physician, nurse practitioner, physi-
15 cal, occupational or speech therapist, certified dietitian,
16 and other providers as the Secretary shall designate by
17 regulation that meet standards established by the Sec-
18 retary.

19 "(c) APPROVAL REQUIRED FOR REIMBURSEMENT.—
20 No individual or agency shall be eligible for reimbursement
21 for services provided to an individual under this part unless
22 the Case Management Agency approves the provision of
23 services to such individual or agency.

24 "SEC. 2615. PAYMENT FOR SERVICES.

25 "(a) CASE MANAGEMENT AGENCIES.—The Secretary
26 shall pay an amount monthly to each Case Management

1 Agency that equals the sum of the amounts allotted by the
2 Screening Agency for eligible individuals in the geographic
3 jurisdiction of such Case Management Agency who have
4 been determined by such Screening Agency to be eligible to
5 receive services covered under this part.

6 "(b) SERVICE PROVIDERS.—

7 "(1) DIRECT PAYMENTS.—The Case Manage-
8 ment Agency shall make direct payments to certified
9 home care and home health agencies, and other quali-
10 fied providers of home and community-based services
11 reimbursable under this part, in accordance with such
12 methods as the State may establish pursuant to regula-
13 tions promulgated by the Secretary.

14 "(2) FULL PAYMENT FOR SERVICES.—All provid-
15 ers of home and community-based care services under
16 the program established under this part shall accept
17 payment rates established by the Case Management
18 Agency as payment in full for services and shall not
19 pass on additional charges to beneficiaries for services
20 rendered under a plan of care.

21 "(c) PROVIDERS OF CASE MANAGEMENT SERVICES.—
22 If a Case Management Agency contracts with a home health
23 or home care agency to provide case management services,
24 the Case Management Agency shall make direct payments to
25 such organization in accordance with such methods as the

1 State may establish pursuant to regulations promulgated by
2 the Secretary.

3 "(d) LIMIT ON PAYMENT FOR HOME HEALTH AND
4 COMMUNITY-BASED SERVICES.—

5 "(1) INITIAL PERIOD.—During the 3-year period
6 beginning on the date of enactment of this title, the
7 maximum amount of payments that may be made to a
8 Case Management Agency for home and community-
9 based services provided to an individual who resides in
10 the geographic jurisdiction of the agency and who is el-
11 igible for services under this part shall be, on an an-
12 nualized basis, not more than 65 percent of the aver-
13 age amount payable, including the cost of ancillary
14 services, for the same number of care days in a nursing
15 home under title XVIII of the Social Security Act (42
16 U.S.C. 1395 et seq.) in the area in which the home
17 and community-based care is provided.

18 "(2) SUBSEQUENT YEARS.—In years subsequent
19 to the period referred to in paragraph (1), the maxi-
20 mum amount referred to in such paragraph shall be es-
21 tablished by the Secretary according to such prospec-
22 tive payment methods as the Secretary may establish
23 by regulation to assure that no payment is made for
24 home and community-based services that will exceed
25 the cost of an alternative placement in a nursing facili-

1 ty, less a reasonable estimate of the cost of room and
2 board in such facilities or in the community.
3 "(e) AMOUNT OF COVERAGE.—
4 "(1) IN GENERAL.—Subject to subsection (d) and
5 other provisions of this subsection, the amount of cov-
6 erage allotted to an eligible individual shall be the
7 amount necessary to carry out the service needs of the
8 individual.
9 "(2) MAXIMUM AVERAGE AMOUNT.—In the case
10 of an individual in a given geographic area, the aver-
11 age amount payable for such individual shall not
12 exceed an amount determined by multiplying—
13 "(A) the maximum amount prescribed in sub-
14 section (d); by
15 "(B) a measure of the severity of the need
16 for services of the individual.
17 "(3) SEVERITY OF NEED FOR SERVICES.—For
18 purposes of paragraph (2), the severity of the need for
19 services of an individual shall be estimated by such sta-
20 tistical models and techniques, that shall include a
21 measure of the severity of dependency in activities of
22 daily living, cognitive impairment, living arrangement,
23 age, and such other factors as the Secretary shall
24 specify by regulation, except that all individuals deter-
25 mined to be eligible for services under this part shall

1 be presumed to face a monthly need for services of at
2 least 5 percent of the maximum allotment. In deter-
3 mining eligibility, the Secretary shall not use any
4 measures of the income and assets of the individual.
5 Expenditures authorized by this paragraph shall be
6 made only for the services specified in this part in ac-
7 cordance with a written care plan prepared through
8 case management services provided by the Case Man-
9 agement Agency or a home care or home health
10 agency under contract with the agency to provide case
11 management services.

12 "(4) CHRONICALLY-ILL INDIVIDUAL.—The
13 amount of coverage allotted in a month to an eligible
14 individual who is a chronically-ill individual, as de-
15 scribed in section 2612(a)(2)(B)(ii), who resides in a
16 State shall be an amount that the Secretary estimates
17 is equal to 100 percent of the amount that would be
18 payable, under the plan of the State approved under
19 title XIX of the Social Security Act during the month
20 if such individual were provided appropriate care in an
21 appropriate institutional setting, if no limit on amount,
22 duration, or scope of covered institutional services ap-
23 plied other than medical necessity.

24 "(f) COPAYMENT.—The amount payable for home and
25 community-based services under this part shall be reduced by

1 a copayment amount equal to 5 percent of the amount of the
2 monthly insurance benefits of the individual under title II of
3 the Social Security Act (42 U.S.C. 401 et seq.), if any, or 10
4 percent of the cost of services provided to the individual,
5 whichever is less.

6 **"SEC. 2616. HOME AND COMMUNITY-BASED CARE ADVISORY**
7 **COUNCIL.**

8 "(a) ESTABLISHMENT.—No later than 60 days after
9 the date of enactment of this title, there shall be established
10 an independent body to be known as the 'Home and Commu-
11 nity-Based Care Advisory Council' (hereinafter referred to in
12 this section as the 'Council').

13 "(b) MEMBERSHIP.—

14 "(1) IN GENERAL.—The Council shall be com-
15 posed of 13 individuals appointed by the Secretary.

16 "(2) EXPERTISE.—To the maximum extent prac-
17 ticable, the Council shall include individuals with ex-
18 pertise in pediatrics, geriatrics, gerontology, disability,
19 case management of home and community-based serv-
20 ices and home and community-based care reimburse-
21 ment, home and community-based care consumers and
22 their representatives, home and community-based care
23 providers and their representatives, professionals with
24 expertise in long-term care including nurses, social
25 workers, discharge planners, third party payors, long-

1 term care ombudsmen, and State and local health and
2 social service agency representatives.
3 "(3) TERM.—An appointment to the Council shall
4 be for a term of not to exceed 4 years.
5 "(c) PURPOSE.—The purpose of the Council shall be—
6 "(1) to assist the Secretary in assuring the prompt
7 and efficient implementation of this part;
8 "(2) to regularly review the implementation of
9 this part; and
10 "(3) to recommend to the Secretary and Congress
11 any necessary modifications of this part.
12 "(d) CONSULTATION.—The Secretary shall regularly
13 and closely consult with the Council in the implementation
14 and administration of this part.
15 "(e) MEETINGS.—To carry out this section, the Secre-
16 tary shall meet with the Council at least once every month
17 during the 24-month period beginning 60 days after the date
18 of enactment of this title and at least quarterly after such
19 period.
20 **"SEC. 2617. QUALITY ASSURANCE BOARDS AND COMMUNITY**
21 **ADVISORY BOARDS.**
22 "(a) QUALITY ASSURANCE BOARD.—A State shall es-
23 tablish and appoint members to a quality assurance board
24 that will monitor the quality of care provided under this part

1 in a given area of the State, pursuant to procedures estab-
2 lished by the Secretary by regulation.

3 "(b) COMMUNITY ADVISORY BOARD.—A State shall
4 establish and appoint members to a community advisory
5 board for each Case Management Agency pursuant to regula-
6 tions by the Secretary. The advisory board shall be composed
7 of consumers of services and their families, representatives of
8 agencies and organizations, professionals providing services
9 to the elderly, and public members. Public members and con-
10 sumers and their families shall form a majority of the mem-
11 bers of the advisory board.

12 **"SEC. 2618. HOME AND COMMUNITY-BASED CARE QUALITY**
13 **ASSURANCE.**

14 "(a) HOME AND COMMUNITY-BASED CARE SERVICES
15 CONSUMERS' BILL OF RIGHTS.—The Secretary shall pro-
16 mulgate regulations that shall establish a bill of rights for
17 consumers of home and community-based services (hereafter
18 referred to in this section as the 'consumer'), that shall recog-
19 nize the following as the rights of consumers that may be
20 asserted by the consumer or the representative or guardian of
21 the consumer:

22 "(1) TREATMENT OF INDIVIDUAL.—To be treat-
23 ed with courtesy, respect, and full recognition of one's
24 dignity, individuality, and right to control one's own
25 household and lifestyle.

1 "(2) FULL INFORMATION.—To be fully informed
2 by the individual's case management team of his or her
3 condition.
4 "(3) REFUSAL OF TREATMENT.—To refuse all or
5 part of any treatment, care, or service, and to be in-
6 formed of the likely consequences of such refusal.
7 "(4) NONDISCRIMINATION.—To receive treat-
8 ment, care, and services in compliance with all State
9 and local laws and regulations without discrimination
10 in the provision or quality of services based on race,
11 religion, gender, age, or creed (except as provided
12 under the Age Discrimination Act of 1975 (42 U.S.C.
13 6101 et seq.)), or because of a change in the source of
14 payment.
15 "(5) FREEDOM FROM ABUSE.—To be free from
16 mental and physical abuse, neglect, and exploitation,
17 and to be free from chemical and physical restraints.
18 "(6) RESPECT AND PRIVACY.—To receive respect
19 and privacy in the home care consumer's treatment,
20 care, and services in caring for personal needs, in com-
21 munications, and in all daily activities.
22 "(7) CONFIDENTIALITY.—To be assured of the
23 confidential treatment of personal and financial records
24 and to approve or refuse the release of such records to

1 any individuals outside the agency except as otherwise
2 required by law or third-party payment contract.
3 "(8) EXERCISE OF RIGHTS.—To be free to fully
4 exercise the consumer's civil rights and to be assisted
5 in doing so when assistance is needed.
6 "(9) TRANSITION OF SERVICES.—To receive as-
7 sistance to assure a smooth transition in services con-
8 sistent with the welfare of the home care consumer.
9 "(b) HOME AND COMMUNITY-BASED PROVIDER QUAL-
10 ITY ASSURANCE REQUIREMENTS.—
11 "(1) IN GENERAL.—In addition to such other re-
12 quirements as may apply, the Secretary shall promul-
13 gate regulations that require that in order to receive
14 funding under this title for the provision of home or
15 community-based services (hereinafter referred to in
16 this section as 'services'), all qualified providers shall,
17 not later than 6 months after the date of the publica-
18 tion of such regulations—
19 "(A) comply with the consumers' bill of
20 rights promulgated under subsection (a);
21 "(B)(i) implement procedures for promptly re-
22 viewing and resolving the grievances of consum-
23 ers; and
24 "(ii) provide an oral notification and a writ-
25 ten copy of such procedures to each consumer (or

1 the representative or guardian of the consumer)
2 who receives services provided by a qualified pro-
3 vider;
4 "(C) ensure that each provider employed by
5 or under contract with a home care or home
6 health agency receives training—
7 "(i) sufficient to meet a level of profi-
8 ciency established by the Secretary in regu-
9 lations (in consultation with representatives
10 of the elderly, disabled, and children, home
11 health and home care agencies, and experts
12 in the fields of geriatric nursing, pediatric
13 nursing, geriatric social work, pediatric social
14 work, mental health, rehabilitation, and other
15 appropriate health care professionals) that
16 are appropriate in content and amount as are
17 consistent with the requirements of section
18 4021(b) of the Omnibus Budget Reconcilia-
19 tion Act of 1987;
20 "(ii) that develops separate levels of
21 proficiency in and is reflective of the range of
22 skills required of providers that provide dif-
23 ferent levels of services; and
24 "(iii) the extent of which shall be made
25 available on request to each consumer with

1 respect to the amount of training or level of
2 certification achieved by each provider;
3 "(D) supervise all care providers employed
4 by or under contract with a qualified provider in
5 accordance with regulations promulgated by the
6 Secretary (including regular random on-site super-
7 visory visits by registered nurses or other appro-
8 priate health care professionals); and
9 "(E) perform annual evaluations of the qual-
10 ity of services provided by providers employed by
11 or under contract with a qualified provider that
12 shall document consumer involvement through a
13 process that shall include client interviews.
14 "(2) DURABLE MEDICAL EQUIPMENT SERV-
15 ICES.—In addition to such other requirements as may
16 apply, to receive funding for the provision of durable
17 medical equipment services under this title, a qualified
18 provider shall in each case of a consumer to which
19 such services are provided—
20 "(A) issue written instructions for the oper-
21 ation of such equipment;
22 "(B) provide sufficient training to the con-
23 sumer, the family of the consumer, and the staff
24 to permit the appropriate and safe operation of all
25 such equipment; and

1 "(C) formulate an emergency plan that is ap-
2 propriate for the services provided to the home
3 care consumer.
4 "(c) CASE MANAGEMENT AGENCY QUALITY ASSUR-
5 ANCE REQUIREMENTS.—In addition to such other require-
6 ments as may apply, the Secretary shall promulgate regula-
7 tions requiring that an agency, to receive funding for the pro-
8 vision of case management services under this Act, shall, not
9 later than 6 months after the date of the publication of such
10 regulations—
11 "(1)(A) comply with the consumers' bill of rights
12 promulgated under subsection (a); and
13 "(B) provide an oral notification and a written
14 copy of such bill of rights to each consumer (or the
15 representative or guardian of the consumer) who re-
16 ceives services under this Act;
17 "(2)(A) implement procedures for the prompt
18 review and resolution of the grievances of consumers;
19 and
20 "(B) provide an oral notification and a written
21 copy of such procedures to each consumer (or the rep-
22 resentative or guardian of such consumer) who receives
23 services from the agency;
24 "(3) provide to each consumer (or the representa-
25 tive or guardian of the consumer) a written statement

1 of the services to be provided to the consumer and the
2 schedule for the provision of such services, as agreed
3 on by the consumer;

4 "(4) provide to each consumer a clear written
5 statement as to how the consumer (or the representa-
6 tive or guardian of the consumer), may appeal the ben-
7 efit and level decisions made by the agency;

8 "(5) maintain procedures that assure prompt
9 access by eligible consumers to services;

10 "(6) ensure that the personnel that provide case
11 management services to each consumer have received
12 adequate training as prescribed in regulations promul-
13 gated by the Secretary, in consultation with the appro-
14 priate Home Care Quality Assurance Board; and

15 "(7) establish and implement case management
16 procedures that shall include—

17 "(A) a plan of care that establishes reasona-
18 ble and measurable client objectives and the serv-
19 ices to be provided to meet such objectives;

20 "(B) a plan of care that employs outcome
21 measures of care insofar as they are appropriate
22 and available for each consumer served;

23 "(C) methods for a review that shall be con-
24 ducted at least once during every 3-month period
25 of—

1 "(i) the needs of the consumer; and
2 "(ii) the plan of care for the consumer;
3 "(D) methods for follow-up and on-going
4 monitoring of patient and services delivery; and
5 "(E) a statement of the criteria and proce-
6 dures to be applied for the discharge or transfer of
7 the consumer to another agency, program, or
8 service.
9 "(d) STANDARD AND EXTENDED SURVEY.—Section
10 1891(c) and (d) of the Social Security Act (42 U.S.C.
11 1395bbb(c) and (d)) shall apply to home health agencies certi-
12 fied to receive payments for services provided under this title.
13 "(e) SURVEY.—The Secretary shall develop and imple-
14 ment a standard and extended survey of home care agencies
15 certified to receive payments for services provided under this
16 title.
17 **"SEC. 2619. CERTIFICATION.**
18 "(a) REQUIREMENT.—
19 "(1) IN GENERAL.—A State shall—
20 "(A) survey home care agencies, home
21 health agencies, and adult day health care centers
22 to determine their eligibility to participate in the
23 program established under this part; and
24 "(B) certify such an agency or center as eli-
25 gible to participate in such program if the agency

1 meets the requirements of this part and regula-
2 tions prescribed by the Secretary.
3 "(2) FREQUENCY.—A State shall conduct the
4 survey and certification required under paragraph (1)
5 not less than once during each fiscal year.
6 "(b) INDIVIDUAL PROVIDERS.—
7 "(1) IN GENERAL.—To be eligible to be reim-
8 bursed for services covered under this part, a qualified
9 service provider referred to in section 2614 shall be li-
10 censed or, if applicable, certified by the State in which
11 the provider practices pursuant to the requirements of
12 this part and regulations prescribed by the Secretary.
13 "(2) HOMEMAKERS AND HOME HEALTH
14 AIDES.—To be reimbursed for services covered under
15 this part, a homemaker or home health aide must be a
16 trained employee of a certified home care or home
17 health agency working under professional supervision.
18 "(3) WAIVER.—The Secretary may waive the
19 certification requirement for providers that do not pro-
20 vide direct patient care.
21 **"SEC. 2620. REIMBURSEMENT.**
22 "(a) ACCEPTANCE OF REFERRALS AND REIMBURSE-
23 MENT.—
24 "(1) IN GENERAL.—Except as provided in para-
25 graph (2), a home health or home care agency or other

1 provider certified by a State to provide services reim-
2 bursable under this part shall provide services to all in-
3 dividuals referred to the provider by a Case Manage-
4 ment Agency or by an organization under contract
5 with the agency to provide case management services
6 and accept as payment in full the reimbursement
7 amounts provided under this part.

8 "(2) EXCEPTION.—The service requirement im-
9 posed under paragraph (1) shall not apply if the re-
10 quirement would be in conflict with the operating poli-
11 cies under which the provider was certified (such as
12 the maximum number of individuals an agency may
13 care for at any time).

14 "(b) ADDITIONAL SERVICES.—Nothing contained in
15 this part shall be construed to preclude any individual who is
16 eligible to receive services under this part from purchasing
17 home and community-based services that are more generous
18 than services provided for in the care plan of the individual.
19 If an individual purchases more generous services, a provider
20 may not charge such individual higher rates for such services
21 than the amount the provider is reimbursed under this part.

22 "(c) RELATIONSHIP TO OTHER ENTITLEMENT PRO-
23 GRAMS.—Notwithstanding any other provision of law, in the
24 case of any service covered under this part that is also cov-
25 ered under another Federally administered entitlement pro-

1 gram, the Secretary shall act as a secondary payer under this
2 part.
3 "(d) REIMBURSEMENT.—Reimbursement for services
4 provided under this part shall be subject to the requirements
5 of this part and regulations prescribed by the Secretary.

6 "PART C—COVERAGE OF FIRST 6 MONTHS OF
7 NURSING HOME CARE

8 "SEC. 2621. BENEFITS.

9 "(a) IN GENERAL.—Subject to subsection (c), an indi-
10 vidual who meets the eligibility criteria prescribed in section
11 2622 shall be eligible under the program established by this
12 part for coverage for services described in subsection (b) pro-
13 vided to the individual by a nursing facility that are required
14 by the individual, while the individual is an inpatient of the
15 facility, for a period of time not to exceed 6 months for a spell
16 of illness.
17 "(b) TYPES.—Coverage may be provided under this
18 part for—
19 "(1) nursing care provided by or under the super-
20 vision of a registered professional nurse;
21 "(2) bed and board in connection with the furnish-
22 ing of nursing care;
23 "(3) physical, occupational, or speech therapy fur-
24 nished by a facility or by others under arrangements
25 with a facility;

1 "(4) medical social services;

2 "(5) drug, biological, supply, appliance, and equip-
3 ment for use in the facility, that is ordinarily furnished
4 by the facility for the care and treatment of an inpa-
5 tient;

6 "(6) medical service of an intern or resident-in-
7 training under an approved teaching program of a hos-
8 pital with which a facility has in effect a transfer
9 agreement or other diagnostic or therapeutic service
10 provided by a hospital with which a facility has in
11 effect a transfer agreement; and

12 "(7) such other health services necessary to the
13 health of a patient as are generally provided by a nurs-
14 ing home facility.

15 "(c) BENEFITS AFTER COVERED STAYS.—An individ-
16 ual shall be eligible for additional nursing home coverage
17 under this part subsequent to a covered stay if—

18 "(1) the individual has not been an inpatient in a
19 hospital or nursing facility for at least 6 consecutive
20 months after any covered stay; and

21 "(2)(A) the individual has a diagnosis that is dif-
22 ferent than that provided for the preceding nursing
23 home stay; or

"(B) there has been a substantial worsening of the condition of the individual since the latest discharge of the individual.

"SEC. 2622. ELIGIBILITY.

"(a) IN GENERAL.—An individual shall be eligible for benefits under this part if—

"(1)(A) the individual is—

"(i) 65 years of age or older; or

"(ii) eligible for benefits under Part A of title XVIII of the Social Security Act (42 U.S.C. 1395 et seq.) as the result of disability; and

"(B) has been determined by a Screening Agency through a screening process (conducted in accordance with section 2602) to be—

"(i) completely dependent with respect to at least one activity of daily living or unable to perform two or more activities of daily living without human assistance or supervision; or

"(ii) so cognitively impaired (due to adult onset or acquired chronic organic disease of the brain, occurring in clear consciousness, and including those individuals who would meet such criteria except for the presence of a transient delirium in such individuals) as to require substantial supervision from another individual because such

1 impaired individual engages in inappropriate be-
2 havior that poses a substantial health and safety
3 hazard to such impaired individual or to others;
4 "(2)(A) the individual is under 19 years of age;
5 and
6 "(B) has been determined by a Screening Agency
7 through a screening process (conducted in accordance
8 with section 2602)—
9 "(i) to be unable to perform two or more
10 age-appropriate activities of daily living without
11 human assistance or supervision; or
12 "(ii) to require both a medical devise to com-
13 pensate for the loss of a vital body function that is
14 necessary to avert death or major loss of bodily
15 functional capacity and substantial and ongoing
16 nursing care to avert death or further disability;
17 "(3) the individual (or legal guardian) has filed an
18 application for such benefits, and is in need of, benefits
19 covered under this title;
20 "(4) receiving nursing home services in a nursing
21 facility would be in the best interest of the individual;
22 and
23 "(5) the Secretary determines that the individual
24 meets the eligibility requirements imposed under this
25 subsection.

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

6 **"SEC. 2623. LIMITATIONS ON PAYMENT.**

7 "(a) IN GENERAL.—Monthly reimbursement for nursing
8 home services covered under this part shall be an amount the
9 Secretary determines to be reasonable and appropriate,
10 taking into account the average cost of providing appropriate
11 care.

12 "(b) PROSPECTIVE PAYMENT.—To the extent feasible,
13 the Secretary shall establish a prospective payment mecha-
14 nism for payment for nursing home services covered under
15 this part that takes into account the expected resource utili-
16 zation of individual patients based on the degree of impair-
17 ment of the patients and other factors affecting service re-
18 quirements.

19 **"SEC. 2624. REIMBURSEMENT.**

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

1 "SEC. 2625. RELATIONSHIP TO OTHER ENTITLEMENT PRO-
2 GRAMS.

3 "Notwithstanding any other provision of law, in the
4 case of any service covered under this part that is also cov-
5 ered under any other Federally administered entitlement pro-
6 gram, the Secretary shall act as a secondary payer under this
7 part.

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

10 "SEC. 2631. ESTABLISHMENT OF FEDERAL LONG-TERM CARE
11 INSURANCE PROGRAM.

12 "The Secretary shall establish an optional insurance
13 program for individuals 45 and over to cover nursing home
14 stays that exceed 6 months.

15 "SEC. 2632. ELIGIBILITY.

16 "(a) DETERMINATION.—
17 "(1) IN GENERAL.—A Screening Agency shall
18 determine whether an individual is eligible to receive
19 benefits covered under this part.
20 "(2) SCREENING TOOL.—The agency shall use
21 the same screening the first 6 months of nursing home
22 care under part C in order to determine the continued
23 need of an individual for nursing home care and there-
24 fore eligibility for benefits under this part.
25 "(3) PERIODIC EVALUATION.—The Case Man-
26 agement Agency shall continue to make such an eval-

1 uation periodically, pursuant to regulations of the Sec-
2 retary, as long as an individual remains in a nursing
3 home.
4 "(b) ELECTION OF COVERAGE.—
5 "(1) IN GENERAL.—Subject to the other provi-
6 sions of this subsection, an individual shall have the
7 option to purchase coverage under this part at 45
8 years of age or at 65 years of age.
9 "(2) INITIAL YEAR.—During the 1-year period
10 beginning on the effective date of this part, an individ-
11 ual who is 45 years of age or over shall be eligible to
12 purchase insurance under this part, except that such an
13 individual shall not be eligible to purchase insurance
14 while confined to a hospital or nursing home or within
15 6 months after a period of confinement in a nursing
16 home or 90 days after a period of confinement in a
17 hospital.
18 "(3) EXTENSION BEYOND INITIAL YEAR.—If an
19 individual is confined to a nursing home or hospital
20 during a period that extends beyond the first year after
21 the effective date of this part, an individual shall be eli-
22 gible to enroll in the program established by this part
23 during the 60-day period beginning after the individ-
24 ual's first spell of illness.

1 "(4) SUBSEQUENT YEARS.—During years subse-
2 quent to the period referred to in paragraph (2), an in-
3 dividual shall be eligible to purchase insurance under
4 this part within 6 months of the 45th or 65th birthday
5 of the individual.

6 "(5) ACTIVATION OF BENEFITS.—To receive cov-
7 erage under the insurance program established by this
8 part, an individual shall have purchased such coverage
9 at least 1 month prior to admission to a nursing facili-
10 ty, unless the reason for the need of services is because
11 of an accident or stroke subsequent to the date that
12 such individual signed up for coverage under this part.

13 **"SEC. 2633. PREMIUM RATES.**

14 "(a) IN GENERAL.—The Secretary shall determine one
15 premium rate for individuals electing to purchase coverage
16 under this part at age 45 (or between ages 45 and 64 during
17 the initial enrollment period) and a separate rate for those
18 who elect such coverage at age 65 (or at age 65 and over
19 during the initial enrollment period).

20 "(b) REVISION.—The Secretary shall revise the premi-
21 ums annually.

22 "(c) RATES.—In developing premium rates under the
23 program established by this part, the Secretary shall establish
24 rates that are expected to cover 45 percent of the estimated

1 costs of nursing home stays that exceed 6 months for those
2 individuals enrolled in the program.

3 "(d) COST SHARING FOR LOW-INCOME INDIVID-
4 UALS.—

5 "(1) IN GENERAL.—Subject to paragraph (2), the
6 Secretary shall pay—

7 "(A) an amount equal to 100 percent of the
8 amount of the premium charged an eligible indi-
9 vidual under this section if the income of the indi-
10 vidual does not exceed 100 percent of the poverty
11 line for a single individual (as defined in section
12 673(2) of the Community Services Block Grant
13 Act (42 U.S.C. 9902(2)));

14 "(B) an amount equal to 75 percent of the
15 amount of the premium charged an eligible indi-
16 vidual under this section if the income of the indi-
17 vidual is between 100 percent and 150 percent of
18 the poverty line for a single individual (as defined
19 in section 673(2) of the Community Services
20 Block Grant Act (42 U.S.C. 9902(2))); and

21 "(C) an amount equal to 50 percent of the
22 amount of the premium charged an eligible indi-
23 vidual under this section if the income of the indi-
24 vidual is between 150 percent and 200 percent of
25 the poverty line for a single individual (as defined

1 in section 673(2) of the Community Services
2 Block Grant Act (42 U.S.C. 9902(2))).
3 "(2) MINIMUM PAYMENT.—Notwithstanding
4 paragraph (1), an eligible individual who elects to pur-
5 chase insurance under this part shall pay not less than
6 $5 per month as part of the premium for such insur-
7 ance.

8 **"SEC. 2634. BENEFITS.**

9 "(a) TYPES.—An eligible individual who elects to pur-
10 chase insurance under this part shall be eligible to receive
11 from a nursing facility for an unlimited period of time (contin-
12 gent on the continued need of the individual for services)—
13 "(1) nursing care, provided by or under the super-
14 vision of a registered professional nurse;
15 "(2) physical, occupational, or speech therapy fur-
16 nished by the facility or by others under arrangements
17 with the facility;
18 "(3) medical social services;
19 "(4) drugs, biologicals, supplies, appliances, and
20 equipment for use in the facility, that are ordinarily
21 furnished by the facility for the care and treatment of
22 inpatients;
23 "(5) medical services of interns and residents-in-
24 training under an approved teaching program of a hos-
25 pital with which the facility has in effect a transfer

1 agreement and other diagnostic or therapeutic services
2 provided by a hospital with which the facility has in
3 effect a transfer agreement; and
4 "(6) such other health services necessary to the
5 health of patients as are generally provided by nursing
6 facilities.
7 "(b) DURATION.—The duration of benefits covered
8 under this part shall be unlimited as long as the Case Man-
9 agement Agency determines, through its periodic review of a
10 patient, that the patient continues to require nursing home
11 services.
12 **"SEC. 2635. QUALIFIED SERVICE PROVIDERS.**
13 "(a) IN GENERAL.—Covered nursing home services
14 under this part shall be provided by qualified service
15 providers.
16 "(b) TYPES.—A provider shall be considered a qualified
17 service provider under this part if the provider is a nursing
18 facility that is certified by the State and meets the require-
19 ments of this part and any other standards established by the
20 Secretary by regulation for the safe and efficient provision of
21 services covered under this part.
22 **"SEC. 2636. REIMBURSEMENT.**
23 "(a) AMOUNT.—Monthly reimbursement for nursing
24 home services under this part shall be 65 percent of the
25 amount the Secretary determines to be reasonable and appro-

1 priate to cover the cost of care provided under this part,
2 taking into account the average cost of providing appropriate
3 care in the most efficient manner.

4 "(b) PROSPECTIVE PAYMENT.—To the extent feasible,
5 the Secretary shall establish a prospective payment mecha-
6 nism for payment for nursing home services under this part
7 that takes into account the expected resource utilization of
8 individual patients based on their degree of disability and
9 other factors determining service requirements.

10 "(c) ROOM AND BOARD.—

11 "(1) IN GENERAL.—Notwithstanding section
12 2632(b)(2), payment for room and board under this part
13 shall be made by an individual participating in the pro-
14 gram established by this part for those days spent in a
15 nursing facility beyond 6 months.

16 "(2) MANNER OF PAYMENT.—Such payments for
17 room and board shall be made by an individual directly
18 to the nursing facility.

19 "(3) RATES.—Charges for room and board shall
20 be 35 percent of the average per diem rate paid by the
21 Secretary to nursing facilities receiving reimbursement
22 under this part.

1 "PART E—TRAINING AND RESEARCH

2 "SEC. 2641. GRANTS FOR TRAINING FOR HOME AND COMMUNI-
3 TY-BASED CARE FOR THE ELDERLY.

4 "(a) IN GENERAL.—The Secretary shall make grants to
5 schools of nursing, social work, allied health, and public
6 health of accredited universities to develop and conduct pro-
7 grams to train individuals in the provision, supervision, plan-
8 ning, and analysis of home and community-based care and
9 nursing home care for the elderly, disabled, and chronically ill
10 children and in the administration of such programs.

11 "(b) USE OF FUNDS.—Funding made available under
12 this section may be used for curriculum development, faculty
13 support, and traineeships and fellowships.

14 "(c) GRANT PREFERENCES.—In awarding grants under
15 this section, the Secretary shall give a preference to pro-
16 grams that—

17 "(1) provide for the development or conduct of
18 programs for continuing education and certification of
19 professionals currently working in the field of geriatric
20 health in the provision of services to the chronically
21 impaired and working in the field of pediatric care spe-
22 cialization in the provision of care services to chron-
23 ically ill, disabled, and medical technology dependent
24 children;

25 "(2) have established or will establish affiliations
26 with nursing homes, agencies providing home and com-

1 munity-based care, senior citizen centers, adult day
2 care centers, and other institutions and agencies pro-
3 viding health and social services to the impaired elder-
4 ly, for the purpose of providing in-service training to
5 individuals being trained at the grant-receiving institu-
6 tion and technical assistance to the institution provid-
7 ing services; and

8 "(3) have established or will establish affiliations
9 with programs of geriatric training based in accredited
10 medical schools or schools of nursing, or both.

11 "(d) AUTHORIZATION OF APPROPRIATIONS.—There
12 are authorized to be appropriated to carry out this section
13 $15,000,000 for fiscal year 1991, $20,000,000 for fiscal year
14 1992, and $25,000,000 for fiscal year 1993.

15 **"SEC. 2642. GRANTS FOR HOME HEALTH AIDES.**

16 "(a) IN GENERAL.—The Secretary shall make grants to
17 State approved programs (that meet requirements established
18 by the Secretary relating to minimum course hours, curricu-
19 lum content, competency evaluation, and qualifications of in-
20 structors) to develop and conduct programs to train individ-
21 uals in the provision of home health aide services. Such train-
22 ing programs shall be designed and conducted according to
23 guidelines and requirements established by the Secretary by
24 regulation.

1 "(b) GRANT PREFERENCES.—Preference shall be given
2 to programs that have established or will have established
3 affiliations with nursing homes, agencies providing home and
4 community-based care, senior citizen centers, adult day
5 health care centers, and other institutions providing health
6 and social services to the impaired elderly, for the purpose of
7 providing in-service training to individuals being trained at
8 the grant-receiving program and technical assistance to the
9 institution providing services.
10 "(c) AUTHORIZATION OF APPROPRIATIONS.—There
11 are authorized to be appropriated to carry out this section
12 $10,000,000 for each of the fiscal years 1991 and 1992 and
13 $25,000,000 for fiscal year 1993.
14 **"SEC. 2643. GRANTS FOR MODEL CONSUMER TRAINING PRO-**
15 **GRAMS.**
16 "(a) IN GENERAL.—The Secretary shall make grants
17 available to accredited university schools of nursing to devel-
18 op model consumer training programs. Such programs shall
19 provide information and training about the delivery of home
20 care services for caregivers as well as general information
21 about the home and community-based care service system for
22 consumers or potential consumers of home care or home
23 health services, or both, pursuant to regulations established
24 by the Secretary.

"(b) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated to carry out this section $5,000,000 for fiscal year 1991, $10,000,000 for fiscal year 1992, and $15,000,000 for fiscal year 1993.

"SEC. 2644. CENTERS FOR LONG-TERM CARE PLANNING AND TECHNICAL ASSISTANCE.

"(a) IN GENERAL.—The Secretary shall through grants or contracts, or both, assist public or private nonprofit entities in meeting the costs of planning and developing new centers, and operating existing and new centers, for multidisciplinary health planning development and assistance under this section for the purpose of—

"(1) assisting the Secretary in carrying out this part;

"(2) providing such technical and consulting assistance as States may require;

"(3) conducting research, studies, and analysis of planning and resource development for the provision of long-term care services; and

"(4) developing long-term care planning approaches, methodologies, policies, and standards.

"(b) NUMBER OF CENTERS.—The Secretary shall provide assistance under this section so that at least 6 such centers shall be in operation by January 1, 1992.

1 "(c) CASE-MANAGEMENT AGENCIES.—Agencies as-
2 sisted under this section—
3 "(1) may enter into arrangements with Case Man-
4 agement Agencies for the provision of such services as
5 may be appropriate and necessary in assisting the
6 agencies in performing their functions under this part;
7 and
8 "(2) shall develop and use methods (satisfactory to
9 the Secretary) to disseminate to such agencies long-
10 term care planning approaches, methodologies, policies,
11 and standards.
12 "(d) STAFF.—
13 "(1) DIRECTOR.—Each center shall have a full-
14 time director who possesses a demonstrated capacity
15 for substantial accomplishment and leadership in the
16 field of planning and resource development in the area
17 of long-term care.
18 "(2) ADDITIONAL STAFF.—Each center shall
19 employ such other additional staff as may be appropri-
20 ate. The staff of the center shall meet such additional
21 requirements as the Secretary may by regulation pre-
22 scribe.
23 "(e) AUTHORIZATION OF APPROPRIATIONS.—There
24 are authorized to be appropriated to carry out this section

1 $10,000,000 for fiscal year 1991 and $15,000,000 for each
2 of the fiscal years 1992 and 1993.

3 **"PART F—DEMONSTRATION PROJECTS**

4 **"SEC. 2651. DEMONSTRATION PROJECTS FOR SERIOUSLY MEN-**
5 **TALLY ILL INDIVIDUALS.**

6 "(a) IN GENERAL.—The Secretary shall conduct at
7 least 5 (but not more than 10) demonstration projects to de-
8 termine the relative effectiveness, cost, and impact on quality
9 of long-term home care of using different models of providing
10 and reimbursing long-term home care services for seriously
11 mentally ill individuals and family caregivers.

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

16 "(1) has schizophrenia, bipolar or unipolar disor-
17 der or other significant mental illness that restrict the
18 ability of the individual to function in activities of daily
19 living, employment, and social interaction;

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

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

1 "(c) REQUIREMENTS.—Demonstration projects con-
2 ducted under this section shall—
3 "(1) each be conducted over a period of 3 years;
4 "(2) be conducted in sites that are chosen to be
5 geographically diverse and include at least one rural
6 site;
7 "(3) be sensitive to the needs of racial and ethnic
8 minorities;
9 "(4) include outreach and case management ac-
10 tivities;
11 "(5) be responsive to family needs and concerns
12 and appropriately involve and consult with family
13 members regarding the provision of services under this
14 section;
15 "(6) specify, at the time of application, specific
16 outcome expectations to be met by the project and
17 identify appropriate mechanisms for measuring such
18 outcomes; and
19 "(7) include testing the use of different agencies
20 as Case Management Agencies and providing for the
21 selection of such agencies in consultation with the
22 Comptroller General.
23 "(d) OTHER SERVICES.—Demonstration projects con-
24 ducted under this subsection may—

1 "(1) provide services or reimbursement for nursing
2 care, homemaker or homehealth aide services, psycho-
3 social services, medical services, including the provi-
4 sion, monitoring, and testing of necessary medications,
5 client and family education, training, and counseling,
6 respite care, crisis intervention, information and refer-
7 ral services, and rehabilitation; and
8 "(2) provide services to seriously mentally ill indi-
9 viduals or provide services to home caregivers (includ-
10 ing family members) when such services augment and
11 support home caregivers in the care of seriously men-
12 tally ill individuals.
13 "(e) EVALUATION.—The Secretary shall provide for the
14 evaluation of the projects on a concurrent basis and shall
15 prepare and submit to the appropriate Committees of Con-
16 gress, not later than 18 months after the initiation of the
17 projects and on the completion of the projects, a report on the
18 findings of the evaluation. Such evaluation shall measure the
19 cost and effectiveness of funded projects against the outcome
20 expectations identified in the initial applications and include
21 relevant data on client and family satisfaction and perceived
22 benefits, together with such additional information as the
23 Secretary may consider appropriate.
24 "(f) AUTHORIZATION OF APPROPRIATIONS.—There
25 are authorized to be appropriated to carry out this section for

1 each of the fiscal years 1991, 1992, and 1993, not to exceed
2 $10,000,000 to carry out demonstration projects under this
3 section and not to exceed $1,000,000 to carry out the eval-
4 uation of such projects under subsection (e).

5 "SEC. 2652. DEMONSTRATION PROJECTS FOR WORKING AGE
6 INDIVIDUALS WITH SEVERE FUNCTIONAL LIMI-
7 TATIONS.

8 "(a) IN GENERAL.—The Secretary shall conduct at
9 least 5 and not more than 10 demonstration projects to deter-
10 mine the feasibility of providing long-term home care benefits
11 for working-age individuals with severe functional limitations
12 (as defined in subsection (b)).

13 "(b) DEFINITION.—As used in this section, the term
14 'working-age individual with severe functional limitations'
15 means an individual who is over 18 years of age, but under
16 65 years of age, who is not entitled to benefits under title
17 XVIII of the Social Security Act but who is a chronically ill
18 individual, within the meaning of section 1861(jj)(1)(A)(i) of
19 such Act.

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

22 "(1) shall include, in the items and services cov-
23 ered under long-term home care, personal care serv-
24 ices, short term respite, and emergency assistance and
25 shall permit coverage of items and services provided

1 either by home health agencies or by other qualified
2 persons;
3 "(2) may provide for limited cost-sharing for long-
4 term home care;
5 "(3) shall provide that payment rates for long-
6 term home care provided by persons other than home
7 health agencies shall be comparable to the payment
8 rates for such care provided by home health agencies;
9 "(4) shall provide that each plan of care for an in-
10 dividual shall take into account the capability of the in-
11 dividual to direct the long-term home care of the indi-
12 vidual and to train persons in providing that care;
13 "(5) shall test the effectiveness of consumer-di-
14 rected living centers that are primarily engaged in as-
15 sisting working age individuals with severe functional
16 limitations in maximizing their independence;
17 "(6) shall, to the maximum extent practicable,
18 cover working age individuals with severe functional
19 limitations who—
20 "(A) are at imminent risk of institutionaliza-
21 tion within 30 days if such individual is not pro-
22 vided long-term home care;
23 "(B) are institutionalized but who, if provid-
24 ed long-term home care, could be discharged from
25 the institution; or

1 "(C) need long-term home care to secure or
2 continue employment, to increase independence,
3 to enable present caregivers to secure or continue
4 employment, or to stabilize families;
5 "(7) shall include projects under which personal
6 care services are made available away from the pri-
7 mary residence of the individual, as well as at that res-
8 idence; and
9 "(8) shall include projects under which family
10 members may be employed as caregivers if the family
11 members would be employed if not providing such care
12 or if the individual requires more than 20 hours a week
13 of long-term home care.
14 "(d) CONSULTATION, EVALUATION, REPORT.—
15 "(1) CONSULTATION.—In designing and evaluat-
16 ing the projects conducted under this section, the Sec-
17 retary shall consult with experts in the field of disabil-
18 ity policy and independent living and with groups rep-
19 resenting working age individuals with severe function-
20 al limitations.
21 "(2) EVALUATION.—The Secretary shall provide
22 for the evaluation of the projects conducted under this
23 section on a concurrent basis. Such evaluation shall in-
24 clude an evaluation of the size of the demand, cost, rel-
25 ative effectiveness, and impact on quality of life, of

1 providing long-term home care to working age individ-
2 uals with severe functional limitations.

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

11 "(e) AUTHORIZATION OF APPROPRIATIONS.—There
12 are authorized to be appropriated —

13 "(1) for each of fiscal years 1991, 1992, and
14 1993 not to exceed $10,000,000 to carry out demon-
15 stration projects under this section; and

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

19 **"SEC. 2653. GENERAL AUTHORITY.**

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

1 "(b) Social Security Act.—The Secretary may
2 waive such requirements of title XVIII of the Social Security
3 Act as may be required to carry out demonstration projects
4 under this section.".

5 **SEC. 3. CONFORMING AMENDMENTS.**

6 (a) Section 305(i) of the Public Health Service (42
7 U.S.C. 242c(i)) is amended by striking out "2511" each
8 place it appears and inserting in lieu thereof "2713".

9 (b) Sections 406(a)(2), 480(a)(2), 485(a)(2), and 505(a)(2)
10 of such Act (42 U.S.C. 284a(a)(2), 287a(a)(2), 287c–2(a)(2),
11 and 290aa–3a(a)(2)) are each amended by striking out
12 "2101" and inserting in lieu thereof "2701".

13 (c) Sections 465(f) and 497 of such Act (42 U.S.C. 286f
14 and 289f) are each amended by striking out "2601" and in-
15 serting in lieu thereof "2701".

16 **SEC. 4. EFFECTIVE DATE.**

17 (a) In General.—Except as otherwise provided in this
18 section, this Act and the amendments made by this Act shall
19 become effective on the date of enactment of this Act.

20 (b) Coverage of Home and Community-Based
21 Care Services.—Part B of title XXVI of the Public
22 Health Service Act (as added by section 2 of this Act) shall
23 require payment for services provided in accordance with
24 such part after 1 year after the date of enactment of this Act.

1 (c) COVERAGE FOR NURSING HOME CARE.—Part C of
2 such title shall apply to nursing home care provided in ac-
3 cordance with such part on or after January 1 of the third
4 year that begins after the date of enactment of this Act.
5 (d) FEDERAL LONG-TERM CARE INSURANCE PRO-
6 GRAM.—Part D of such title shall require the establishment
7 of a Federal long-term care insurance program in accordance
8 with such part on and after January of the second year that
9 begins after the date of enactment of this Act. Payment for
10 nursing care under such part shall begin on January 1 of
11 third year that begins after the date of enactment of this Act.
12 (e) TRAINING AND RESEARCH.—Part E of such title
13 shall require training and research programs in accordance
14 with such part on and after January 1, 1991.

○

I

101st CONGRESS
2d Session

H. R. 4070

To provide for universal access to basic group health benefits coverage and to remove barriers and provide incentives in order to make such coverage more affordable.

IN THE HOUSE OF REPRESENTATIVES

February 22, 1990

Mr. Grandy (for himself, Mr. Goodling, and Mr. Bunning) introduced the following bill; which was referred jointly to the Committees on Education and Labor, Ways and Means, and Energy and Commerce

---

A BILL

To provide for universal access to basic group health benefits coverage and to remove barriers and provide incentives in order to make such coverage more affordable.

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 "Universal Health Bene-
5 fits Empowerment and Partnership Act of 1990".
6 **SEC. 2. FINDINGS AND DECLARATION OF POLICY.**
7 (a) Findings.—The Congress finds that—

1 (1) the health care delivery system of the United
2 States provides most Americans with a level of access
3 and quality of care that is unsurpassed;
4 (2) for a significant minority of Americans, the
5 system works less well because they cannot obtain or
6 otherwise do not have basic health care coverage under
7 either public or private programs;
8 (3) these individuals represent a diversity of situa-
9 tions for which there is no single solution;
10 (4) assuring access to basic health care coverage
11 and quality care for these individuals is a compelling
12 national priority that will require commitments from
13 both the private and public sectors;
14 (5) the most practical and effective solutions for
15 these access problems are ones that—
16 (A) preserve the pluralistic base of the health
17 care delivery system of the United States;
18 (B) emphasize incentives, innovation, and the
19 removal of current barriers to access; and
20 (C) recognize that both the complexity of the
21 problem and the existence of fiscal constraints
22 means that responsibility must be shared among
23 employers, employees, insurers, providers, and
24 patients, as well as Federal, State, and local
25 governments;

1 (6) Federal efforts need to be closely coordinated
2 with others who share in the responsibility for improv-
3 ing access to basic health care services;
4 (7) Federal efforts need to reflect not only the di-
5 versity of interested parties but also the diversity of
6 areas where action is appropriate, including public
7 health, basic group health coverage, State initiatives,
8 medical malpractice laws, Medicaid, and tax incentives;
9 and
10 (8) improving access requires dealing with many
11 of the most difficult problems in the health system, in-
12 cluding—
13 (A) the escalating costs, State mandated
14 health benefits, and other factors that have made
15 health care coverage less affordable for many em-
16 ployers and individuals, especially the near poor
17 who need more creative workplace and public op-
18 tions to be able to obtain basic health care cover-
19 age; and
20 (B) the inability of many individuals to pro-
21 tect themselves against catastrophic health care
22 expenses because preexisting conditions make
23 them "uninsurable".
24 (b) PURPOSES.—Therefore the Congress declares the
25 purposes of this Act to be to provide a sound, flexible, and

1 workable Federal framework to simultaneously address the
2 issues of access to basic health care coverage and the afford-
3 ability of such coverage, with an emphasis on improving
4 health care quality by—
5 (1) empowering employers, employees, and other
6 individuals to obtain more affordable basic health care
7 coverage, and
8 (2) providing incentives for private and public-pri-
9 vate partnership arrangements to be established for
10 such purposes.
11 (c) DECLARATION OF POLICY.—In carrying out such
12 purposes, it is the policy of this Act to—
13 (1) provide universal access to basic group health
14 coverage for all Americans under plans offered by em-
15 ployers or, in the case in which such coverage is un-
16 available to employees and other individuals from pri-
17 vate sources or existing public programs, under a State
18 health benefits system; and
19 (2) make such basic health coverage more afford-
20 able—
21 (A) by removing barriers and encouraging
22 "group" plans and arrangements to spread risk
23 and lower expenses;
24 (B) by preempting State health benefit man-
25 dates, thereby encouraging group health coverage

1 providers to offer lower cost basic coverage to the
2 uninsured;
3 (C) by preempting State barriers to the pro-
4 viding of managed care, thereby encouraging com-
5 petition, innovation of cost-control approaches,
6 and quality review;
7 (D) by encouraging the development of treat-
8 ment practice guidelines and outcomes research to
9 aid in reducing unnecessary services, increasing
10 quality care, and reducing malpractice costs;
11 (E) by eliminating tax inequities and
12 barriers—
13 (i) to the full deductibility of contribu-
14 tions to health plans covering the self-em-
15 ployed, and
16 (ii) to the establishment of soundly fi-
17 nanced multiple employer basic group health
18 plans.
19 **SEC. 3. UNIVERSAL COVERAGE UNDER GROUP HEALTH PLANS**
20 **AND STATE HEALTH BENEFITS SYSTEMS.**
21 (a) IN GENERAL.—Subtitle B of title I of the Employee
22 Retirement Income Security Act of 1974 is amended—
23 (1) by striking the heading for part 6 and inserting
24 the following:

1 "**Subpart E—Continuation Coverage Requirements**";

2 (2) by redesignating sections 601 through 608 as

3 sections 641 through 648, respectively; and

4 (3) by inserting after part 5 the following:

5 "PART 6—UNIVERSAL COVERAGE UNDER GROUP HEALTH PLANS

6 AND STATE HEALTH BENEFITS SYSTEMS

7 "**Subpart A—General Provisions**

8 "**SEC. 601. DEFINITIONS AND SPECIAL RULES.**

9 "(a) IN GENERAL.—For purposes of this part—

10 "(1) GROUP HEALTH PLAN.—The term 'group

11 health plan' means an employee welfare benefit plan

12 providing medical care (as defined in section 213(d) of

13 the Internal Revenue Code of 1986) to participants or

14 beneficiaries directly or through insurance, reimburse-

15 ment, or otherwise.

16 "(2) BASIC GROUP HEALTH PLAN.—

17 "(A) IN GENERAL.—The term 'basic group

18 health plan' means a group health plan, or any

19 combination of two or more group health plans,

20 which includes at least a basic health benefits

21 provision.

22 "(B) TREATMENT OF UNINSURABLE

23 RISKS.—A plan which excludes from coverage

24 any individual (who would otherwise be eligible

25 for coverage) solely because the individual is an

26 uninsurable risk shall not be treated as a basic

1 group health plan, unless the requirements of sub-
2 paragraph (D) are met for purposes of this sub-
3 paragraph with respect to such individual.
4 "(C) TREATMENT OF MATERIAL PRE-EX-
5 ISTING CONDITIONS.—A plan which provides
6 coverage to any individual under a substantial re-
7 striction based on a material pre-existing condition
8 shall not be treated as a basic group health plan,
9 unless the requirements of subparagraph (D) are
10 met for purposes of this subparagraph with re-
11 spect to such individual.
12 "(D) EXEMPTION WHERE ADEQUATE
13 STATE HEALTH BENEFITS SYSTEM OR ALTER-
14 NATIVE SYSTEM IS AVAILABLE.—The require-
15 ments of this subparagraph are met with respect
16 to any individual—
17 "(i) for purposes of subparagraph (B), if
18 such individual is eligible for coverage under
19 a health benefits system established and
20 maintained by a State under terms and con-
21 ditions in accordance with subpart C (or any
22 alternative basic health benefits system with
23 respect to which the Secretary of Health and
24 Human Services has made a determination
25 pursuant to section 4 of the Universal Health

1 Benefits Empowerment and Partnership Act
2 of 1990 relating to the element of coverage
3 described in section 4(a)(2)(B)(i) of such Act
4 (relating to treatment of individuals as unin-
5 surable risks)), or
6 "(ii) for purposes of subparagraph (C), if
7 such individual is eligible for coverage for
8 the material pre-existing condition referred to
9 in subparagraph (C) under a health benefits
10 system established and maintained by a State
11 under terms and conditions in accordance
12 with subpart C (or any alternative basic
13 health benefits system with respect to which
14 the Secretary of Health and Human Services
15 has made a determination pursuant to section
16 4 of the Universal Health Benefits
17 Empowerment and Partnership Act of 1990
18 relating to the element of coverage described
19 in section 4(a)(2)(B)(ii) of such Act (relating
20 to treatment of material pre-existing condi-
21 tions)).
22 "(3) BASIC HEALTH BENEFITS PROVISION.—The
23 term 'basic health benefits provision' means, with re-
24 spect to any plan or combination of plans, an arrange-
25 ment which—

1 (A) provides to individuals provided coverage
2 under such plan or combination of plans, directly
3 or through insurance, reimbursement, or other-
4 wise, medical care (as defined in section 213(d) of
5 the Internal Revenue Code of 1986)—

6 "(i) which consists of services deter-
7 mined by the Secretary of Health and
8 Human Services, under regulations pre-
9 scribed by such Secretary pursuant to section
10 3(c) of the Universal Health Benefits
11 Empowerment and Partnership Act of 1990,
12 to consist of basic health care services (in-
13 cluding physician's, inpatient hospital, and
14 outpatient hospital services which are preva-
15 lent under group health plans and other serv-
16 ices which may be necessary for basic health
17 care), and

18 "(ii) which is covered at a percentage of
19 cost determined by such Secretary under
20 such regulations (by means of deductibles,
21 coinsurance, and other limits on covered
22 services) to be not less than a percentage
23 which is, taking into account the population
24 covered and the extent of cost currently cov-

1 ered under group health plans, adequate to
2 meet basic health care needs, and
3 "(B) in the case of any individual described
4 in paragraph (2) (B) or (C) in relation to a basic
5 group health plan maintained by the employer of
6 such individual (or of the person of whom such in-
7 dividual is a dependent), requires contributions by
8 the employer of not less than the amount provided
9 under the plan with respect to individuals covered
10 under such plan who are similarly situated, disre-
11 garding any condition under the plan relating to
12 uninsurable risks (in the case of an individual de-
13 scribed in paragraph (2)(B)) or to material pre-ex-
14 isting conditions (in the case of an individual de-
15 scribed in paragraph (2)(C)).
16 "(4) DEPENDENT.—The term 'dependent' means,
17 with respect to any individual, any person who—
18 "(A) is the spouse or surviving spouse of the
19 individual, or
20 "(B) is, under regulations of the Secretary, a
21 child of such individual who—
22 "(i) is under 18 years of age,
23 "(ii) is under 23 years of age and a full-
24 time student, or

1 "(iii) is otherwise dependent on such
2 individual.
3 "(5) EMPLOYER.—The term 'employer' shall
4 have the meaning applicable under section 3(5), except
5 that such term shall include any State (or political sub-
6 division thereof), or any agency or instrumentality of 1
7 or more of the foregoing.
8 "(6) ELIGIBLE INDIVIDUAL.—The term 'eligible
9 individual' means any employee or dependent thereof
10 who is not covered under a basic group health plan
11 which is maintained by the employer and to which the
12 employer makes contributions, unless such employee or
13 dependent—
14 "(A) was eligible for coverage under such
15 plan but such coverage was declined under such
16 plan, or
17 "(B) is excluded from coverage under the
18 plan as an uninsurable risk but is eligible for unin-
19 surable risk coverage under any health benefits
20 system established and maintained by a State in
21 accordance with subpart C (or any alternative
22 basic health benefits system with respect to which
23 the Secretary of Health and Human Services has
24 made a determination pursuant to section 4 of the
25 Universal Health Benefits Empowerment and

1 Partnership Act of 1990 relating to the element
2 of coverage described in section 4(a)(2)(B)(i) of
3 such Act (relating to treatment of individuals as
4 uninsurable risks)).
5 "(7) UNINSURABLE RISK.—An individual shall be
6 deemed to have been rejected for coverage by a basic
7 group health plan or a health benefits system estab-
8 lished and maintained by a State as an 'uninsurable
9 risk'' if the plan or system supports the denial of
10 coverage—
11 "(A) in such terms, or
12 "(B) in such other terms or under such cir-
13 cumstances as are, subject to such regulations as
14 the Secretary of Health and Human Services may
15 prescribe, reasonably equivalent to such a denial.
16 "(8) MATERIAL PRE-EXISTING CONDITION.—An
17 individual shall be deemed to have been provided cov-
18 erage by a basic group health plan, or by a health ben-
19 efits system established and maintained by a State,
20 under a restriction based on a 'material pre-existing
21 condition' if, subject to such regulations as the Secre-
22 tary of Health and Human Services may prescribe,
23 under the plan or system—

1 "(A) benefits (which would otherwise be pay-
2 able) are not paid solely on the basis of a material
3 pre-existing condition, or
4 "(B) the costs for coverage of the individual
5 with a material pre-existing condition, to either an
6 employer or to the individual, are at a rate mate-
7 rially greater than costs for coverage of similarly
8 situated individuals without such a material pre-
9 existing condition, to the extent such costs are
10 payable to a third party.
11 "(b) CROSS-REFERENCES.—
12 "(1) GENERAL RULE.—Except as otherwise pro-
13 vided in this part, for definitions of terms used in this
14 part, see section 3.
15 "(2) SECRETARY.—Except with respect to refer-
16 ences specifically to the Secretary of Health and
17 Human Services, for the definition of 'Secretary', see
18 section 3(13).
19 "(3) REGULATIONS.—Except with respect to pro-
20 visions for which regulatory authority is specifically
21 provided to the Secretary of Health and Human Serv-
22 ices, for provisions governing regulatory authority
23 under this part, see section 505.

1 "Subpart B—Required Coverage Options; Group Health
2 Payroll Deduction Plans

3 "SEC. 611. COVERAGE FOR ELIGIBLE INDIVIDUALS UNDER
4 BASIC GROUP HEALTH PLANS OR GROUP
5 HEALTH PAYROLL DEDUCTION PLANS.

6 "(a) REQUIREMENT THAT EMPLOYERS OFFER COV-
7 ERAGE FOR ELIGIBLE INDIVIDUALS UNDER BASIC GROUP
8 HEALTH PLANS OR GROUP HEALTH PAYROLL DEDUC-
9 TION PLANS.—Each employer shall maintain with respect to
10 each eligible individual a basic group health plan under which
11 coverage of such individual may be elected or a group health
12 payroll deduction plan (as defined in section 612).

13 "(b) SPECIAL RULES.—

14 "(1) EXCLUSION OF CERTAIN EMPLOYERS.—

15 "(A) IN GENERAL.—This section shall not
16 apply to any employer for any plan year if, as of
17 the beginning of such plan year—

18 "(i) such employer (including any prede-
19 cessor thereof) has been an employer for less
20 than 2 years,

21 "(ii) such employer has no more than 2
22 individuals in such employer's employ, or

23 "(iii) no more than 2 individuals in such
24 employer's employ are not covered under
25 any basic group health plan.

1 "(B) EXCLUSION OF FAMILY MEMBERS.—
2 Under such procedures as the Secretary may pre-
3 scribe, any relative of an employer may be, at the
4 election of the employer, excluded from consider-
5 ation as an employee for purposes of this para-
6 graph. In the case of an employer that is not an
7 individual, an employee who is a relative of a key
8 employee (as defined in section 416(i)(1) of the In-
9 ternal Revenue Code of 1986) of the employer
10 may, at the election of the key employee, be con-
11 sidered a relative excludible under this subpara-
12 graph.
13 "(2) EXCLUSION OF CERTAIN TEMPORARY EM-
14 PLOYEES.—A plan shall not be treated as failing to
15 meet the requirements of this section solely because a
16 period of service by an employee of not more than 60
17 days is required under the plan for coverage of such
18 employee or any dependent thereof under the plan.
19 **"SEC. 612. GROUP HEALTH PAYROLL DEDUCTION PLANS.**
20 "(a) GENERAL RULE.—For purposes of this subpart,
21 the term 'group health payroll deduction plan' means a basic
22 group health plan under which amounts are deducted by the
23 employer from the employee's wages pursuant to an election
24 by the employee and paid as a contribution to such plan in
25 accordance with such regulations as the Secretary may pre-

1 scribe relating to withholding procedures and timely payment
2 of premiums.
3 "(b) ELECTIONS.—
4 "(1) IN GENERAL.—Any election by an employee
5 under a group health payroll deduction plan shall
6 specify the amount which is to be deducted in relation
7 to the benefits provided under the plan. Any such elec-
8 tion may be revoked or changed by the employee
9 under the terms of the plan.
10 "(2) MANNER FOR MAKING OR REVOKING ELEC-
11 TIONS.—Any election under a group health payroll de-
12 duction plan (and any revocation or change of such an
13 election) shall be made in such form and in such
14 manner as the Secretary may by regulations prescribe.
15 **"SEC. 613. AVAILABILITY OF COVERAGE UNDER STATE**
16 **HEALTH BENEFITS SYSTEMS.**
17 "In any case in which there is in effect, as of the begin-
18 ning of a plan year of any group health payroll deduction
19 plan, an entity determined by the Secretary of Health and
20 Human Services to be a health benefits system which is es-
21 tablished and maintained by a State and meets the require-
22 ments of subpart C with respect to the employee, such plan
23 shall not be treated as failing to meet the requirements of
24 section 612(a) for such plan solely because the amounts de-
25 ducted are, under such plan, paid for such plan year or the

1 succeeding plan year as a contribution to such a system ac-
2 cepting coverage of such employee rather than to such plan,
3 if a provider of group health plan coverage with respect to
4 the plan rejects an individual otherwise eligible for coverage
5 under such plan because of a requirement that a certain
6 number or percentage of individuals otherwise eligible for
7 coverage under the plan are not covered.

8 "Subpart C—State Health Benefits Systems

9 **"SEC. 621. GENERAL REQUIREMENTS.**

10 "(a) IN GENERAL.—For purposes of this part, a health
11 benefits system established and maintained by a State in ac-
12 cordance with this subpart is any system which—
13 "(1) is established by State law,
14 "(2) is administered by a nonprofit corporation
15 which is established by and regulated under the laws of
16 such State and with respect to which the requirements
17 of subsection (b) are met,
18 "(3) meets the reporting requirements of section
19 622,
20 "(4) meets the participation requirements of sec-
21 tion 623 with respect to residents of the State,
22 "(5) meets the benefit requirements of section
23 624,
24 "(6) meets the contribution requirements of sec-
25 tion 625, and

1 "(7) provides coverage in accordance with subpart
2 D (relating to uninsurable risks and material pre-exist-
3 ing conditions) with respect to residents of the State.
4 "(b) GOVERNANCE OF SYSTEM.—The requirements of
5 this subsection are met with respect to a corporation referred
6 to in subsection (a)(2) if—
7 "(1) such corporation is governed by a Board of
8 Directors whose membership includes repesentatives of
9 at least employers, employee organizations, and provid-
10 ers of group health plan coverage, and
11 "(2) such corporation is subject under State law
12 to the supervision of an agency of the State which is
13 responsible for the regulation of providers of group
14 health plan coverage.
15 **"SEC. 622. REPORTING REQUIREMENTS.**
16 "(a) IN GENERAL.—A health benefits system estab-
17 lished and maintained by a State meets the reporting require-
18 ments of this section if the system maintains a program under
19 which the system provides, upon the request of group health
20 payroll deduction plans under which amounts are paid from
21 such plans to the system, such information held by the
22 system as the plans require to meet the requirements of part
23 1 of subtitle B of title I.
24 "(b) FORM OF REQUESTS.—Each system shall be re-
25 quired to process requests made under this section only if

1 such requests are made in such form and manner as may be
2 prescribed in regulations of the Secretary.

3 **"SEC. 623. PARTICIPATION REQUIREMENTS.**

4 "(a) IN GENERAL.—A health benefits system estab-
5 lished and maintained by a State meets the participation re-
6 quirements of this section if the system provides that an indi-
7 vidual is provided coverage under the system if such individ-
8 ual—
9 "(1) is an eligible individual (as defined in section
10 601(a)(6)),
11 "(2) is an individual required to be provided cov-
12 erage under subpart E of this part or under title XXII
13 of the Public Health Service Act,
14 "(3) is an individual described in section 632, or
15 "(4) is an individual (other than an individual de-
16 scribed in paragraph (1), (2), or (3)) who is not covered
17 under any arrangement providing basic health care
18 services described in section 601(a)(3)(A),
19 and is not otherwise eligible for coverage under a basic group
20 health plan or under a plan for medical assistance under title
21 XIX of the Social Security Act.

22 "(b) EXCLUSIONS.—A health benefits system estab-
23 lished and maintained by a State does not meet the participa-
24 tion requirements of this section unless such system excludes
25 from coverage—

1 "(1) except to the extent permitted under section
2 625(c)(3), individuals entitled to benefits under title
3 XVIII or XIX of the Social Security Act, or
4 "(2) inmates of public institutions.

5 **"SEC. 624. BENEFITS REQUIREMENTS.**

6 "(a) IN GENERAL.—A health benefits system estab-
7 lished and maintained by a State meets the benefits require-
8 ments of this section if the system provides medical care in
9 the form of at least the following options, available at the
10 election of the individual provided coverage:
11 "(1) BASIC AND CATASTROPHIC BENEFITS.—
12 Coverage of basic health care services (including physi-
13 cian's services, inpatient and outpatient hospital serv-
14 ices, and other services that may be necessary for basic
15 health care), including catastrophic coverage.
16 "(2) CATASTROPHIC ONLY COVERAGE.—Cata-
17 strophic coverage with respect to basic health care
18 services.
19 "(3) BENEFITS EQUIVALENT TO STATE EMPLOY-
20 EE BENEFITS.—Benefits which are equivalent to cov-
21 erage available to a substantial number of employees of
22 the State government.
23 "(b) COST CONTAINMENT AND QUALITY OF CARE.—A
24 health benefits system established and maintained by a State
25 shall, to the maximum extent practicable, taking into account

1 quality of care, provide for a hospital precertification utiliza-
2 tion review program, constraint of costs to the extent practi-
3 cable through the use of appropriately managed care, and
4 such other cost containment procedures as may from time to
5 time be proven effective.

6 "(c) TREATMENT OF UNINSURABLE RISKS AND MATE-
7 RIAL PRE-EXISTING CONDITIONS.—In any case in which
8 the requirements of section 633 are met with respect to any
9 individual with respect to whom the system meets the re-
10 quirements of section 631, the requirements of subsection (a)
11 shall be treated as satisfied with respect to such individual.

12 "(d) DURATION OF COVERAGE.—Subject to section
13 623(b), coverage under a health benefits system established
14 and maintained by a State shall not terminate solely by
15 reason of the termination of a period of coverage required
16 under subpart E of this part or title XXII of the Public
17 Health Service Act.

18 "(e) COVERAGE UNDER STATE SYSTEM SECONDARY
19 TO COVERAGE UNDER EMPLOYEE BENEFIT PLANS.—Cov-
20 erage under a health benefits system established and main-
21 tained by a State with respect to any claim shall be second-
22 ary to coverage provided under any employee benefit plan
23 with respect to such claim.

1 "SEC. 625. CONTRIBUTION REQUIREMENTS.

2 "(a) IN GENERAL.—Except as otherwise provided in
3 this section, a health benefits system established and main-
4 tained by a State meets the contribution requirements of this
5 section if the system does not require, for coverage of individ-
6 uals described in paragraphs (1) and (2) of section 623(a),
7 contributions in excess of levels determined—

8 "(1) on the basis of its own experience with re-
9 spect to covered individuals described in such para-
10 graphs (1) and (2), and

11 "(2) without regard to any coverage provided
12 under the system to individuals who are not described
13 in such paragraphs (1) and (2).

14 "(b) VARIANCES IN RATE LEVEL.—

15 "(1) SEPARATE SCHEDULE REQUIRED FOR CHIL-
16 DREN-ONLY COVERAGE.—A health benefits system es-
17 tablished and maintained by a State does not meet the
18 contribution requirements of this section unless the
19 system provides for a separate schedule of contribu-
20 tions with respect to children-only coverage.

21 "(2) OTHER VARIANCES PERMITTED.—A health
22 benefits system established and maintained by a State
23 shall not be treated as failing to meet the requirements
24 of this section solely because the system otherwise pro-
25 vides for differing rates of contributions to reflect the
26 age, family composition, or income of the covered indi-

1 vidual and the location at which the covered individual
2 is expected to normally receive medical care.
3 "(c) CERTAIN STATE AND OTHER CONTRIBUTIONS
4 PERMITTED.—A health benefits system established and
5 maintained by a State shall not be treated as failing to meet
6 the requirements of this section solely because the system
7 provides for—
8 "(1) payment by the State or any other entity of
9 part or all of the contribution with respect to any cov-
10 ered individual,
11 "(2) varying the amount of such payment based
12 on the individual's income or any other basis, or
13 "(3) payment by the State or any other entity of
14 all or part of monthly premiums for purposes of enroll-
15 ment under section 1818 or 1818A of the Social Secu-
16 rity Act, or of premiums under section 1916(c) of such
17 Act.
18 "(d) MAXIMIZED PARTICIPATION.—A health benefits
19 system established and maintained by a State shall be treated
20 as failing to meet the contribution requirements of this sec-
21 tion if the Secretary of Health and Human Services deter-
22 mines, under regulations prescribed by such Secretary and on
23 the basis of past experience, that, under such system, contri-
24 butions are not established and maintained in such form and
25 manner as to be promotive of participation in the system.

1 "SEC. 626. RECIPROCITY AND RELIANCE BY STATES ON
2 OTHER STATE SYSTEMS.

3 "The requirements of the preceding provisions of this
4 subpart may be met with respect to any State by means of
5 reciprocity agreements between such State and any other
6 State with respect to which such requirements are met.

7 "SEC. 627. REGULATORY AUTHORITY OF SECRETARY OF
8 HEALTH AND HUMAN SERVICES.

9 "The Secretary of Health and Human Services shall
10 prescribe such regulations as such Secretary considers neces-
11 sary to carry out the provisions of this subpart (other than
12 section 622).

13 **"Subpart D—State Coverage for Uninsurable Risks and**
14 **Material Pre-Existing Conditions**

15 "SEC. 631. STATE COVERAGE FOR UNINSURABLE RISKS AND
16 PRE-EXISTING CONDITIONS.

17 "A health benefits system established and maintained by
18 a State provides coverage in accordance with this subpart if
19 such system—

20 "(1) meets the participation requirements of
21 section 632,

22 "(2) meets the benefits requirements of section
23 633, and

24 "(3) to the extent practicable and actuarially
25 sound, provides for separate accounting for such cover-
26 age so as to separately account at least for individuals

1 described in section 632(1)(A) and for individuals de-
2 scribed in section 632(2)(A).

3 "SEC. 632. PARTICIPATION REQUIREMENTS FOR UNINSUR-
4 ABLE RISKS AND MATERIAL PRE-EXISTING
5 CONDITIONS.

6 "A health benefits system established and maintained by
7 a State meets the participation requirements of this section if
8 the system meets the following requirements:

9 "(1) COVERAGE FOR UNINSURABLE RISKS.—The
10 system provides that an individual is provided coverage
11 under the system if such individual—

12 "(A) is an employee (or a dependent thereof)
13 and has been rejected for coverage under a basic
14 group health plan maintained by the employer or
15 by the system but would be eligible for such cov-
16 erage but for the rejection of such employee (or
17 dependent) as an uninsurable risk, or

18 "(B) is not an employee (or dependent) de-
19 scribed in subparagraph (A), and—

20 "(i) is rejected for coverage under the
21 system, or

22 "(ii) in the case of an individual not oth-
23 erwise eligible for coverage under a basic
24 group health plan, the system, or title XIX
25 of the Social Security Act, is rejected for

1 coverage under any policy of insurance
2 which provides at least basic health care
3 services described in section 601(a)(3)(A),
4 but would be eligible for such coverage but for the
5 rejection of such individual as an uninsurable risk.
6 "(2) COVERAGE FOR MATERIAL PRE-EXISTING
7 CONDITIONS.—The system provides that an individual
8 is provided coverage under the system for any material
9 pre-existing condition if such individual—
10 "(A) is an employee (or a dependent thereof)
11 who is provided coverage under a basic group
12 health plan or the system under a substantial re-
13 striction based on such material pre-existing con-
14 dition, or
15 "(B) is not an employee (or dependent) de-
16 scribed in subparagraph (A), and—
17 "(i) is provided coverage under the
18 system under subpart C, or
19 "(ii) in the case of an individual not oth-
20 erwise eligible for coverage under a basic
21 group health plan, the system under subpart
22 C, or title XIX of the Social Security Act, is
23 provided coverage under a policy of insur-
24 ance which provides at least basic health
25 care services,

1 but such coverage is provided under such a sub-
2 stantial restriction.

3 "SEC. 633. BENEFITS REQUIREMENTS FOR UNINSURABLE
4 RISKS AND MATERIAL PRE-EXISTING CONDI-
5 TIONS.

6 "A health benefits system established and maintained by
7 a State meets the benefits requirements of this section if the
8 system provides, directly or through insurance, reinsurance,
9 or otherwise—

10 "(1) in the case of individuals described in section
11 632(1), benefits described in section 624(a), and

12 "(2) in the case of individuals described in section
13 632(2), coverage of the material pre-existing condition
14 which is not otherwise covered to the extent necessary
15 to constitute basic health care services described in
16 section 601(a)(3)(A) with respect to such condition, in
17 accordance with such regulations as the Secretary of
18 Health and Human Services may prescribe.

19 "SEC. 634. REGULATORY AUTHORITY OF SECRETARY OF
20 HEALTH AND HUMAN SERVICES.

21 "The Secretary of Health and Human Services shall
22 prescribe such regulations as such Secretary considers neces-
23 sary to carry out the provisions of this subpart.".

24 (b) Regulations for Defining Basic Health
25 Care Provisions.—

1 (1) INITIAL REGULATIONS.—Not later than
2 July 1, 1991, the Secretary of Health and Human
3 Services shall publish in the Federal Register proposed
4 regulations referred to in section 601(a)(3) of the Em-
5 ployee Retirement Income Security Act of 1989 (as
6 amended by subsection (a)). In prescribing such pro-
7 posed regulations, the Secretary shall take into account
8 recommendations submitted to the Secretary by the
9 Federal Advisory Council on Health Care Coverage
10 and Costs pursuant to section 9(d)(1) of this Act.
11 (2) INTERIM REVIEW PERIOD BEFORE ISSUANCE
12 OF FINAL REGULATIONS.—The Secretary of Health
13 and Human Services shall not issue the regulations re-
14 ferred to in section 601(a)(3) of the Employee Retire-
15 ment Income Security Act of 1974 in final form before
16 July 1, 1992.
17 (3) REVISION OF REGULATIONS.—In revising, on
18 or after the effective date of the amendments made by
19 this section, the regulations referred to in section
20 601(a)(3) of the Employee Retirement Income Security
21 Act of 1974, the Secretary of Health and Human
22 Services shall take into account recommendations sub-
23 mitted to the Secretary by the Federal Advisory Coun-
24 cil on Health Care Coverage and Costs pursuant to
25 section 9(d)(2) of this Act.

1 (c) ENFORCEMENT OF CERTAIN PROVISIONS BY SEC-
2 RETARY OF HEALTH AND HUMAN SERVICES.—Section
3 502(a) of the Employee Retirement Income Security Act of
4 1974 (29 U.S.C. 1132(a)) is amended by adding at the the
5 end, after and below paragraph (6), the following new flush
6 sentence:
7 "With respect to provisions of subparts C and D of part 6
8 (other than section 622), the references to 'Secretary' in
9 paragraph (5), and in other provisions of this part relating to
10 actions brought under such paragraph, shall be deemed a ref-
11 erence to the Secretary of Health and Human Services.".
12 (d) CLERICAL AMENDMENT.—The table of contents in
13 section 1 of such Act is amended by striking out the items
14 relating to part 6 of subtitle B of title I and inserting the
15 following new items:

"PART 6—COVERAGE UNDER GROUP HEALTH PLANS AND STATE HEALTH BENEFITS SYSTEMS

"Subpart A—General Provisions

"Sec. 601. Definitions and special rules.

"Subpart B—Required Coverage Options; Group Health Payroll Deduction Plans

"Sec. 611. Coverage for eligible individuals under basic group health plans or group health payroll deduction plans.
"Sec. 612. Group health payroll deduction plans.
"Sec. 613. Availability of coverage under State health benefits systems.

"Subpart C—State Health Benefits Systems

"Sec. 621. General requirements.
"Sec. 622. Reporting requirements.
"Sec. 623. Participation requirements.
"Sec. 624. Benefits requirements.
"Sec. 625. Contribution requirements.
"Sec. 626. Reciprocity and reliance by States on other State systems.
"Sec. 627. Regulatory Authority of Secretary of Health and Human Services.

"Subpart D—State Coverage for Uninsurable Risks and Material Pre-Existing Conditions

"Sec. 631. State coverage for uninsurable risks and material pre-existing conditions.
"Sec. 632. Participation requirements for uninsurable risks and material pre-existing conditions.
"Sec. 633. Benefit requirements for uninsurable risks and material pre-existing conditions.
"Sec. 634. Regulatory authority of Secretary of Health and Human Services.

"Subpart E—Continuation Coverage Requirements

"Sec. 641. Plans must provide continuation coverage to certain individuals.
"Sec. 642. Continuation coverage.
"Sec. 643. Qualifying event.
"Sec. 644. Applicable premium.
"Sec. 645. Election.
"Sec. 646. Notice requirements.
"Sec. 647. Definitions.
"Sec. 648. Regulations.".

1 **SEC. 4. ALTERNATIVES TO STATE HEALTH BENEFITS**
2 **SYSTEMS.**
3 (a) ALTERNATIVE BASIC HEALTH BENEFITS
4 SYSTEMS.—
5 (1) IN GENERAL.—If, at any time before the ef-
6 fective date for the amendments made by section 3, the
7 Secretary of Health and Human Services determines,
8 under regulations prescribed by the Secretary—
9 (A) that there is in effect, with respect to
10 any group of individuals, an arrangement which is
11 an alternative basic health benefits system, and
12 (B) that, with respect to such group of indi-
13 viduals, such system meets requirements (provided
14 in such regulations) for a specified element of cov-
15 erage which are substantially equivalent to the re-
16 quirements of the specified ERISA provision

1 which is applicable to such specified element of
2 coverage,
3 then the requirements of such specified ERISA provi-
4 sion shall be treated as met with respect to such indi-
5 viduals until such Secretary nullifies such determina-
6 tion under such regulations.
7 (2) DEFINITIONS AND SPECIAL RULES.—For
8 purposes of this subsection—
9 (A) ALTERNATIVE BASIC HEALTH BENE-
10 FITS SYSTEM.—The term "alternative basic
11 health benefits system" means, with respect to
12 any group of individuals, any arrangement (other
13 than a health benefits system established and
14 maintained by a State in accordance with subpart
15 C of part 6 of subtitle B of title I of ERISA)
16 which—
17 (i) includes at least a basic health bene-
18 fits provision (as defined in section 601(a)(3)
19 of ERISA), and
20 (ii) meets, with respect to such individ-
21 uals, the reporting requirements of section
22 622 of ERISA, the participation require-
23 ments of section 623 of ERISA, the benefits
24 requirements of section 624 of ERISA, and

1 the contribution requirements of section 625
2 of ERISA.
3 (B) SPECIFIED ELEMENT OF COVERAGE.—
4 The term "specified element of coverage" means
5 any of the following:
6 (i) TREATMENT OF UNINSURABLE
7 RISKS.—Rejection by a plan of an individual
8 for coverage as an uninsurable risk, within
9 the meaning of section 601(a)(7) of ERISA.
10 (ii) TREATMENT OF MATERIAL PRE-
11 EXISTING CONDITIONS.—Provision of cover-
12 age by a plan to an individual under a re-
13 striction based on a material pre-existing
14 condition, within the meaning of section
15 601(a)(8) of ERISA.
16 (iii) PROVISION OF CONTINUATION COV-
17 ERAGE.—Provision of coverage by a plan to
18 qualified beneficiaries required under subpart
19 E of part 6 of subtitle B of title I of ERISA
20 or under title XXII of the Public Health
21 Service Act.
22 (C) SPECIFIED ERISA PROVISIONS.—
23 (i) TREATMENT OF UNINSURABLE
24 RISKS.—The "specified ERISA provision"
25 applicable to the specified element of cover-

1 age described in subparagraph (B)(i) is sec-
2 tion 601(a)(2)(D)(i) of ERISA.
3 (ii) TREATMENT OF MATERIAL PRE-
4 EXISTING CONDITIONS.—The "specified
5 ERISA provision" applicable to the specified
6 element of coverage described in subpara-
7 graph (B)(ii) is section 601(a)(2)(D)(ii) of
8 ERISA.
9 (iii) PROVISION OF CONTINUATION COV-
10 ERAGE.—The "specified ERISA provisions"
11 applicable to the specified element of cover-
12 age described in subparagraph (B)(iii) are
13 section 641(b) of ERISA, section 4980B(f)(8)
14 of the Internal Revenue Code of 1986 (as
15 amended by section 3(b)), and section
16 2201(b) of the Public Health Service Act (as
17 amended by section 5(c)).
18 (D) STATE.—The term "State" has the
19 meaning provided in section 3(10) of ERISA.
20 (E) ERISA.—The term "ERISA" means
21 the Employee Retirement Income Security Act of
22 1974, as amended by this Act.
23 (b) FEDERAL ASSISTANCE IN ESTABLISHMENT OF
24 UNIVERSAL COVERAGE.—

1 (1) GRANT PROGRAM.—The Secretary of Health
2 and Human Services shall establish by regulation a
3 program of monetary assistance in the form of grants
4 to health benefits systems established and maintained
5 by States (within the meaning of section 3(10) of the
6 Employee Retirement Income Security Act of 1974)
7 pursuant to the amendments made by this Act and to
8 alternative basic health benefits systems with respect
9 to which such Secretary has made determinations de-
10 scribed in subparagraphs (A) and (B) of subsection
11 (a)(1). Grants to any system shall be in such amount as
12 such Secretary considers appropriate to facilitate the
13 effectuation of the policies of this Act.
14 (2) AUTHORIZATION OF APPROPRIATIONS.—
15 There is authorized to be appropriated for the Depart-
16 ment of Health and Human Services, for the purpose
17 of carrying out the provisions of paragraph (1),
18 $200,000,000 for each of the fiscal years 1991, 1992,
19 and 1993.

20 **SEC. 5. CONTINUATION COVERAGE AND STATE HEALTH BENE-**
21 **FITS SYSTEMS OR ALTERNATIVE SYSTEMS.**

22 (a) AMENDMENT TO ERISA.—Section 641(b) of the
23 Employee Retirement Income Security Act of 1974 (as re-
24 designated by section 3) is amended to read as follows:

1 "(b) SUBSTITUTION OF STATE HEALTH BENEFITS
2 SYSTEM OR ALTERNATIVE SYSTEM.—The requirements of
3 this subpart may be met by providing, as an option to quali-
4 fied beneficiaries or otherwise, for coverage of them under an
5 applicable health benefits system established and maintained
6 by a State (or any alternative basic health benefits system
7 with respect to which the Secretary of Health and Human
8 Services has made a determination pursuant to section 4 of
9 the Universal Health Benefits Empowerment and Partner-
10 ship Act of 1990 relating to the element of coverage de-
11 scribed in section 4(a)(2)(B)(iii) of such Act (relating to provi-
12 sion of continuation coverage)) in lieu of coverage as other-
13 wise required under this subpart.".
14 (b) CONFORMING AMENDMENT TO INTERNAL REVE-
15 NUE CODE.—Section 4980B of the Internal Revenue Code
16 of 1986 (relating to excise tax for failure to satisfy continu-
17 ation coverage requirements of group health plans) is
18 amended—
19 (1) in subsection (d), by striking paragraph (1) and
20 redesignating paragraphs (2) and (3) as paragraphs (1)
21 and (2), respectively; and
22 (2) by adding at the end of subsection (f) the fol-
23 lowing new paragraph:
24 "(8) SUBSTITUTION OF STATE HEALTH BENE-
25 FITS SYSTEM OR ALTERNATIVE SYSTEM.—The re-

1 quirements of this subsection may be met by providing,
2 as an option to qualified beneficiaries or otherwise, for
3 coverage of them under an applicable health benefits
4 system established and maintained by a State in ac-
5 cordance with part 6 of subtitle B of title I of the Em-
6 ployee Retirement Income Security Act of 1974 (or
7 any alternative basic health benefits system with re-
8 spect to which the Secretary of Health and Human
9 Services has made a determination pursuant to section
10 4 of the Universal Health Benefits Empowerment and
11 Partnership Act of 1990 relating to the element of
12 coverage described in section 4(a)(2)(B)(iii) of such Act
13 (relating to provision of continuation coverage)) in lieu
14 of coverage as otherwise required under this subsec-
15 tion.''.
16 (c) CONFORMING AMENDMENT TO PUBLIC HEALTH
17 SERVICE ACT.—Section 2201 of the Public Health Service
18 Act is amended by striking subsection (b) and inserting the
19 following new subsection:
20 "(b) SUBSTITUTION OF STATE HEALTH BENEFITS
21 SYSTEM OR ALTERNATIVE SYSTEM.—The requirements of
22 this title may be met by providing, as an option to qualified
23 beneficiaries or otherwise, for coverage of them under an ap-
24 plicable health benefits system established and maintained by
25 a State in accordance with part 6 of subtitle B of title I of the

1 Employee Retirement Income Security Act of 1974 (or any
2 alternative basic health benefits system with respect to which
3 the Secretary of Health and Human Services has made a
4 determination pursuant to section 4 of the Universal Health
5 Benefits Empowerment and Partnership Act of 1990 relating
6 to the element of coverage described in section 4(a)(2)(B)(iii)
7 of such Act (relating to provision of continuation coverage))
8 in lieu of coverage as otherwise required under this title.".

9 **SEC. 6. PREEMPTION OF STATE LAW TO PROVIDE FOR MORE**
10 **AFFORDABLE HEALTH CARE COVERAGE.**

11 (a) IN GENERAL.—Section 514(b)(2)(B) of the Employ-
12 ee Retirement Income Security Act of 1974 (29 U.S.C.
13 1144(b)(2)(B)) is amended—
14 (1) by inserting "(i)" after "(B)"; and
15 (2) by adding at the end the following new clause:
16 "(ii) A provision of State law which provides that one or
17 more specific benefits must be provided or made available by
18 a contract or policy of health insurance issued to an employee
19 benefit plan, or which provides that services rendered by one
20 or more particular classes of health care providers must be
21 covered under such a contract or policy, is a law which re-
22 lates to an employee benefit plan within the meaning of sub-
23 section (a) and is not a law which regulates insurance within
24 the meaning of subparagraph (A).".

1 (b) Preemption of Certain State Laws Re-
2 stricting Managed Care Under Employee Welfare
3 Benefit Plans.—Section 514(b) of such Act is amended by
4 adding at the end the following new paragraph:
5 "(9) For purposes of this section, a provision of State
6 law which in any manner restricts managed care under an
7 employee welfare benefit plan providing medical care (as de-
8 fined in section 213(d) of the Internal Revenue Code of 1986)
9 to participants or beneficiaries directly or through insurance,
10 reimbursement, or otherwise, by restricting the ability to ne-
11 gotiate provider reimbursement rates or to set such rates for
12 any provider, limiting the number or type of providers, or
13 restricting utilization or quality review in connection with
14 such plan shall be deemed a law which relates to an employ-
15 ee benefit plan within the meaning of subsection (a) and not a
16 law which regulates insurance within the meaning of para-
17 graph (2)(A).".

18 **SEC. 7. ENCOURAGEMENT OF MULTIPLE EMPLOYER AR-**
19 **RANGEMENTS PROVIDING BASIC HEALTH BEN-**
20 **EFITS.**

21 (a) Tax Exempt Status.—Paragraph (9) of section
22 501(c) of the Internal Revenue Code of 1986 (relating to
23 exempt organizations) is amended—
24 (1) by inserting "(A)" after "(9)"; and
25 (2) by adding at the end the following:

1 "(B) Any determination of whether a multiple em-
2 ployer welfare arrangement (as defined in section 3(25)
3 of the Employee Retirement Income Security Act of
4 1974) is a voluntary employees' beneficiary association
5 meeting the requirements of this paragraph shall be
6 made without regard to any determination of common-
7 ality of interest or geographic location if—
8 "(i) such arrangement provides at least basic
9 health care services described in section
10 601(a)(3)(A) of the Employee Retirement Income
11 Security Act of 1974, and
12 "(I) such arrangement is fully insured,
13 or
14 "(II) there is a provision of applicable
15 State law which provides standards, requir-
16 ing the maintenance of specified levels of re-
17 serves and specified levels of contributions,
18 which such arrangement must meet in order
19 to be considered under such law able to pay
20 benefits in full when due, and
21 "(ii) meets the reporting requirements similar
22 to the requirements of section 622 of such Act.".
23 (b) REPORTING REQUIREMENTS FOR MEWA'S.—Sec-
24 tion 4 of the Employee Retirement Income Security Act of

1974 (29 U.S.C. 1003) is amended by adding at the end the following new subsection:

"(c) A multiple employer welfare arrangement that provides medical care (as defined in section 213(d) of the Internal Revenue Code of 1986) to employees or their dependents shall be treated as an employee welfare benefit plan for purposes of this title with respect to the requirements of this title relating to the filing of annual reports under section 103, except that such requirements shall not be treated as met with respect to such arrangement unless such report is also filed with the insurance commissioner (or similar official) of each State in which at least 5 percent of the individuals covered under such arrangement reside.".

SEC. 8. TREATMENT PRACTICE GUIDELINES AND OUTCOMES RESEARCH FOR ALL AMERICANS.

(a) AGENCY FOR HEALTH CARE POLICY AND RESEARCH.—So much of part A of title IX of the Public Health Service Act as precedes section 902(c) is amended to read as follows:

"PART A—ESTABLISHMENT AND GENERAL DUTIES

"SEC. 901. ESTABLISHMENT.

"(a) IN GENERAL.—There is established within the Service an agency to be known as the Agency for Health Care Policy and Research.

1 "(b) PURPOSE.—The purpose of the Agency is to en-
2 hance the quality, appropriateness, and effectiveness of
3 health care services for all Americans, and access to such
4 services, through the establishment of a broad base of scien-
5 tific research and through the promotion of improvements in
6 clinical practice and in the organization, financing, and deliv-
7 ery of health care services.

8 "(c) APPOINTMENT OF ADMINISTRATOR.—There shall
9 be at the head of the Agency an official to be known as the
10 Administrator for Health Care Policy and Research. The Ad-
11 ministrator shall be appointed by the Secretary. The Secre-
12 tary, acting through the Administrator, shall carry out the
13 authorities and duties established in this title.

14 **"SEC. 902. GENERAL AUTHORITIES AND DUTIES.**

15 "(a) IN GENERAL.—In carrying out section 901(b), the
16 Administrator shall conduct and support research, demon-
17 stration projects, evaluations, training, guideline develop-
18 ment, and the dissemination of information, on health care
19 services and on systems for the delivery of such services to
20 all Americans, including activities with respect to—

21 "(1) the effectiveness, efficiency, and quality of
22 health care services;

23 "(2) subject to subsection (d), the outcomes of
24 health care services and procedures;

1 “(3) clinical practice, including primary care and
2 practice-oriented research;
3 “(4) health care technologies, facilities, and
4 equipment;
5 “(5) health care costs, productivity, and market
6 forces;
7 “(6) health promotion and disease prevention;
8 “(7) health statistics and epidemiology; and
9 “(8) medical liability.
10 “(b) REQUIREMENTS WITH RESPECT TO RURAL
11 AREAS AND UNDERSERVED POPULATIONS.—In carrying
12 out subsection (a), the Administrator shall undertake and sup-
13 port research, demonstration projects, and evaluations with
14 respect to—
15 “(1) the delivery of health care services in rural
16 areas (including frontier areas) to Americans of all
17 ages; and
18 “(2) the health of low-income groups, minority
19 groups, and the elderly.”.
20 (b) FORUM FOR QUALITY AND EFFECTIVENESS IN
21 HEALTH CARE.—So much of part B of title IX of the Public
22 Health Service Act as precedes section 912(c) is amended to
23 read as follows:

1 "PART B—FORUM FOR QUALITY AND
2 EFFECTIVENESS IN HEALTH CARE

3 **"SEC. 911. ESTABLISHMENT OF OFFICE.**

4 "There is established within the Agency an office to be
5 known as the Office of the Forum for Quality and Effective-
6 ness in Health Care. The office shall be headed by a Direc-
7 tor, who shall be appointed by the Administrator.

8 **"SEC. 912. DUTIES.**

9 "(a) ESTABLISHMENT OF FORUM PROGRAM.—The
10 Administrator, acting through the Director, shall establish a
11 program to be known as the Forum for Quality and Effec-
12 tiveness in Health Care. For the purpose of promoting the
13 quality, appropriateness, and effectiveness of health care, the
14 Director, using the process set forth in section 913, shall
15 arrange for the development and periodic review and up-
16 dating of—

17 "(1) clinically relevant guidelines that may be
18 used by physicians, educators, and health care practi-
19 tioners to assist in determining how diseases, disorders,
20 and other health conditions can most effectively and
21 appropriately be prevented, diagnosed, treated, and
22 managed clinically; and

23 "(2) standards of quality, performance measures,
24 and medical review criteria through which health care
25 providers and other appropriate entities may assess or

1 review the provision of health care and assure the
2 quality of such care.
3 "(b) CERTAIN REQUIREMENTS.—Guidelines, stand-
4 ards, performance measures, and review criteria under sub-
5 section (a) shall—
6 "(1) be based on the best available research and
7 professional judgment regarding the effectiveness and
8 appropriateness of health care services and procedures;
9 "(2) be presented—
10 "(A) in formats appropriate for use by physi-
11 cians, health care practitioners, providers, medical
12 educators, and medical review organizations,
13 "(B) in formats appropriate for use by group
14 health plans (as defined in section 601(a)(1) of the
15 Employee Retirement Income Security Act of
16 1974), health benefits systems established and
17 maintained by States in accordance with subpart
18 C of part 6 of subtitle B of title I of the Employ-
19 ee Retirement Income Security Act of 1974, and
20 alternative basic health benefits systems with re-
21 spect to which the Secretary has made a determi-
22 nation pursuant to section 4 of the Universal
23 Health Benefits Empowerment and Partnership
24 Act of 1990 relating to an element of coverage
25 described in section 4(a)(2)(B) of such Act, and

1 "(C) in formats appropriate for use by con-
2 sumers of health care; and
3 "(3) include treatment-specific or condition-specif-
4 ic practice guidelines for clinical treatments and condi-
5 tions in forms appropriate for use in clinical practice,
6 for use in educational programs, and for use in review-
7 ing quality and appropriateness of medical care.".
8 (c) DISSEMINATION OF STANDARDS, CRITERIA,
9 ETC.—Section 914(c) of the Public Health Service Act is
10 amended to read as follows:
11 "(c) DISSEMINATION.—
12 "(1) IN GENERAL.—The Director shall promote
13 and support the dissemination of the guidelines, stand-
14 ards, performance measures, and review criteria de-
15 scribed in section 912(a).
16 "(2) ORGANIZATIONS UTILIZED.—Such dissemi-
17 nation shall be carried out through—
18 "(1) organizations representing health care
19 providers,
20 "(2) group health plans (as defined in section
21 601(a)(1) of the Employee Retirement Income Se-
22 curity Act of 1974),
23 "(3) health benefits systems established and
24 maintained by States in accordance with subpart

1 C of part 6 of subtitle B of title I of the Employ-
2 ee Retirement Income Security Act of 1974,
3 "(4) alternative basic health benefits systems
4 with respect to which the Secretary has made a
5 determination pursuant to section 4 of the Univer-
6 sal Health Benefits Empowerment and Partner-
7 ship Act of 1990 relating to an element of cover-
8 age described in section 4(a)(2)(B) of such Act,
9 "(5) organizations representing health care
10 consumers,
11 "(6) peer review organizations,
12 "(7) accrediting bodies, and
13 "(8) other appropriate entities.".
14 (d) STUDY OF ROLE OF PRACTICE GUIDELINES IN RE-
15 DUCING MALPRACTICE COSTS.—As soon as practicable
16 after the date of the enactment of this Act, the Federal Advi-
17 sory Council on Health Care Coverage and Costs shall un-
18 dertake a study of the manner in which practice guidelines
19 may be used in reducing medical malpractice costs. The
20 Council shall submit the results of such study together with
21 any recommendations to the Secretary of Health and Human
22 Services.
23 (e) AUTHORIZATION OF ADDITIONAL APPROPRIA-
24 TIONS.—Section 926(a) of the Public Health Service Act is
25 amended by adding at the end the following: "In addition to

1 amounts otherwise authorized by this subsection, for the pur-
2 pose of carrying out the amendments made by section 8 of
3 the Universal Health Benefits Empowerment and Partner-
4 ship Act of 1990, there are authorized to be appropriated
5 $10,000,000 for fiscal year 1991, $15,000,000 for fiscal year
6 1992, and $20,000,000 for fiscal year 1993.".

7 **SEC. 9. FEDERAL ADVISORY COUNCIL ON HEALTH CARE**
8 **COVERAGE AND COSTS.**

9 (a) IN GENERAL.—There is hereby established a Fed-
10 eral Advisory Council on Health Care Coverage and Costs
11 for the purpose of reviewing, overseeing, and making recom-
12 mendations relating to the implementation of the provisions
13 of this Act and studying the causes of changes in the costs of
14 health care coverage and delivery.

15 (b) MEMBERSHIP.—The Council shall consist of a
16 Chairman and 12 other persons, appointed by the Secretary
17 of Health and Human Services with the concurrence of the
18 Secretary of Labor and without regard to the provisions of
19 title 5, United States Code, governing appointments in the
20 competitive service. The appointed members shall, to the
21 extent possible, represent organizations of small and large
22 employers, employee organizations, health care providers,
23 providers of group health plan coverage, State and local gov-
24 ernments, the field of actuarial counseling, and the general
25 public.

1 (c) EXPENSES.—

2 (1) SERVICES AND ASSISTANCE.—The Council is
3 authorized to engage such technical assistance, includ-
4 ing actuarial services, as may be required to carry out
5 its functions, and the Secretary of Health and Human
6 Services and the Secretary of Labor shall, in addition,
7 make available to the Council such secretarial, clerical,
8 and other assistance as it may require to carry out
9 such functions. The Secretary of Health and Human
10 Services and the Secretary of Labor shall, in addition,
11 make available to the Council such actuarial and other
12 pertinent data prepared by the Department of Health
13 and Human Services, the Department of Labor, or
14 other agencies of the Government as it may require to
15 carry out such functions.

16 (2) TRAVEL AND PER DIEM.—Appointed members
17 of the Council, while serving on the business of the
18 Council (inclusive of travel time), while so serving
19 away from their homes or regular places of business,
20 may be allowed travel expenses, including per diem in
21 lieu of subsistence, as authorized by section 5703 of
22 title 5, United States Code, for persons in the Govern-
23 ment employed intermittently.

24 (d) FUNCTIONS.—The Council shall—

1 (1) make timely recommendations to the Secretary
2 of Health and Human Services for purposes of the is-
3 suance of initial regulations in accordance with para-
4 graphs (1) and (2) of section 3(b),
5 (2) make recommendations to the Secretary of
6 Health and Human Services relating to appropriate
7 mechanisms for and the frequency of revisions of regu-
8 lations in accordance with paragraph (3) of section
9 3(b),
10 (3) otherwise advise the Secretary of Health and
11 Human Services and the Secretary of Labor with re-
12 spect to the implementation of the amendments made
13 by this Act,
14 (4) offer States and other entities advice regarding
15 health benefits systems and implementation of the
16 amendments made by this Act,
17 (5) serve as a forum for exchange of advice, rec-
18 ommendations, and information regarding the amend-
19 ments made by this Act, their implementation, and
20 health benefits systems established and maintained by
21 States, and otherwise foster cooperation between
22 States and other entities in implementing such amend-
23 ments,
24 (6) make from time to time such recommendations
25 as it considers appropriate relating to possible improve-

1 ments relating to the financing and affordability of
2 health care coverage for individuals eligible for cover-
3 age under health benefits systems established and
4 maintained by States and other entities, and
5 (7) make from time to time such recommendations
6 to the Secretary of Health and Human Services and to
7 the Congress as it considers appropriate relating to
8 changes in the costs of health care coverage and
9 delivery.
10 (e) REPORTS.—The Council shall, at least annually,
11 submit a report to the Secretary of Health and Human Serv-
12 ices and the Secretary of Labor of any findings or recommen-
13 dations relating to matters considered by the Council, and
14 such reports shall thereupon be transmitted to the Congress.
15 (f) FINAL REPORT AND TERMINATION.—Upon the re-
16 quest of the Secretary of Health and Human Services, the
17 Council shall submit a final report to such Secretary and the
18 Secretary of Labor. The Council shall terminate upon the
19 submission of such final report.

20 **SEC. 10. INCREASE IN DEDUCTION FOR HEALTH INSURANCE**
21 **COSTS OF SELF-EMPLOYED INDIVIDUALS**
22 **FROM 25 PERCENT TO 100 PERCENT.**

23 (a) IN GENERAL.—Paragraph (1) of section 162(l) of
24 the Internal Revenue Code of 1986 (relating to special rules

1 for health insurance costs of self-employed individuals) is
2 amended by striking "25 percent of".
3 (b) Repeal of Termination Provision.—Para-
4 graph (5) of section 162(l) of such Code (relating to termina-
5 tion) is repealed.

6 **SEC. 11. EFFECTIVE DATES.**

7 (a) Sections 3 and 5.—The amendments made by
8 section 3 shall take effect January 1, 1993, and the amend-
9 ments made by section 5 shall apply with respect to plan
10 years beginning on or after such date.
11 (b) Section 4.—The provisions of section 4 shall take
12 effect on the date of the enactment of this Act.
13 (c) Section 6.—The amendments made by section 6(b)
14 shall take effect January 1, 1991. The amendments made by
15 section 6(a) shall take effect January 1, 1991, except that
16 with respect to plans in effect on the date of the enactment of
17 this Act, such amendments shall take effect on the effective
18 date of section 3.
19 (d) Section 7.—The amendments made by section 7(a)
20 shall apply with respect to determinations made on or after
21 January 1, 1991. The amendment made by section 7(b) shall
22 apply to plan years beginning on or after January 1, 1991.
23 (e) Section 8.—The amendments made by section 8
24 shall take effect January 1, 1991.

1 (f) SECTION 9.—The provisions of section 9 shall take
2 effect on the date of the enactment of this Act.
3 (g) SECTION 10.—The amendments made by section 10
4 shall apply with respect to taxable years beginning on or
5 after January 1, 1991.

○

II

101st CONGRESS
2d Session

S. 2199

To amend the Internal Revenue Code of 1986 with respect to the tax treatment of the transfer of excess pension assets to retiree health accounts, and for other purposes.

IN THE SENATE OF THE UNITED STATES

February 28 (legislative day, January 23), 1990

Mr. Packwood (for himself and Mr. Boschwitz) introduced the following bill; which was read twice and referred to the Committee on Finance

---

A BILL

To amend the Internal Revenue Code of 1986 with respect to the tax treatment of the transfer of excess pension assets to retiree health accounts, 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; AMENDMENT OF 1986 CODE.**
4 (a) Short Title.—This Act may be cited as the
5 "Health and Long-Term Care Security Act of 1990".
6 (b) Amendment of 1986 Code.—Except as otherwise
7 expressly provided, whenever in this Act an amendment or
8 repeal is expressed in terms of an amendment to, or repeal of,
9 a section or other provision, the reference shall be considered

1 to be made to a section or other provision of the Internal
2 Revenue Code of 1986.

3 TITLE I—TREATMENT OF LONG-
4 TERM HEALTH CARE

5 SEC. 101. MEDICAL DEDUCTIONS FOR LONG-TERM HEALTH
6 CARE EXPENSES.

7 (a) IN GENERAL.—Section 213(d) (defining medical
8 care) is amended by adding at the end thereof the following
9 new paragraph:
10 "(9) LONG-TERM HEALTH CARE.—
11 "(A) IN GENERAL.—The term 'medical care'
12 includes long-term health care.
13 "(B) LONG-TERM HEALTH CARE.—For pur-
14 poses of subparagraph (A)—
15 "(i) IN GENERAL.—The term 'long-
16 term health care' means the providing by a
17 qualified provider in a qualified facility of
18 necessary diagnostic, preventive, therapeutic,
19 rehabilitative, and personal care services, re-
20 quired by a chronically ill individual.
21 "(ii) CERTAIN ITEMS NOT INCLUDED.—
22 The term 'long-term health care' does not in-
23 clude basic medicare supplement coverage,
24 basic hospital expense coverage, basic medi-
25 cal-surgical expense coverage, hospital con-

1 finement indemnity coverage, major medical
2 expense coverage, disability income protec-
3 tion coverage, accident only coverage, speci-
4 fied disease or specified accident coverage, or
5 limited benefit health coverage.
6 "(iii) QUALIFIED FACILITY.—For pur-
7 poses of the subparagraph, the term 'quali-
8 fied facility' means—
9 "(I) a rehabilitative, hospice, or
10 adult day care facility, including a hos-
11 pital, retirement home, skilled nursing
12 facility (within the meaning of section
13 1919(a) of the Social Security Act), or
14 other similar facility determined by the
15 plan administrator, or
16 "(II) a home where the chronically
17 ill individual resides.
18 "(iv) CHRONICALLY ILL INDIVIDUAL.—
19 For purposes of this subparagraph, the term
20 'chronically ill individual' means an individ-
21 ual whose disability is such that the individ-
22 ual has been certified as requiring assistance
23 with daily living (as defined by the plan ad-
24 ministrator) for a period of at least 90 days.

1 "(v) QUALIFIED PROVIDER.—For pur-
2 poses of this subparagraph, the term 'quali-
3 fied provider' means a medical practitioner
4 licensed under State law, registered nurse, li-
5 censed vocational nurse, qualified therapist,
6 or trained home health aid (or any organiza-
7 tion employing such providers), but does not
8 include a relative or other person who ordi-
9 narily resides in the home where the chron-
10 ically ill individual resides."

11 (b) EFFECTIVE DATE.—

12 (1) IN GENERAL.—The amendment made by this
13 section shall apply to taxable years beginning after De-
14 cember 31, 1990.

15 (2) NO INFERENCE.—Nothing in the amendment
16 made by this section shall be construed to infer that
17 long-term health care is or is not medical care for pur-
18 poses of section 213 of the Internal Revenue Code of
19 1986 for taxable years beginning before January 1,
20 1991, and any determination of such issue shall be
21 made as if this section had not been enacted.

1 SEC. 102. TREATMENT OF LONG-TERM HEALTH CARE INSUR-
2 ANCE CONTRACTS FOR INCOME TAXATION OF
3 INSURANCE COMPANIES.

4 (a) IN GENERAL.—Section 818 (relating to other defini-
5 tions and special rules involving life insurance companies) is
6 amended by adding at the end thereof the following new
7 subsection:

8 "(g) TREATMENT OF LONG-TERM HEALTH CARE IN-
9 SURANCE CONTRACTS.—

10 "(1) GENERAL RULE.—For purposes of this sub-
11 chapter, insurance contracts which provide long-term
12 health care shall be treated in the same manner as
13 noncancellable accident or health insurance contracts.

14 "(2) LONG-TERM HEALTH CARE.—For purposes
15 of paragraph (1), the term 'long-term health care' has
16 the meaning given such term by section 213(d)(9)(B)."

17 (b) EFFECTIVE DATE.—The amendment made by this
18 section shall apply to contracts entered into before, on, or
19 after the date of the enactment of this Act.

20 TITLE II—EMPLOYER FUNDING
21 OF MEDICAL BENEFITS

22 SEC. 201. MEDICAL BENEFITS FOR RETIRED EMPLOYEES AND
23 THEIR SPOUSES AND DEPENDENTS.

24 (a) IN GENERAL.—Section 401(h) (relating to medical,
25 etc., benefits for retired employees and their spouses and de-
26 pendents) is amended to read as follows:

1 "(h) RETIREE HEALTH ACCOUNTS.—
2 "(1) GENERAL RULE.—Under regulations pre-
3 scribed by the Secretary, a defined benefit plan may
4 establish and maintain a separate health benefits ac-
5 count for the payment of medical benefits of retired
6 employees and their spouses and dependents.
7 "(2) SEPARATE ACCOUNTING REQUIRED.—An
8 employer establishing a health benefits account shall
9 maintain separate accounts within the health benefits
10 account for funded reserve accounts established under
11 section 420A.
12 "(3) USE OF ASSETS.—Subject to the provisions
13 of part III of this subchapter, the corpus or income of
14 a health benefits account shall not be used for, or di-
15 verted to, any purpose other than providing medical
16 benefits to retired employees and their spouses and
17 dependents.
18 "(4) KEY EMPLOYEES.—
19 "(A) IN GENERAL.—In the case of an em-
20 ployee who is a key employee—
21 "(i) a separate account shall be estab-
22 lished and maintained for medical benefits
23 payable to such employee (and the employ-
24 ee's spouse or dependents), and

1 "(ii) medical benefits of such employee,
2 spouse, or dependents which are attributable
3 to plan years beginning after March 31,
4 1984, for which the employee is a key em-
5 ployee may be payable only from such ac-
6 count.

7 "(B) KEY EMPLOYEE.—For purposes of sub-
8 paragraph (A), the term 'key employee' means
9 any employee who, at any time during the plan
10 year or any preceding plan year during which
11 contributions were made on behalf of such em-
12 ployee, is or was a key employee (as defined in
13 section 416(i)).

14 "(5) APPLICABLE RULES.—For rules applicable
15 to health benefits accounts, see subpart E of this part
16 (sec. 420 et seq.)."

17 (b) CONFORMING AMENDMENT.—Section 415(l)(2) (re-
18 lating to treatment of certain medical benefits) is amended by
19 inserting "by reason of section 401(h)(4)" after "dependents"
20 in subparagraph (B).

21 (c) EFFECTIVE DATE.—

22 (1) IN GENERAL.—Except as provided in para-
23 graph (2), the amendments made by this section shall
24 apply to years beginning after December 31, 1990.

25 (2) TRANSITION RULE.—In the case of—

1 (A) a plan other than a defined benefit plan,
2 or
3 (B) a defined benefit plan which elects, at
4 such time and in such manner as the Secretary of
5 the Treasury or his delegate may prescribe, to
6 have this paragraph apply,
7 which on or before the date of the enactment of this
8 Act established an account to which section 401(h) of
9 the Internal Revenue Code of 1986 (as in effect before
10 the amendments made by this section) applied (and
11 which is in existence on such date), the amendments
12 made by this section shall not apply to such account.

13 **SEC. 202. TREATMENT OF HEALTH BENEFITS ACCOUNTS.**

14 (a) IN GENERAL.—Part III of subchapter D of chapter
15 1 (relating to health benefits accounts), as added by section
16 301 of this Act, is amended by adding at the end thereof the
17 following new subpart:

18 **"Subpart B—Treatment of Health Benefits Accounts**

"Sec. 420A. Deduction for employer contributions to health benefits accounts.
"Sec. 420B. Funded reserve account.
"Sec. 420C. Definitions; special rules.

19 **"SEC. 420A. DEDUCTION FOR EMPLOYER CONTRIBUTIONS TO**
20 **HEALTH BENEFITS ACCOUNTS.**

21 "(a) GENERAL RULE.—Amounts paid by an employer
22 to a defined benefit plan which are allocated to a health bene-
23 fits account—

1 "(1) shall not be allowed as a deduction under this
2 chapter, but
3 "(2) if they would otherwise be deductible, shall
4 be allowed as a deduction under this section for the
5 taxable year in which paid.
6 "(b) LIMITATION.—The amount of the deduction
7 allowable under subsection (a)(2) for any taxable year shall
8 not exceed the health benefits account's qualified cost for the
9 taxable year.
10 "(c) QUALIFIED COST.—For purposes of this section—
11 "(1) IN GENERAL.—The term 'qualified cost'
12 means, with respect to any taxable year, the sum of—
13 "(A) the qualified direct cost for such taxable
14 year, plus
15 "(B) subject to the limitation of section
16 420B(b), any addition to the funded reserve ac-
17 count established under section 420B.
18 "(2) QUALIFIED DIRECT COST.—
19 "(A) IN GENERAL.—The term 'qualified
20 direct cost' means, with respect to any taxable
21 year, the aggregate amount (including administra-
22 tive expenses) which would have been allowable
23 as a deduction to the employer with respect to the
24 qualified section 401(h) medical benefits provided

1 through the health benefits account during the
2 taxable year if—
3 "(i) such benefits were provided directly
4 by the employer, and
5 "(ii) the employer used the cash receipts
6 and disbursements method of accounting.
7 "(B) TIME WHEN BENEFITS PROVIDED.—
8 For purposes of subparagraph (A), a benefit shall
9 be treated as provided when such benefit would
10 be includible in the gross income of the employee
11 if provided directly by the employer (or would be
12 so includible but for any provision of this chapter
13 excluding such benefit from gross income).

14 **"SEC. 420B. FUNDED RESERVE ACCOUNT.**

15 "(a) GENERAL RULE.—For purposes of this subpart
16 and section 401(h), the term 'funded reserve account' means
17 an account within a health benefits account—
18 "(1) to which contributions paid or accrued to a
19 defined benefit plan are allocated to provide a reserve
20 for the payment of qualified section 401(h) medical
21 benefits of employees and their spouses and depend-
22 ents,
23 "(2) with respect to which the only contributions
24 allocated are employer contributions, and
25 "(3) with respect to which—

1 "(A) the vesting requirements of subsection
2 (c),
3 "(B) the portability requirements of subsec-
4 tion (d), and
5 "(C) the availability requirements of subsec-
6 tion (e),
7 are met.
8 "(b) LIMITATION ON ALLOCATION TO ACCOUNT.—
9 "(1) IN GENERAL.—No amount may be allocated
10 to a funded reserve account (and taken into account
11 under section 420A(c)(1)(B)) to the extent such addi-
12 tion results in the amount allocated to such account
13 exceeding the account limit.
14 "(2) ACCOUNT LIMIT.—The account limit for any
15 taxable year is an amount equal to 125 percent of the
16 termination liability of the account as of the close of
17 the last plan year ending with or within the taxable
18 year.
19 "(3) TERMINATION LIABILITY.—For purposes of
20 this section—
21 "(A) IN GENERAL.—The term 'termination
22 liability' means the present value of the qualified
23 section 401(h) medical benefits—
24 "(i) which are to be provided to employ-
25 ees (and their spouses and dependents), and

1 "(ii) any portion of which is to be pro-
2 vided through a funded reserve account.
3 "(B) DETERMINATIONS.—The termination
4 liability under subparagraph (A) shall be deter-
5 mined—
6 "(i) on the basis of actuarial assump-
7 tions which are used in determining the full-
8 funding limitation of the plan under section
9 412(c)(7),
10 "(ii) as if the benefits under the plan
11 commenced at Social Security retirement
12 age, and
13 "(iii) by not taking into account any
14 portion of the maximum annual benefit under
15 the plan for—
16 "(I) benefits (other than post-
17 retirement long-term health care ben-
18 efits) in excess of $1,500,or
19 "(II) post-retirement long-term
20 health care benefits in excess of $1,500.
21 "(C) ADJUSTMENTS TO ACCOUNT.—The
22 amount in the account shall be adjusted at such
23 time and in such manner as the Secretary may
24 prescribe to take into account income, gains, de-

1 ductions, or losses which are properly allocable to
2 amounts in the account.
3 "(D) ACTUARIAL ADJUSTMENT.—For pur-
4 poses of determining termination liability, the ben-
5 efits provided to any participant under the plan
6 shall be actuarially adjusted to reflect any com-
7 mencement of benefits before or after Social Secu-
8 rity retirement age.
9 "(E) EMPLOYEE.—For purposes of this
10 paragraph, the term 'employee' does not include a
11 former employee.
12 "(F) COST-OF-LIVING ADJUSTMENT.—In the
13 case of years beginning after 1992, the $1,500
14 amounts in subparagraph (B) shall be adjusted an-
15 nually at the same time and in the same manner
16 as under section 415(d).
17 "(c) VESTING REQUIREMENTS.—
18 "(1) IN GENERAL.—The requirements of this sub-
19 section are met if the requirements of either subpara-
20 graph (A) or (B) of section 411(a)(2) are met with re-
21 spect to the accrued qualified section 401(h) medical
22 benefits derived from amounts which are allocated to
23 the funded reserve account.
24 "(2) UNIFORM RATE OF ACCRUAL OF BENE-
25 FITS.—

1 "(A) IN GENERAL.—Except as provided in
2 this paragraph, a plan shall not be treated as
3 meeting the requirements of this subsection unless
4 the rate at which benefits accrue during a plan
5 year is the same for all participants.

6 "(B) SPECIAL RULES FOR CERTAIN INDIVID-
7 UALS AGE 55 AND OVER.—A plan shall not be
8 treated as failing to meet the requirements of this
9 subsection if the plan provides that an employee
10 who as of the close of the plan year in which he
11 attains age 55 has accrued less than 30 percent of
12 the maximum amount of benefits which may be
13 accrued under the plan may accrue benefits during
14 succeeding plan years at a greater rate than the
15 rate for other employees (but not in excess of 125
16 percent of such other rate).

17 "(C) MINIMUM HOURS OF SERVICE.—For
18 purposes of subparagraph (A), an employee shall
19 not be treated as a participant for any plan year
20 unless such individual completes more than 500
21 hours of service during such year.

22 "(3) CERTAIN RULES MADE APPLICABLE.—
23 Except to the extent inconsistent with the provisions of
24 this subpart, the rules of section 411 shall apply for
25 purposes of this subsection.

1 "(d) PORTABILITY REQUIREMENTS.—

2 "(1) IN GENERAL.—Except as provided in para-
3 graph (2), the requirements of this subsection are met
4 if, in accordance with procedures determined by the
5 Secretary, the plan provides that—

6 "(A) except as provided in regulations, the
7 plan shall transfer, within 120 days after an em-
8 ployee separates from service with the employer
9 or after the termination of the plan, the present
10 value of the nonforfeitable accrued qualified sec-
11 tion 401(h) medical benefits of the employee at-
12 tributable to amounts which are allocated to the
13 funded reserve account to—

14 "(i) a plan which is maintained by an
15 employer of such employee and which main-
16 tains a health benefits account, or

17 "(ii) if the employer does not maintain a
18 plan described in clause (i), an individual re-
19 tirement account established for the benefit
20 of such employee, and

21 "(B) the plan accepts transfers under sub-
22 paragraph (A) from another plan or individual
23 retirement account.

24 "(2) NO TRANSFERS AFTER EMPLOYEE IS DIS-
25 ABLED OR ATTAINS RETIREMENT AGE.—Except in

1 the case of a termination of a plan, a plan shall not
2 meet the requirements of this subsection if it permits
3 the transfer of a benefit after—
4 "(A) an employee has attained Social Securi-
5 ty retirement age, or
6 "(B) an employee has become disabled
7 (within the meaning of section 72(m)(7)).
8 "(3) INCLUSION IN INCOME WHERE MORE THAN
9 1 ACCOUNT.—
10 "(A) IN GENERAL.—If—
11 "(i) an individual is a participant or
12 beneficiary under 2 or more plans maintain-
13 ing a funded reserve account or individual
14 retirement account to which assets were
15 transferred from such a plan, and
16 "(ii) such individual does not (within a
17 reasonable period) consolidate the present
18 value of the individual's nonforfeitable ac-
19 crued benefit in all such plans and the assets
20 so transferred to all such accounts into 1
21 such plan or into 1 such account,
22 then an amount equal to the sum of the present
23 value of such benefits and the fair market value of
24 such assets shall be treated as distributed in cash
25 to such individual at the close of the plan year for

1 the plan or account involved and such distribution
2 shall be included in gross income.
3 "(B) SPECIAL RULES.—
4 "(i) EMPLOYEE MUST CONSOLIDATE
5 INTO PLAN OF CURRENT EMPLOYER.—In
6 the case of an employee who is employed by
7 an employer maintaining a plan described in
8 subparagraph (A)(i), a consolidation satisfies
9 subparagraph (A) only if such consolidation is
10 into such a plan maintained by such
11 employer.
12 "(ii) MORE THAN 1 CURRENT EMPLOY-
13 ER.—If an individual is a participant in more
14 than 1 plan described in subparagraph (A)(i)
15 by reason of being currently employed by
16 more than 1 employer, such plans shall be
17 treated as 1 plan for purposes of subpara-
18 graph (A).
19 "(iii) EMPLOYEE WITH NO CURRENT
20 EMPLOYER MAINTAINING PLAN.—In the
21 case of an employee who is currently not
22 employed by an employer maintaining a plan
23 described in subparagraph (A)(i), a consolida-
24 tion satisfies subparagraph (A) only if such
25 consolidation is into—

1 "(I) a plan described in subpara-
2 graph (A)(i) maintained by his most
3 recent employer maintaining such plan,
4 or
5 "(II) an individual retirement ac-
6 count of the individual.
7 "(C) AMOUNT TRANSFERRED NOT INCLUD-
8 IBLE IN INCOME.—No amount shall be includible
9 in gross income by reason of any transfer which is
10 part of a consolidation required under this para-
11 graph.
12 "(e) RETIRED EMPLOYEES NOT COVERED BY HEALTH
13 BENEFITS ACCOUNT MAY ELECT COVERAGE.—
14 "(1) IN GENERAL.—The requirements of this sub-
15 section are met if the plan provides that a former em-
16 ployee who—
17 "(A) is in pay status under the plan, but
18 "(B) is not eligible to receive all or any por-
19 tion of qualified section 401(h) medical benefits
20 provided for any period through the funded re-
21 serve account,
22 is entitled to elect such benefits for himself or his
23 spouse and dependents. A plan shall not be treated as
24 failing to meet the requirements of this subsection if an
25 employee is required to pay a premium for such bene-

1 fits as long as such premium does not exceed 102 per-
2 cent of applicable premium for the period such benefits
3 are provided.

4 "(2) APPLICABLE PREMIUM.—For purposes of
5 paragraph (1), the applicable premium for any period
6 shall be determined in the same manner as under sec-
7 tion 4980B(f)(4).

8 **"SEC. 420C. DEFINITIONS; SPECIAL RULES.**

9 "(a) QUALIFIED SECTION 401(h) MEDICAL BENE-
10 FITS.—For purposes of this subpart, the term 'qualified sec-
11 tion 401(h) medical benefits' means benefits—

12 "(1) which are—

13 "(A) benefits for sickness, accident, hospitali-
14 zation, and medical expenses of former employees
15 who are in pay status under the plan (and their
16 spouse or dependents) after the former
17 employee—

18 "(i) has attained Social Security retire-
19 ment age, or

20 "(ii) is disabled (within the meaning of
21 section 72(m)(7)), or

22 "(B) post-retirement long-term health care
23 benefits, and

24 "(2) which are provided through 1 or more of the
25 following:

1 "(A) insurance acquired by the plan, or
2 "(B) self-insurance by the employer or the
3 plan.
4 Such term does not include any applicable health benefits (as
5 defined in section 420(e)(1)(C)) which are paid out of assets
6 transferred to the health benefits account in a qualified trans-
7 fer under section 420.
8 "(b) POST-RETIREMENT LONG-TERM HEALTH
9 CARE.—For purposes of this subpart—
10 "(1) IN GENERAL.—The term 'post-retirement
11 long-term health care' means long-term health care
12 benefits provided to a former employee (or the spouse
13 of the former employee) who is in pay status under the
14 plan after the former employee—
15 "(A) has attained Social Security retirement
16 age, or
17 "(B) is disabled (within the meaning of sec-
18 tion 72(m)(7)).
19 "(2) SPOUSE OF DECEASED EMPLOYEE.—For
20 purposes of paragraph (1), the spouse of a deceased
21 employee shall be treated—
22 "(A) as a former employee, and
23 "(B) as satisfying the requirements of para-
24 graph (1) if such spouse was receiving benefits im-
25 mediately before the death of the employee.

1 "(3) LONG-TERM HEALTH CARE BENEFIT.—
2 "(A) IN GENERAL.—The term 'long-term
3 health care benefit' means a benefit which con-
4 sists of the providing by a qualified provider in a
5 qualified facility of necessary diagnostic, preven-
6 tive, therapeutic, rehabilitative, and personal care
7 services, required by a chronically ill individual.
8 "(B) CERTAIN ITEMS NOT INCLUDED.—The
9 term 'long-term health care benefits' does not in-
10 clude basic medicare supplement coverage, basic
11 hospital expense coverage, basic medical-surgical
12 expense coverage, hospital confinement indemnity
13 coverage, major medical expense coverage, dis-
14 ability income protection coverage, accident only
15 coverage, specified disease or specified accident
16 coverage, or limited benefit health coverage.
17 "(4) QUALIFIED FACILITY.—The term 'qualified
18 facility' means—
19 "(A) a rehabilitative, hospice, or adult day
20 care facility, including a hospital, retirement
21 home, skilled nursing facility (within the meaning
22 of section 1919(a) of the Social Security Act), or
23 other similar facility determined by the plan ad-
24 ministrator, or

1 "(B) a home where the chronically ill indi-
2 vidual resides.
3 "(5) CHRONICALLY ILL INDIVIDUAL.—The term
4 'chronically ill individual' means an individual whose
5 disability is such that the individual has been certified
6 as requiring assistance with daily living (as defined by
7 the plan administrator) for a period of at least 90 days.
8 "(6) QUALIFIED PROVIDER.—The term 'qualified
9 provider' means a medical practitioner licensed under
10 State law, registered nurse, licensed vocational nurse,
11 qualified therapist, or trained home health aid (or any
12 organization employing such providers), but does not
13 include a relative or other person who ordinarily re-
14 sides in the home where the chronically ill individual
15 resides.
16 "(c) HEALTH BENEFITS ACCOUNT.—For purposes of
17 this subpart, the term 'health benefits account' means an ac-
18 count established and maintained under section 401(h).
19 "(d) SOCIAL SECURITY RETIREMENT AGE.—For pur-
20 poses of this subpart, the term 'Social Security retirement
21 age' has the meaning given such term by section 415(b)(8)."
22 (b) INDIVIDUAL RETIREMENT ACCOUNTS.—
23 (1) IN GENERAL.—Section 408 is amended by re-
24 designating subsection (p) as subsection (q) and by in-

1 serting after subsection (o) the following new subsec-
2 tion:
3 "(p) SPECIAL RULES FOR FUNDED RESERVE AC-
4 COUNTS.—
5 "(1) IN GENERAL.—A trust shall not be treated
6 as an individual retirement account under subsection
7 (a) unless the trust instrument provides that the trust
8 will accept transfers of assets as provided in section
9 420B(d)(1).
10 "(2) ACCOUNTING.—The trustee of an individual
11 retirement account shall maintain separate accounting
12 for assets transferred to the account under section
13 420B(d)(1) (and any income allocable thereto)."
14 (2) PENALTY FOR EARLY DISTRIBUTIONS.—Sec-
15 tion 72(t) (relating to 10-percent additional tax on
16 early distributions) is amended by adding at the end
17 thereof the following new paragraph:
18 "(6) EARLY DISTRIBUTION OF MEDICAL BENE-
19 FITS.—If—
20 "(A) a taxpayer receives a distribution of
21 amounts transferred to an individual retirement
22 account under section 420B(d)(1) (or any income
23 or gain allocable thereto), and
24 "(B) such distribution—

1 "(i) is made before the individual attains
2 Social Security retirement age (within the
3 meaning of section 415(b)(8)) or becomes dis-
4 abled (within the meaning of subsection
5 (m)(7)), or
6 "(ii) exceeds the amount of qualified
7 section 401(h) medical expenses of the tax-
8 payer, his spouse, or dependents for the tax-
9 able year,
10 then paragraph (1) shall apply to such distribution or
11 such excess, except that '50 percent' shall be substitut-
12 ed for '10 percent'. Paragraph (2) shall not apply to a
13 distribution to which this paragraph applies."
14 (c) EXCISE TAX ON ALLOCATED ASSETS NOT USED
15 TO PROVIDE RETIREE HEALTH BENEFITS.—Section 4980
16 (relating to tax on reversion of qualified plan assets to em-
17 ployers) is amended by adding at the end thereof the follow-
18 ing new subsection:
19 "(e) ASSETS ALLOCATED TO RETIREE HEALTH BEN-
20 EFITS ACCOUNTS.—In the case of a plan which establishes a
21 health benefits account described in section 401(h), if—
22 "(1) amounts are allocated to a funded reserve ac-
23 count under section 420B, and
24 "(2) any amount in such account is paid or dis-
25 tributed other than to pay for qualified section 401(h)

1 medical benefits (as defined in section 420C(a)) provid-
2 ed through such account,
3 the amount so paid or distributed shall be treated as an em-
4 ployer reversion for purposes of this section, except that sub-
5 section (a) shall be applied by substituting '100 percent' for
6 '25 percent'."
7 (d) CONFORMING AMENDMENTS.—
8 (1) Section 419(e) (defining welfare benefit fund) is
9 amended by adding at the end thereof the following
10 new paragraph:
11 "(5) HEALTH BENEFITS ACCOUNTS.—The term
12 'welfare benefits fund' does not include any health ben-
13 efits account established under section 401(h)."
14 (2) The table of contents for part III of subchap-
15 ter D of chapter 1 is amended by inserting before the
16 item relating to section 420 the following new items:

"Subpart A. Excess pension assets.
"Subpart B. Treatment of health benefit accounts.

17 **"Subpart A—Excess Pension Assets".**
18 (e) EFFECTIVE DATE.—
19 (1) IN GENERAL.—Except as provided in para-
20 graph (2), the amendments made by this section shall
21 apply to contributions after December 31, 1990, in
22 taxable years ending after such date.

1 (2) INDIVIDUAL RETIREMENT ACCOUNTS.—The
2 amendments made by subsection (b) shall apply to ac-
3 counts established after December 31, 1990.

4 TITLE III—TRANSFER OF EXCESS 5 PENSION ASSETS

6 SEC. 301. TRANSFER OF EXCESS PENSION ASSETS TO RE- 7 TIREE HEALTH ACCOUNTS.

8 (a) IN GENERAL.—Subchapter D of chapter 1 (relating
9 to deferred compensation) is amended by adding at the end
10 thereof the following new part:

11 "PART III—TREATMENT OF TRANSFERS TO 12 RETIREE HEALTH ACCOUNTS

"Sec. 420. Transfers of excess pension assets to retiree health accounts.

13 "SEC. 420. TRANSFERS OF EXCESS PENSION ASSETS TO RETIR- 14 EE HEALTH ACCOUNTS.

15 "(a) GENERAL RULE.—If there is a qualified transfer of
16 any excess pension assets of a defined benefit plan to a health
17 benefits account which is part of such plan—
18 "(1) a trust which is part of such plan shall not be
19 treated as failing to meet the requirements of subsec-
20 tion (a) or (h) of section 401 solely by reason of such
21 transfer (or any other action authorized under this sec-
22 tion),
23 "(2) no amount shall be includible in the gross
24 income of the employer maintaining the plan solely by

1 reason of such transfer, and such transfer shall not be
2 treated as an employer reversion for purposes of sec-
3 tion 4980, and

4 "(3) the limitations of subsection (d) shall apply to
5 such employer.

6 "(b) QUALIFIED TRANSFER.—For purposes of this sec-
7 tion—

8 "(1) IN GENERAL.—The term 'qualified transfer'
9 means a transfer of excess pension assets by a defined
10 benefit plan to a health benefits account in a taxable
11 year beginning after December 31, 1990, with respect
12 to which the plan meets—

13 "(A) the use requirements of subsection
14 (c)(1),

15 "(B) the minimum benefit requirements of
16 subsection (c)(2), and

17 "(C) the long-term health care requirements
18 of subsection (c)(3).

19 "(2) ONLY 1 TRANSFER PER YEAR.—

20 "(A) IN GENERAL.—No more than 1 trans-
21 fer with respect to any plan during a taxable year
22 may be treated as a qualified transfer.

23 "(B) EXCEPTION.—A transfer described in
24 paragraph (4) shall not be taken into account for
25 purposes of subparagraph (A).

1 "(3) LIMITATION ON AMOUNT TRANSFERRED.—
2 The amount of excess pension assets which may be
3 transferred in a qualified transfer shall not exceed the
4 amount which is reasonably estimated to be the
5 amount the employer maintaining the plan will pay out
6 of such account under such plan during the taxable
7 year of the transfer for qualified current retiree health
8 liabilities.
9 "(4) SPECIAL RULE FOR 1990.—
10 "(A) IN GENERAL.—Subject to the provi-
11 sions of subsection (c), a transfer shall be treated
12 as a qualified transfer if such transfer—
13 "(i) is made after the close of the tax-
14 able year preceding the taxpayer's first tax-
15 able year beginning after December 31,
16 1990, and before the due date (including ex-
17 tensions) for filing the return of tax for such
18 preceding taxable year, and
19 "(ii) does not exceed the expenditures of
20 the employer for qualified current retiree
21 health liabilities for such preceding taxable
22 year.
23 "(B) INCLUSION WITH 1991 TRANSFER.—
24 An employer may elect to include the transfer de-
25 scribed in subparagraph (A) as part of the quali-

1 fied transfer for the employer's first taxable year
2 beginning after December 31, 1990. If an election
3 is made under this subparagraph, the limitation
4 under paragraph (3) for the taxable year shall be
5 increased by the amount determined under sub-
6 paragraph (A)(ii).
7 "(C) COORDINATION WITH REDUCTION
8 RULE.—Subsection (e)(1)(B) shall not apply to a
9 transfer described in subparagraph (A) with re-
10 spect to contributions to a welfare benefit fund.
11 "(5) TERMINATION.—No transfer in any taxable
12 year beginning after December 31, 1995, shall be
13 treated as a qualified transfer.
14 "(c) REQUIREMENTS OF PLANS TRANSFERRING
15 ASSETS.—
16 "(1) USE OF TRANSFERRED ASSETS.—
17 "(A) IN GENERAL.—Any assets transferred
18 to a health benefits account in a qualified transfer
19 (and any income allocable thereto) shall be used
20 only to pay qualified current retiree health liabil-
21 ities (whether directly or through reimbursement).
22 "(B) AMOUNTS NOT USED TO PAY FOR
23 HEALTH BENEFITS.—Any assets transferred to a
24 health benefits account in a qualified transfer (and
25 any income allocable thereto) which are not used

1 as provided in subparagraph (A) for the taxable
2 year of such transfer—
3 "(i) shall be transferred out of the ac-
4 count to the transferor plan, but
5 "(ii) shall not be includible in the gross
6 income of the employer for such taxable
7 year, and shall not be treated, for purposes
8 of section 4980, as an employer reversion.
9 "(2) MINIMUM BENEFIT REQUIREMENTS.—
10 "(A) IN GENERAL.—The requirements of
11 this paragraph are met if the applicable employer
12 cost for each year during the benefit maintenance
13 period is not less than the highest applicable em-
14 ployer cost for the 2 taxable years immediately
15 preceding the taxable year of the qualified
16 transfer.
17 "(B) APPLICABLE EMPLOYER COST.—For
18 purposes of this paragraph—
19 "(i) IN GENERAL.—The term 'applica-
20 ble employer cost' means the average em-
21 ployer cost per covered employee in provid-
22 ing applicable health benefits to covered em-
23 ployees.
24 "(ii) COVERED EMPLOYEE.—The term
25 'covered employee' means any employee who

1 is taken into account in determining the
2 qualified current retiree health liabilities with
3 respect to any qualified transfer.
4 "(C) BENEFIT MAINTENANCE PERIOD.—For
5 purposes of this paragraph, the term 'benefit
6 maintenance period' means the 3-taxable-year
7 period beginning with the taxable year in which
8 the qualified transfer occurs. If there is more than
9 1 qualified transfer applicable to any taxable year,
10 this paragraph shall be applied by taking into ac-
11 count the highest applicable employer cost.
12 "(D) MULTIPLE PLANS.—If applicable
13 health benefits are provided through more than 1
14 plan, such plans shall be treated as 1 plan for de-
15 termining the applicable employer cost.
16 "(E) SEPARATE APPLICATION FOR MEDI-
17 CARE-ELIGIBLE EMPLOYEES.—At the election of
18 the employer, this paragraph may be applied sep-
19 arately with respect to—
20 "(i) employees who are entitled to bene-
21 fits under title XVIII of the Social Security
22 Act, and
23 "(ii) employees not described in clause
24 (i).

1 "(3) LONG-TERM HEALTH CARE REQUIRE-
2 MENTS.—
3 "(A) IN GENERAL.—The requirements of
4 this paragraph are met if each employer maintain-
5 ing the plan—
6 "(i) makes available on and after the re-
7 quired beginning date a program providing
8 for long-term health care benefits to current
9 or retired employees through—
10 "(I) a health benefits account,
11 "(II) a cafeteria plan (as defined in
12 section 125(d)), or
13 "(III) any other arrangement
14 meeting the requirements of this chap-
15 ter, and
16 "(ii) participates in the cost of such pro-
17 gram.
18 "(B) LONG-TERM HEALTH CARE.—For pur-
19 poses of subparagraph (A)—
20 "(i) IN GENERAL.—The term 'long-
21 term health care benefit' means a benefit
22 which consists of the providing by a qualified
23 provider in a qualified facility of necessary
24 diagnostic, preventive, therapeutic, rehabili-

1 tative, and personal care services, required
2 by a chronically ill individual.
3 "(ii) CERTAIN ITEMS NOT INCLUDED.—
4 The term 'long-term health care benefits'
5 does not include basic medicare supplement
6 coverage, basic hospital expense coverage,
7 basic medical-surgical expense coverage, hos-
8 pital confinement indemnity coverage, major
9 medical expense coverage, disability income
10 protection coverage, accident only coverage,
11 specified disease or specified accident cover-
12 age, or limited benefit health coverage.
13 "(iii) QUALIFIED FACILITY.—For pur-
14 poses of this subparagraph, the term 'quali-
15 fied facility' means—
16 "(I) a rehabilitative, hospice, or
17 adult day care facility, including a hos-
18 pital, retirement home, skilled nursing
19 facility (within the meaning of section
20 1919(a) of the Social Security Act), or
21 other similar facility determined by the
22 plan administrator, or
23 "(II) a home where the chronically
24 ill individual resides.

1 "(iv) CHRONICALLY ILL INDIVIDUAL.—
2 For purposes of this subparagraph, the term
3 'chronically ill individual' means an individ-
4 ual whose disability is such that the individ-
5 ual has been certified as requiring assistance
6 with daily living (as defined by the plan ad-
7 ministrator) for a period of at least 90 days.
8 "(v) QUALIFIED PROVIDER.—For pur-
9 poses of this subparagraph, the term 'quali-
10 fied provider' means a medical practitioner
11 licensed under State law, registered nurse, li-
12 censed vocational nurse, qualified therapist,
13 or trained home health aid (or any organiza-
14 tion employing such providers), but does not
15 include a relative or other person who ordi-
16 narily resides in the home where the chron-
17 ically ill individual resides.
18 "(C) REQUIRED BEGINNING DATE.—For
19 purposes of paragraph (1), the term 'required be-
20 ginning date' means the later of the date which
21 is—
22 "(i) 2 years after the date of the enact-
23 ment of this paragraph, or

1 "(ii) 2 years after the date on which
2 excess pension assets are allocated to the
3 excess asset account.
4 A plan may provide a date which is earlier than
5 the date determined under the preceding sentence.
6 "(d) LIMITATIONS ON EMPLOYER.—For purposes of
7 this title—
8 "(1) DEDUCTION LIMITATIONS.—No deduction
9 shall be allowed—
10 "(A) for the transfer of any amount to a
11 health benefits account in a qualified transfer (or
12 any retransfer to the plan under subsection
13 (c)(1)(B)),
14 "(B) for qualified current retiree health liabil-
15 ities paid out of the assets (and income) described
16 in subsection (c)(1), or
17 "(C) for any amounts to which subparagraph
18 (B) does not apply and which are paid for quali-
19 fied current retiree health liabilities for the tax-
20 able year to the extent such amounts are not
21 greater than the excess (if any) of—
22 "(i) the amount determined under sub-
23 paragraph (A) (and income allocable thereto),
24 over

1 "(ii) the amount determined under sub-
2 paragraph (B).
3 "(2) NO CONTRIBUTIONS ALLOWED.—An em-
4 ployer may not contribute after December 31, 1990,
5 any amount to a health benefits account or welfare
6 benefit fund (as defined in section 419(e)(1)) with re-
7 spect to qualified current retiree health liabilities for
8 which transferred assets are required to be used under
9 subsection (c)(1).
10 "(e) DEFINITION AND SPECIAL RULES.—For purposes
11 of this section—
12 "(1) QUALIFIED CURRENT RETIREE HEALTH LI-
13 ABILITIES.—For purposes of this section—
14 "(A) IN GENERAL.—The term 'qualified cur-
15 rent retiree health liabilities' means, with respect
16 to any taxable year, the aggregate amounts (in-
17 cluding administrative expenses) which would
18 have been allowable as a deduction to the em-
19 ployer for such taxable year with respect to appli-
20 cable health benefits provided during such taxable
21 year if—
22 "(i) such benefits were provided directly
23 by the employer, and
24 "(ii) the employer used the cash receipts
25 and disbursements method of accounting.

1 For purposes of the preceding sentence, the rule
2 of section 419(c)(3)(B) shall apply.

3 "(B) REDUCTIONS FOR AMOUNTS PREVI-
4 OUSLY SET ASIDE.—The amount determined
5 under subparagraph (A) shall be reduced by any
6 amount previously contributed to a health benefits
7 account or welfare benefit fund (as defined in sec-
8 tion 419(e)(1)) to pay for the qualified current re-
9 tiree health liabilities.

10 "(C) APPLICABLE HEALTH BENEFITS.—
11 The term 'applicable health benefits' means health
12 benefits which are provided through the health
13 benefits account maintained by the employer to
14 employees of such employer who—

15 "(i) are eligible for pension benefits
16 under the defined benefit plan maintaining
17 the health benefits account, and

18 "(ii) have retired on or before the date
19 of the qualified transfer.

20 "(D) KEY EMPLOYEES EXCLUDED.—If an
21 employee is a key employee (within the meaning
22 of section 416(i)(1)) with respect to any plan year
23 ending in a taxable year, such employee shall not
24 be taken into account in computing qualified cur-
25 rent retiree health liabilities for such taxable year.

1 "(2) EXCESS PENSION ASSETS.—The term
2 'excess pension assets' means the excess (if any) of—
3 "(A) the amount determined under section
4 412(c)(7)(A)(ii), over
5 "(B) the amount determined under section
6 412(c)(7)(A)(i).
7 "(3) HEALTH BENEFITS ACCOUNT.—The term
8 'health benefits account' means an account established
9 and maintained under section 401(h).
10 "(4) COORDINATION WITH FULL-FUNDING LIMI-
11 TATION.—For purposes of determining the full-funding
12 limitation of any plan under paragraph (7) or (12) of
13 section 412(c), the assets transferred to a health bene-
14 fits account in a qualified transfer (and any income al-
15 locable thereto) shall be treated as assets of such
16 plan."
17 (b) CONFORMING AMENDMENT.—Section 401(h) is
18 amended by inserting ", and subject to the provisions of sec-
19 tion 420" after "Secretary".
20 (c) EFFECTIVE DATE.—The amendments made by this
21 section shall apply to taxable years beginning after
22 December 31, 1990.

○