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HEALTH CARE REFORM UPDATE

AOTA Executive Board Meeting
September 9, 1994
Bethesda, Maryland

****

I. Status of Mitchell-Gephardt Leadership Proposals

II. Current Congressional Activities

A. Senate

1. Mainstream Proposal
2. Harkin Alternative
3. Domenici-Nunn

B. House

1. Rowland-Bilirakis-Cooper

III. Outlook for Further Congressional Action

ALTERNATIVES TO MITCHELL-GEPHARDT LEADERSHIP BILLS

HOUSE

ROWLAND-BILIRAKIS-COOPER

SENATE

MAINSTREAM PROPOSAL

HARKIN ALTERNATIVE

DOMENICI-NUNN
(mirrors Rowland-Bilirakis-Cooper)

AOTA PRINCIPLES AS ADDRESSED IN MAINSTREAM PROPOSAL

UNIVERSAL COVERAGE	-	NO
INSURANCE REFORM	-	YES
COMPREHENSIVE BENEFITS WITH BROAD OT COVERAGE	-	YES (QUALIFIED)
MENTAL HEALTH PARITY	-	YES
LONG TERM CARE	-	YES
PROVIDER PROTECTIONS	-	YES

8/23/94
12 p.m.

MAINSTREAM COALITION PROPOSED AGREEMENT

PART ONE - COVERAGE

I. INSURANCE COVERAGE

This section guarantees access to Certified Health Plans for all U.S. citizens and lawful residents. It details the establishment of Community-Rated Areas (CRAs), institutes insurance market reforms, standardizes benefits packages, sets standards for Certified Health Plans (CHPs), establishes subsidies for low-income individuals and expands tax deductibility of health insurance premiums to individuals and the self-employed.

A. Assurance of Universal Coverage

1. A Health Commission must report to Congress biennially on the status of health insurance coverage in the nation. The report must include, but is not limited to, the structure and performance measures of every market area, including the following:

   a. Demographics of the uninsured, and findings on why those individuals are uninsured;

   b. Structure of delivery system;

   c. Number and organizational form of health plans;

   d. Level of enrollment in health plans;

   e. State implementation of responsibilities, including establishment of coverage areas;

   f. Status of insurance reforms;

   g. Development of purchasing groups and other buyer reforms;

   h. Success of market and other mechanisms of controlling health expenditures and premium costs in the market area and nationally;

   i. Adequacy of subsidies for low income individuals;

j. Status of Medicare beneficiaries, and their transition into Medicare Risk Contracts and CHPs;

k. Coverage progress among those who are employed, including status and level of voluntary employer contributions and participation rates in pools and among large employers;

l. Percentage of individuals who are enrolled in CHPs, separated into categories of Medicare, Medicaid, employed individuals and individuals eligible for low-income subsidies;

m. Informal recommendations, specific to each market area, on how the area might increase coverage among the residents and further moderate growth in premiums; and,

n. Evaluation of adequacy of benefit packages.

B. Coverage Recommendations

1. Establishes a national goal that 95% of all Americans will have health care coverage by 2002.

2. If this goal is not met, the Commission must submit formal and specific recommendations to Congress by January 1, 2002. The recommendations shall include methods to reach universal coverage in market areas that have failed to meet that target. They must address all relevant parties, including states, employers, employees, unemployed and low income individuals, public program beneficiaries, etc.

3. In addition to any other recommendations it submits, the Commission must make separate recommendations on the following:

   a. A method of encouraging full coverage which does not require any assessments on or contributions from employers;

   b. A schedule of assessments or contributions to encourage employers who are not doing so to purchase coverage for their employees;

   c. Possible adjustments to the benefits packages;

   d. Possible adjustments to subsidies; and,

   e. Possible adjustments to tax treatment of benefits.

4. Congressional Consideration of the Health Care Commission Report. The Commission recommendations are fully amendable, but are subject to an expedited process for consideration.

C. Community-Rated Area

The major vehicle for reorganizing the health care marketplace would be the establishment of geographic areas called Community-Rated Areas (CRAs). Employees of employers with 100 or fewer employees and individuals residing or working in the CRA would be pooled together and would be eligible for insurance at an age-adjusted community rate. CRAs are established by each state and a minimum number of 100,000 lives must be included in the CRA rating pool. States may enter into cooperative agreements to establish interstate CRAs.

Within each CRA, consumers will have several different options available to purchase health insurance. Employers and individuals may purchase coverage directly from an insurer or agent, they may enroll at designated state enrollment sites or they may choose to join a purchasing cooperative. Accountable Health Plans may charge different administrative (or enrollment) fees depending upon how the plan is purchased. If a Point of Service (POS) Option or fee-for-service plan is not available in the CRA in which an individual lives or works, the individual may purchase such a plan in an adjacent CRA.

D. Insurance Market Reforms

The Secretary of HHS shall, within six months of enactment, and in consultation with private expert entities such as the National Association of Insurance Commissioners (NAIC), develop federal standards which Certified Health Plans must meet in order to be deductible by an employer or an individual. While these federal standards will be established by the Secretary of HHS, certification of the plan will be by the state or the Department of Labor depending on the nature of the Health Plan. In general, all Certified Health Plans must:

1. Guarantee issue to all qualified applicants.

2. Guarantee availability throughout the entire CRA in which it is offered. States may waive this requirement for closed-panel networks if they meet anti-redlining standards.

3. Guarantee renewal to all qualified enrollees, except in instances of non-payment of premiums or fraud or misrepresentation.

4. Not deny, limit, or condition coverage based on health status, claims

experience, or medical history during the annual open enrollment period. The bill includes a first-time enrollment amnesty extended for a certain period after the date of enactment. Individuals are encouraged to maintain continuous coverage. Continuous coverage means that the period between the date of enrollment in a health plan and the last date of coverage may be no longer than three months. If an individual has not maintained continuous coverage or is enrolling in a plan for the first time after the initial open enrollment period, coverage may be subject to a pre-existing condition limitation of no more than six months. Pregnancy and pre-natal care are exempted from this limitation.

5. Comply with all rating requirements, including age and family size adjustments, within the coverage area.

6. Comply with enrollment process.

7. Comply with financial solvency requirements, premium and collection criteria.

E. Benefit Packages

1. Within six months of enactment, the Commission shall develop and submit to the Congress clarification of the initial standard and basic benefits packages. These packages must adhere to the following:

   a. The actuarial value of the Standard Benefit Package must be no greater than the actuarial value of the Blue Cross/Blue Shield Standard Option under the Federal Employees Health Benefits program.

   b. The Basic Benefit Package must contain higher cost sharing and/or fewer categories of benefits. It will have a lower actuarial value than the standard benefit package.

   c. Both benefit packages must include medically necessary or appropriate services within the covered benefit categories.

   d. Design the basic and standard benefits packages to prevent adverse risk selection when combined with the risk adjustments called for in the bill.

2. Categories:

   The following categories of benefits are to be included in the benefits package:

a. Inpatient and outpatient care, including hospital and health professional services.
b. Emergency, including appropriate transport services.
c. Preventive services, including services for high risk populations, immunizations, tests and clinician visits.
d. Mental Illness and Substance Abuse.
e. Family planning and pregnancy related services.
f. Prescription drugs and biologicals.
g. Hospice Care services.
h. Home health care services.
i. Outpatient laboratory, radiology and diagnostic services and medical equipment, including orthotics and prosthetics.
j. Extended care and outpatient rehabilitation services.
k. Vision care, hearing aids and dental care for individuals under 22 years of age.
l. Patient care costs pursuant to qualified investigational treatments.

3. Priorities:

Within the constraints of the actuarial limits set in this act, Congress directs the Commission to adhere to the following priorities:

a. Parity for mental health and substance abuse services, which shall consist of a broad array of mental health and rehabilitation services managed to ensure access to medically necessary or appropriate services, and psychologically necessary or appropriate treatment and to encourage the use of outpatient treatments to the greatest extent feasible.

b. Consideration for needs of children and vulnerable populations, including rural and underserved persons.

c. Improving the health of Americans through prevention.

4. Medically Necessary or Appropriate

A Certified Health Plan shall provide for coverage of the categories of benefits described in this section for treatment and diagnostic procedures that are medically necessary or appropriate.

An item or service is "medically necessary or appropriate" if, consistent with prevailing medical standards, it is;

a. For treatment of a medical condition.

b. Safe and effective (i.e., there is sufficient evidence to demonstrate that the service can reasonably be expected to produce the intended health outcome and if the expected benefit outweighs any potential harm.

c. Medically appropriate for the enrollee (i.e., it can reasonably be expected to provide a clinically meaningful benefit for the enrollee).

5. Cost-Sharing

The Commission shall also develop multiple cost sharing schedules which vary by delivery system organization. In making these determinations, the Commission will consult with expert groups for appropriate schedules for covered services. This clarification is subject to approval by Congress under expedited procedures.

6. Limitations

The Commission is prohibited from specifying provider types, or specific procedures or treatment in the benefit packages.

7. Consideration of Commission Recommendations

The Commission will have the authority to propose modifications to the benefits package (within the actuarial value ceiling described above) that would not go into effect unless approved by Congress. The Commission is responsible for any updates to the benefits packages after the first year and these updates are also subject to Congressional approval under expedited procedures.

II. CERTIFIED HEALTH PLANS

A. Accountable Health Plans (AHPs)

1. Definition: a health plan that may be operated as a variety of delivery systems such as indemnity plans, preferred provider organizations, health maintenance organizations, or other delivery systems. An AHP is a health plan that is certified by the state as meeting insurance market reform standards, health plan standards, quality, reporting standards, and other standards. It may be offered in the community-rated or experience-rated markets.

2. Standards

a. Must meet insurance reforms described in (I., D.).

b. May not engage in marketing or other practices intended to discourage and/or limit the issuance to eligible individuals on the basis of health condition, industry, geographic area or other risk factors.

c. Must demonstrate its ability to make available and accessible to each potential enrollee in the area the full range of benefits required under the standard and basic benefit packages.

d. Must not accept enrollment of an individual who is currently enrolled in another AHP.

e. Must make available to nonparticipating providers the criteria used in selecting those providers that are permitted to participate in the plan.

f. Must comply with federal information requirements.

g. Must offer the standard and basic benefit packages, but may also offer benefits in addition to these packages, if such additional benefits are offered and priced separately from the standard and basic benefit packages.

h. Must comply with a system of claims dispute resolution for coverage disputes.

i. Must comply with Essential Community provider provisions.

B. Self-Insured (Risk Bearing) Plans (SIPs)

1. Definition: a group health plan for which the employer or association retains a significant portion of the insurance risk. They are regulated by DoL and are subject to ERISA. They are an option in the experience-rated market. Some association plans serving the community-rated market are grandfathered as discussed in (II., C).

2. Standards:

   a. Self-insured plans must meet all the standards for AHPs, including the insurance market reforms, except they must accept only their own employees or members (and their dependents, if applicable) and the population they must serve and area they must cover is defined by such plan's workforce or membership.

b. Financial solvency standards will be established by the Secretary of the Department of Labor (DoL) consistent with the applicable rules under Part 4 of Title I of ERISA.

c. The Secretary of DoL may take corrective actions to terminate or disqualify a self-insured plan that does not meet the above standards.

C. Certified Association Plans (CAPs)

1. Definition: Associations that have been in existence for three years prior to the date of enactment may continue to sponsor experience-rated health plans for their members who fall within the community-rated market.

2. Standards:

   a. Must meet all standards for AHPs with the following exceptions:

      i. Special solvency requirements will be established by DoL for CAPs.

      ii. Are required only to take any member in their designated association.

3. Requirements for Sponsoring Entity (Association)

   a. Must be organized and maintained in good faith.

   b. Must have appropriate by-laws that specifically state the purpose, as a trade association, industry association, professional association, chamber of commerce, religious organization, or public entity association.

   c. Must have been established and maintained for substantial purposes other than to provide the health care required under this section.

   d. Must be, and have been, in operation (together with its immediate predecessor, if any) for a continuous period of not less than 3 years.

   e. Must receive the active support of its membership.

4. Treatment of Multiple Employer Welfare Arrangements (MEWAs)

a. In general, upon enactment, a MEWA will meet the standards to become either a CAP or an association purchasing cooperative. (defined in Section III., D.)

b. Any self-insured MEWA that has been in effect for not less than 18 months prior to enactment and with respect to which there is an application pending with the domicile state for certification as a CAP, shall be treated as a CHP (if such plan otherwise meets the requirements of this Act);

c. However, MEWAs will not be able to continue to operate if the domicile state can demonstrate that --

i. the sponsor has made fraudulent or material misrepresentation(s) in the application;

ii. the plan that is the subject of the application, on its face, fails to meet the requirements for a complete application; or

iii. a financial impairment exists with respect to the applicant that is sufficient to demonstrate the applicant's inability to continue its operations.

D. Multi-Employer (Taft-Hartley) Plans, Rural Electric Cooperatives (RECs), Rural Telephone Cooperative (RTCs), and Church Plans

Taft-Hartley plans, RECs, RTCs, and Church Plans must meet the same requirements as large employers. (See Section III.B. below)

E. Public Programs

Existing public programs like Medicare, Medicaid, Department of Defense health programs, Department of Veterans Affairs health programs and Indian Health Service programs are considered to be CHPs for the purposes of this section.

F. Pre-emption of Certain State Laws regulating Insurance Plans

The following state laws relating to health plans are preempted for any CHP:

1. State laws that restrict plans from:

a. limiting the number and type of providers who participate in a plan;

b. requiring enrollees to obtain health services from participating providers;

c. requiring enrollees to obtain referral for treatment by a specialist or health institution;

d. establishing different payment rates for participating providers;

e. creating incentives to encourage the use of participating providers;

2. State mandated benefit laws.

G. Patients Right To Self-Determination

1. Extends current requirements under the Patient Self-Determination Act. In notifying patients of their right to execute an advance directive, institutions must also notify individuals of what happens in the absence of an advance directive. Such institutions must also have a process in place to provide for effective communication between the patient and provider regarding treatment decisions and advance directives.

2. Requires Certified Health Plans to notify enrollees of their rights to self-determination in health care decision-making and of the Plan's policy regarding advance directives, and to comply with the other requirements of Patient Self-Determination Act.

3. Clarifies that validly executed advance directives are portable and will be honored in other states.

III. LARGE AND SMALL EMPLOYER RESPONSIBILITIES AND PURCHASING COOPERATIVES

A. Small Employers

1. Definition: employers with 100 or fewer full-time employees.

2. Responsibilities:

a. May not sponsor a self-insured plan, but if a member of an eligible Association may join a CAP.

b. Must provide all employees (including part-time and seasonal)

with the state-provided standard information regarding all AHPs offered in the CRA in which the employer is located.

c. If an employee resides in another CRA, the employer must provide information regarding how to obtain information regarding AHPs available in that CRA.

d. Small employers must make available to their employees a choice of at least three CHPs one of which must be either a point-of-service or a fee for service plan, if available, either by joining a purchasing group or through independent brokers or insurance agents.

e. Payroll Deduction. If an employee requests, employers must arrange for payroll deduction to pay the premium amount due, less any employer contribution, to the health plan or purchasing cooperative selected by the employee.

B. Large Employers

1. Definition: employers with more than 100 full-time employees.

2. Responsibilities:

a. All large employers must offer their employees a choice of at least three CHPs, one of which must be either a point-of-service option or a fee-for-service plan, if available. A large employer may comply with this subsection by offering three CHPs provided by a single carrier.

b. Large employers and their employees are ineligible to join the small employer and individual purchasing cooperatives or to purchase insurance at the community rate either through a broker, independent agent, purchasing cooperative, or public enrollment office.

c. All large employer purchasers are regulated by the DoL and remain subject to ERISA.

d. If an employer contributes to its employee's health coverage, it must provide coverage as of the first day of the month in which an employee becomes eligible. Once terminated, coverage continues through the end of the month of termination.

C. Individual and Small Employer Purchasing Cooperatives

1. Individuals and small employers have the same purchasing power and economies of scale as large companies with the option to buy health insurance through purchasing cooperatives at the age-adjusted community rate.

2. States must establish CRAs and certify purchasing cooperatives.

3. Cooperatives are voluntary and may be either public or private.

4. They may serve multiple community-rated areas in multiple states.

5. Cooperatives do not assume risk, and do not have any regulatory authority.

6. They must accept all individuals and small businesses in the CRA they serve.

7. They must enroll and administer health plans for individuals and employees of small business who wish to join.

8. Membership in these purchasing cooperatives will be voluntary and limited to employers and employees of businesses with 100 or fewer employees, and to all other non-Medicaid U.S. citizens or legal residents not employed by a large employer who live in the CRA.

9. Nothing in the Act shall be construed to require any individual or small employer to purchase exclusively through a purchasing cooperative.

10. Nothing in the Act requires the establishment of a purchasing cooperative nor prohibits the establishment of a purchasing cooperative in an area.

11. Nothing shall be construed to prevent more than one purchasing cooperative in a CRA.

D. Association Purchasing Cooperatives (APCs)

1. Definition: Associations that have been in existence for three years prior to the date of enactment may offer health plans to their members at the adjusted community rate.

2. Standards: Must meet all standards for purchasing cooperatives, except that they may offer plans only to members in their designated association. They are permitted to offer one experience rated plan, but all other plans must be offered at the age-adjusted CRA community

rates.

3. Requirements for Sponsoring Entity (Association)

   a. Must be organized and maintained in good faith.

   b. Must have appropriate by-laws that specifically state the purpose, as a trade association, industry association, professional association, chamber of commerce, religious organization, or public entity association.

   c. Must have been established and maintained for substantial purposes other than to provide the health care required under this section.

   d. Must be, and have been, in operation (together with its immediate predecessor, if any) for a continuous period of not less than 3 years.

   e. Must receive the active support of its membership.

E. Allowing Access to Federal Employee Health Benefit Program

Any plan under the Federal Employee Health Benefit plan offered to federal employees in a CRA must be available for purchase by individual and small group purchasers in that area. Non-federal employee purchasers shall pay a premium amount based on the local community rate for that plan, and shall not be a part of the FEHB insurance pool. Plans offered nationally through FEHB shall not be required to be open to non-federal employee enrollment.

IV. NONDISCRIMINATION PROVISIONS THAT APPLY TO ALL EMPLOYERS:

A. General Rules

Employers that contribute to the purchase of any employee's health care coverage may not discriminate against any employee based on the employee's income. Employers may not vary that dollar amount of their contribution to an employee's health care coverage based on the plan selected by the employee, among those offered by the employer.

1. For purposes of part-time employees, a dollar contribution will constitute an equal dollar contribution if the employer makes a dollar contribution proportionate to the number of hours worked by the part-time employee.

B. Definitions

1. A full-time employee is defined as an individual who is employed for an average of 25 or more hours per week.

2. A part-time employee is defined as an individual who is employed for an average of at least 10 hours per week, but less than 25 hours per week.

3. An individual does not qualify as a full-time or part-time employee until the individual has been employed for six months (i.e., seasonal employees are not treated as part-time employees).

C. Exemption for Collectively Bargained Plans

Single-employer and multi-employer bona fide collectively bargained plans are exempt from these nondiscrimination rules.

V. ROLE OF FEDERAL AND STATE GOVERNMENTS

States establish programs to implement the Act's requirements based on federal guidelines. The federal government does not require states to set up specific processes or bureaucracies. The Federal government continues to oversee ERISA plans. States can implement a single-payer system that allows certain large employers to opt out.

A. Responsibilities of State Governments

1. States must establish a state program to carry out state responsibilities specified in the Act. State responsibilities include:

   a. Certifying insured health plans (as they do now);

   b. Establishing Community-rated Areas;

   c. Establishing procedures for setting up and operating purchasing cooperatives;

   d. Preparing standardized information concerning CHPs;

   e. Administering a risk adjustment program for community-rated health plans; and

   f. Specifying an annual general open enrollment period and an

initial enrollment period for community-rated plans.

2. States must establish State programs by January 1, 1996.

3. States must submit to the Secretary of HHS, at intervals determined by the Secretary, a report on compliance of the state with the above requirements.

B. Responsibilities of Federal Government.

1. The Secretary of HHS must, among other things, periodically review state programs and notify states of failure to comply with federal requirements;

2. The Secretary of Labor's duties include:

   a. Establishing standards for self-insured health plans (in consultation with the Secretary of HHS), including applying certain fiduciary and fund management requirements in ERISA;

   b. Certifying (and decertifying) self-insured health plans.

C. Single Payer systems.

States can implement a single-payer system that allows certain large employers to opt out.

VI. ASSISTANCE TO INDIVIDUALS AND FAMILIES FOR THE GENERAL PURCHASE OF INSURANCE

A. Eligibility For Vouchers:

1. Individuals and/or families not otherwise eligible for Medicare or Medicaid, whose income is less than 200% of the federal poverty level will be eligible for a voucher for the purchase of a CHP.

2. Subsidies will also be available for pregnant women and children up to 18 years with incomes up to 240% of the Federal poverty level.

B. Amount of Voucher

1. For individuals and families with incomes less than 100% of poverty the voucher will be equal to the average premium of the standard benefit packages offered by AHPs in the CRA in which they reside or

work.

2. For individuals and families with income above 100% of the federal poverty level, the Voucher amount will be decreased on a sliding scale basis to 200% of the federal poverty level.

3. Pregnant women and children up to 18 years with incomes less than 185% of the federal poverty level, will receive a full voucher, and from 185% to 240% the voucher amount will be decreased on a sliding scale.

C. Phase-in Schedule for Vouchers

1. Vouchers for individuals and families will be phased-in at the beginning of each year under the following schedule: (subject to additional information from CBO)

Calendar Year	Percentage of Poverty
1997	90%
1998	105%
1999	120%
2000	135%
2001	150%
2002	165%
2003	180%
2004	200%

2. Vouchers for pregnant women and children up to 18 years will be phased in at the beginning of each year under the following schedule:

Calendar Year	Percentage of Poverty
1997	185%
1998	215%
1999	240%

D. Administration of Vouchers

1. The Secretary of HHS will establish a mechanism for determining eligibility for vouchers, for distributing application forms, and to the extent practicable, for allowing enrollment in a CHP at the time of application for subsidy.

2. The Secretary may provide for administration of Vouchers through an

appropriate State agency.

E. Expanded Tax Deductibility (Described in Section XII.,B.)

VII. EXPANDING ACCESS FOR RURAL AND UNDERSERVED POPULATIONS

A. Community-Based Primary Care Grant Program

Competitive grants are authorized to develop community health networks, certified community health plans, and provide capital assistance. The grants will help address geographic, financial and other barriers to health care services in underserved urban and rural areas. The agreement also authorizes rural health plan demonstrations to improve access to plans in rural areas, and a telemedicine program to assist rural providers with specialty consultation, continuing education, referrals, and provider collaboration.

B. Tax Incentives for Practice in Rural, Frontier, and Urban Underserved Areas (As described in Section XII., D.)

C. Medicare Dependent Hospitals

1. Modify Payments to Medicare Dependent Hospitals in the following manner:

   a. base payments on a 36 month period beginning with the first day of the cost reporting period that begins on or after April 1, 1990;

   b. conform target amounts to extension of additional payments;

   c. clarify of updates; and,

   d. extend Medicare-dependent hospital classification through 1999.

D. Limited Service Hospital Program

Expands the EACH/RPCH and MAF programs to all states and makes technical improvements to both programs.

E. Extends the Rural Health Transition Grant Program

Extends the program through FY 1998 with authorized appropriations of $30 million annually, FY 1993 - 1998. Reports from grantees would be required every 12 months. As of October 1, 1994, RPCHs are eligible for rural health

transition grants.

F. Increases of reimbursement to PAs and NPs and Direct Payment for Nurses as Assistants at Surgery under Medicare

1. Certified Nurse Practitioners and Physicians Assistants would be reimbursed at 85% of the RBRVS rate for services performed in all outpatient settings.

2. Under Medicare, certified Nurse Practitioners would be reimbursed at 65% of the RBRVS rate for assisting at surgery in urban areas.

3. States would be required to directly reimburse all certified Nurse Practitioners in a rural area under Medicaid. This expands the current requirement that all states directly reimburse pediatric and family Nurse Practitioners, which gives states the option of directly reimbursing other types of NPs.

4. Under Medicare, registered nurses under the supervision of a physician as an assistant at surgery and legally authorized by the state would be reimbursed.

G. Telemedicine and Related Telecommunications Technology

1. Coordinates various federal grant programs which fund telemedicine and related telecommunications demonstrations and grant programs. This provision establishes a federal interagency task force, coordinated and chaired by the Department of Health and Human Services, would be established to oversee telemedicine and other telecommunications demonstration projects already underway.

2. A demonstration grant program would be established to fund telemedicine and related telecommunications technology in rural areas. The program would be administered through the Secretary of Health and Human Services. Applicants for the grant would be rural health care providers such as rural referral centers, rural health clinics, community health centers, migrant health centers, area health and education centers, local health departments and public hospitals.

VIII. NEW HOME AND COMMUNITY-BASED LONG TERM CARE PROGRAM

A. General

States would have the option of establishing a new program for home and community based long term care for individuals with disabilities

under the Medicaid program. The Secretary would be required to designate an agency responsible for program administration within six months of enactment. States could implement programs on or after January 1, 1998.

B. Eligibility

The State plan must specify a system for conducting an initial screening to determine if a individual has a qualifying level of disability. A State may not limit eligibility for services based on: age, geography, nature, or category of disability, residential setting (other than an institutional setting), or on other grounds specified by the Secretary except that a State would be permitted to limit eligibility for services based on the level of disability. The State plan would have to assure that an individual receiving Medicaid home and community based services would continue to receive an appropriate level of services either under Medicaid. An eligible individual must have an income at or below 150% of the federal poverty level, however, persons with developmental disabilities are not subject to the means test, but will pay cost sharing and premiums based on income.

C. Covered Services

1. **Care Management.**
The State program must make available care management services which include a (1) comprehensive assessment of the individual's need for home and community based services, (2) an individualized plan of care based on the assessment, (3) arrangements for the provision of services specified in the plan of care, and (4) monitoring the delivery of services.

2. **Personal Care.**
The program shall include personal care in the array of services covered by the State. Available personal care services shall include both agency-administered and consumer-directed. States shall act as the employer of personal providing consumer-directed personal care services and assume responsibility for providing bill, provider payment,tax withholding, unemployment insurance and workers' compensation coverage. Beneficiaries shall retain the right to select, hire, terminate, and direct the services of a consumer-directed provider.

3. **Additional Services.**
States may provide a range of services in addition to care management and personal care including; home-maker and chore assistance, home modifications, respite services, assistant devices, adult day services, habilitation and rehabilitation, supported employment, home health services, transportation, and other care or assistive services specified by

the State and approved by the Secretary.

D. Federal Matching Payments to States

Federal matching rate shall be the Federal Medical Assistance Matching Percentage plus 15 percentage points, except that the Federal percentage under this part shall not exceed 90 percent.

E. Funding, Allotments to States

For federal Fiscal years 1996-2002 ten billion dollars.

PART TWO - COST CONTAINMENT & CONSUMER PROTECTION

IX. COST CONTAINMENT

A. Limit On The Amount Of Health Insurance To Be Deductible (described in Section XII.,A.)

B. Medical Liability Reform

1. Alternative Dispute Resolution

   a. No health care malpractice action may be brought in court until final resolution of the claim under an alternative dispute resolution (ADR) method adopted by the state from models developed by the Secretary of HHS, or developed by the state and approved by the Secretary of HHS.

   b. If the party initiating court action following the ADR receives a worse result with respect to liability or a level of damages 33 1/3% below that awarded in the ADR if initiated by plaintiff (or 33 1/3% above if initiated by the defendant) that party must pay the costs and attorneys fees of the other party incurred subsequent to the ADR.

2. Damages

   Non-economic damages awarded to a plaintiff in a health care malpractice claim or action may not exceed $250,000, indexed for inflation. Within one year, an advisory committee will recommend to Congress a sliding scale of limits for non-economic damages, based on severity of harm.

3. Several Liability

The liability of each defendant in a health care malpractice action for non-economic and punitive damages will be based on each defendant's proportion of responsibility for the claimant's harm.

4. Punitive Damages

Seventy-five percent of punitive damage awards will be paid to the state in which the action is brought and such funds will be used for provider licensing, disciplinary activities and quality assurance programs.

5. Fee Reform

Lawyers may not charge contingency fees greater than 33 1/3% of the first $150,000 of the award in a health care malpractice action and 25% of amounts in excess of $150,000. Calculation of permissible contingency fees is based on after tax amounts.

6. Limited Preemption

State laws that have higher limits on attorneys fees and non-economic damages are preempted. This section does not preempt state laws to the extent such laws impose greater restrictions on attorneys fees, damages or liability, or provide additional defenses to malpractice actions.

C. Remedies For Benefit Claims Disputes

In general, all claims disputes are adjudicated by a neutral third-party, not affiliated with the health plan. A clear distinction is made between the coverage dispute resolution process and utilization review negligence.

1. Claims disputes, whether with respect to a pre-authorization decision or a post-treatment payment dispute, would be handled exclusively under an expedited administrative process, unless the plan establishes an alternative mandatory binding arbitration process that is certified by the Department of Labor.

2. The administrative process is Federally run with both urgent and non-urgent post-plan review by Federal grievance review officers with mediation of all claims prior to ruling. All pre-authorization decisions will be granted de-novo review by the hearing officers. Health Plans' post-treatment payment disputes will be given deferential treatment by the decision maker. Decisions

can be appealed to the U.S. Court of Appeals.

3. A plan may establish a mandatory binding arbitration system in which all plan participants would be required to participate. This arbitration process would be required to be certified by the Department of Labor and would have to meet specific consumer protection and neutrality requirements. The provisions of Title 9, U.S. Code, on arbitration shall also govern. This includes the ability to set aside an arbitration award that is in manifest disregard of the law. The arbitrators' decisions would have to be reported to the Department of Labor so that a consistent body of decisions could develop.

4. Remedies available through the administrative process or arbitration are: payment of the claim or ordering the treatment, pre-judgement interest and costs (including reasonable attorney's fees to a prevailing claimant). A plan could recover attorney's fees from the claimant or claimant's counsel (as determined by the hearing officer) in the event of a frivolous claim.

5. If the Department of Labor determines that a plan has a pattern and practice of bad-faith claims denial, the Department can assess a civil monetary penalty of up to $1 million.

6. Persons conducting pre-authorization or utilization review are required to use reasonable care in making medical judgements with respect to determining whether a treatment, item, or service requested by a participant was medically necessary or appropriate. A Federal cause of action has been established to handle these claims.

   a. In order to recover, plaintiff would have to demonstrate that the person's medical judgement to deny coverage, or authorization,fails to satisfy a federally defined standard of care and that the standard medical judgement actually and proximately resulted in the denial or delay of medical care, which resulted in medical harm.

      Plaintiff would also be required to exhaust plan and administrative remedies and to mitigate damages. A decision by a hearing officer or arbitrator (upheld on appeal) that the plan was correct in denying coverage would be a complete defense to this cause of action.

   b. Utilization reviewers that fail to use reasonable care may be liable for compensatory damages with a cap on non-economic damages.

D. Administrative Simplification, Paperwork Reduction, and Privacy

This section would implement a national health information network to reduce the burden of administrative complexity, paperwork, and cost on the health care system; to provide information on cost and quality; and to

provide information tools that allow improved fraud detection, outcomes research, and quality of care.

1. Requirements for the Secretary of HHS

   A. The Secretary would be required to implement a national health information network by adopting standards for:
      1. representing the content and format of health information in both paper and electronic form,
      2. transmitting health information over the network,
      3. conducting transactions using this information,
      4. certifying public or private entities to perform the intermediary functions which implement the network, and
      5. monitoring performance to assure compliance.

   B. The Secretary would be required to establish expedited procedures to adopt health information standards that are already in common use or that are recommended or developed by standards setting organizations accredited by the American National Standards Institute (ANSI).

   C. The Secretary would be required to establish procedures for:
      1. adding codes to previously adopted standards;
      2. making changes to previously adopted standards; and
      3. developing, testing, and adopting new standards.

2. Establishment of a Health Information Advisory Committee

   The Secretary would be required to consult with a Health Information Advisory Committee consisting of 15 members from the private sector including providers, consumers, and experts with practical experience in developing and applying health information and networking standards. The members would be appointed by the President and serve staggered, 5 year terms.

3. Requirements for Health Plans and Health Care Providers

   A. All health plans, including Federal and State health programs, and all health care providers would be required to participate in the health information network either directly or through a contract with a certified health information service.

   B. The Secretary may require other transactions to be conducted electronically, consistent with the goal of reducing administrative costs.

   C. In addition, plans and providers would be required to make certain standard data available electronically on the health information

network to authorized inquiries.

4. Standards for Accessing Health Information

The Secretary would be required to establish technical standards for requesting standard health information from participants in the health information network which assure that a request for health information is authorized under the Privacy and Confidentiality Subtitle or that it requests health information that is not protected under the Privacy and Confidentiality Subtitle because individuals cannot be identified using the information requested.

The Secretary would be required to establish standards for the appropriate release of health information to researchers and government agencies, including public health agencies. The Secretary would establish standards for the electronic identification of a request as one which comes from a person authorized to receive the requested health information under the Subtitle on Privacy and Confidentiality.

5. Replacement of Medicare and Medicaid Coverage Data Bank

The function of the Medicare and Medicaid Coverage Data Bank would be replaced through the requirement on all health plans to ensure the electronic availability on the health information network of standardized enrollment and eligibility information on every covered individual.

In order to be certified, health information network services would be required to be capable of performing automated electronic coordination of benefits and responding to queries from health care providers and health plans, in standardized transactions as defined by the Secretary, regarding the enrollment and coverage for any individual under any health plan.

E. Privacy And Confidentiality

1. Rule Of Nondisclosure For Protected Health Information

All health information that could reasonably be related to a specific individual would be protected from disclosure. Comprehensive protections of this protected health information would apply regardless of form or medium, whether kept in paper files or in electronic databases, whether retained in doctors' offices or insurance company files, or available from an information system or over a computer network.

2. Penalties

Unauthorized disclosures of protected health information would be subject to criminal sanctions, civil actions, and administrative penalties. Penalties would range from fines of up to $50,000 and prison terms of up to one year for wrongful disclosure or obtaining of protected health information, to fines of up to $100,000 and prison terms of up to five years for violations committed under false pretenses, to fines of up to $250,000 and prison terms of up to ten years for offenses committed with intent to sell protected health information for commercial advantage or personal gain.

F. Quality Management and Improvement

The Secretary shall establish a National Quality Council to oversee a program of quality management and improvement designed to enhance the quality, appropriateness and effectiveness of health care services and access to such services.

The National Quality Council, appointed by the President and confirmed by the Senate, has the following duties:

1. develop national goals and performance measures;
2. develop survey methodology and sampling methods;
3. oversee the design and production of Consumer Report Cards;
4. oversee the quality improvement foundation (QIF) demonstration project.

G. Anti-fraud and Abuse Control Program

This subtitle establishes a stronger, better coordinated federal effort to combat fraud and abuse in our health care system. It expands criminal and civil penalties for health care fraud to provide a stronger deterrent to the billing of fraudulent claims and to eliminate waste in our health care system resulting from such practices. It also seeks to deter fraudulent utilization of health care services. It would:

1. Require the HHS Secretary and Attorney General to jointly establish and coordinate a national health care fraud program to combat fraud and abuse in government and Qualified Health Plans;

2. Finance the anti-fraud efforts by setting up an Anti-Fraud and Abuse Trust Fund. Monies from penalties, fines, and damages assessed for health care fraud are dedicated to the Trust Fund to pay for the anti-fraud efforts;

3. Provide better guidance to health care providers through new

safe harbors, interpretive rulings and special fraud alerts to help them comply with fraud and abuse laws.

4. Increase and extend Medicare and Medicaid civil money and criminal penalties for fraud to all health care programs;

5. Bar providers convicted of health care fraud felonies from participating in the Medicare program;

6. Establish a new health care fraud statute patterned after existing mail and wire fraud statutes under Title XXIII of the Criminal Code and allows for criminal forfeiture of proceeds.

X. REFORM OF EXISTING PUBLIC PROGRAMS

A. Medicaid

1. State Flexibility to Contract for Coordinated Care Services

a. States have the option to establish a program under Medicaid program to allow states to enter into contracts with at-risk primary care case management (PCCM) providers.

b. An at-risk PCCM provider must be a physician, group of physicians, a federally qualified health center, a rural health clinic or other entity having other arrangements with physicians operating under contract with a state to provide services under a primary care case management program.

c. Qualified risk contracting entities must:

i. meet federal organizational requirements;

ii. guarantee enrolled access; and,

iii. have a written contract with the state agency that includes:

(a) an experienced-based payment methodology;

(b) premiums that do not discriminate among eligible individuals based on health status;

(c) requirements for health care services; and,

(d) detailed specification of the responsibilities of the

contracting entity and the state for providing for, or arranging for, health care services.

d. Meet federal standards for internal quality assurance.

e. Enter into written provider participation agreements with essential community providers;

1. States are required to contract directly with essential community providers, or at the election of the ECP, each risk contracting entity may enter into agreement to make payments to the essential community provider for services.

B. Medicare

1. Medicare remains a separate program and continues to be federally administered. Beneficiaries enrolled in Part B continue to pay a monthly premium. The statutorily defined Medicare benefits continue to be the Medicare benefit package in both fee-for-service and managed care.

2. Beneficiary opt-in to private Certified Health Plans.

a. Medicare beneficiaries may opt into a certified health plan in their CRA.

b. For individuals choosing an CHP, Medicare will pay the federal contribution calculated for Medicare risk contracts. Individuals are responsible for paying the difference between the premium charged and the federal contribution.

c. During the annual enrollment period, Medicare-eligible persons may choose a new plan through their employer/purchasing cooperative or they may return to the traditional Medicare program.

3. Medicare Select

a. The Medicare Select program would become a permanent option in all States.

b. Medicare Select policies will be offered during Medicare's coordinated open enrollment period.

c. Plans may not discriminate based on health status.

4. Medicare Risk Contract Program

This program is improved to encourage more plan participation including revision of federal payment to help plans to reflect market cost. Additionally, it makes comparing available choices easier for beneficiaries.

5. Administrative Simplification

The Secretary has authority to consolidate the functions of fiscal intermediaries and carriers. Provides for coordination of Medicare and supplemental insurance claims processing. Permits standardized, paperless process.

6. Study and Demonstration for Medicare Cost Containment

a. Requires ProPAC and PPRC to study and make recommendations to Congress regarding ways to slow the rate of Medicare growth at the local market level. The study should include ways to set local expenditure targets and monitor success in controlling costs. Updates for payment rates under Parts A and B should be set to achieve local targeted expenditure levels, while rewarding efficient providers and/or markets.

b. A demonstration is authorized to evaluate Part A expenditures for hospital service and/or Part B expenditures in fee for service using provider-group or State-level volume performance standards.

XI. FISCAL RESPONSIBILITY

Fail-Safe Mechanism

The bill establishes a Fail-Safe mechanism to ensure health care reform reduces the deficit. Details are described below:

1. A Current Health Spending Baseline (CHSB) is established. The CHSB includes:

a. Medicare Expenditures
b. Medicaid Expenditures
c. Health Related Tax Expenditures
   i. The employee exclusion of employer-provided health insurance premiums.
   ii. Employer deduction for health insurance premiums.
   iii. 7.5% floor for deduction of medical expenses.

2. A Health Reform Spending Estimate (HRSE) is established. The HRSE includes:

   a. Everything included in the CHSB.
   b. Deduction for purchase of Certified Health Plans by all self-employed and individuals.
   c. Cigarette excise tax.
   d. Vouchers for purchase of a Certified Health Plan.
   e. Limit on Deductibility of health insurance for employees
   f. Deficit reduction of approximately 100 billion over 10 years (pending discussion with CBO)

3. In any year that the Director of OMB notifies Congress that HRSE will exceed the CHSB, the following automatic actions will occur to prevent a deficit increase:

   a. The voucher phase-in is delayed.
   b. The expanded tax deduction phase-in is slowed down.

4. Congress may act on alternative recommendations made by the National Health Commission to avoid the actions listed above.

5. If Medicare increases are the cause of excess spending, the President must make specific recommendations to reduce Medicare each year.

6. The President is required to identify the percentage of federal taxes that are being spent on total federal health care programs. For each year in which total federal health spending rises, Congress must report on the additional amount of federal taxes that are attributable to federal health care spending.

XII. TAX PROVISIONS

A. Limit on Employer Deductibility

1. Beginning in 1997 the deductibility of employer contributions for the standard or basic health insurance premium cost will be limited to 110% of the average cost of such plans in the community-rated market. For experience rated plans, employers may choose between the limit determined annually for the community-rated market or the plan's actual costs for 1997. The 1997 cost amount is frozen for the purpose of this calculation in subsequent years. This will create additional incentives for employers and employees to bring down the cost of their health plans through more efficient health care delivery. Beginning in the year 2000, supplemental insurance policies that cover copayments and deductibles under the standard or basic plans are non-deductible to the employer and taxable to the employee. Other supplementals remain fully deductible to the employer and excludable to the employee.

B. Assistance to Individuals and Families -- Expanded Tax Deductibility

1. Self-employed individuals are provided a full deduction for the cost of health insurance (i.e., not subject to the 7.5% floor), subject to a phase-in period. The deduction is available only for the cost of either a basic or standard benefits package and is limited to 110% of the average cost of such plans in the community-rated market. To the extent self-employed individuals purchase benefits supplementing such packages, the cost of such supplemental benefits will be deductible as medical expenses under current law (i.e., subject to the 7.5% floor).

2. Individuals (other than self-employed) whose employer does not provide insurance are provided a full deduction for the cost of either the basic or standard benefit packages. To the extent an individual purchases benefits supplementing the packages, the cost of such supplemental benefits will be deductible as medical expenses under current law (i.e., subject to the 7.5% floor).

C. Employer-Provided Health Insurance

1. Through 1999 employees may continue to exclude from gross income all employer-provided health insurance. Beginning January 1, 2000 employer-provided supplemental policies covering co-payments and deductibles must be included in taxable income.

2. Employer provided health care coverage offered through a flexible spending account is includible in employee taxable income beginning in 1996.

D. Tax Incentives for Practice in Rural, Frontier, and Urban Underserved Areas

1. Physicians practicing full-time and either newly certified or newly relocated to a rural, frontier, or urban Health Professional Shortage Areas (HPSA) are allowed a tax credit equal to $1,000 a month, limited to a total credit of $36,000. Tax credits will be prorated in direct relation to the time worked in the HPSA.

2. Nurse practitioners and physician assistants practicing full-time and either newly certified or newly relocated to a rural, frontier, or urban HPSA would be eligible for a tax credit equal to $500 per month, limited to a total credit of $18,000. Tax credits will be prorated in direct relation to the time worked in the HPSA.

3. In order to retain the full value of the credit, the physician, nurse practitioner or physician's assistant must practice continuously in the area for five years.

4. The cost, limited to $32,500 annually, of medical equipment used by a

physician in a rural or frontier HPSA can be immediately expensed.

E. Long Term Care Tax Provisions

1. Expenditures for qualified long-term care services are deductible as medical expenses (i.e. subject to the 7.5% floor). Such services include diagnostic, curing, mitigating, treatment, preventive, therapeutic, rehabilitative, maintenance and personal care. To be deductible, such services must be provided to a person who suffers impairment in two or more activities of daily living or severe cognitive impairment as certified by a licensed health care practitioner.

2. Employer-provided qualified long-term care coverage which meets certain consumer protection standards promulgated by the National Association of Insurance Commissioners, is excluded from an employee's taxable income. Premiums paid by an individual for qualified long-term care coverage are deductible as a medical expense (i.e. subject to the 7.5% floor);

3. NAIC is directed to promulgate standards for the use of uniform language and definitions in qualified long-term care coverage insurance policies, with permissible variations to take into account differences in state licensing requirements for long-term care providers.

F. Tobacco Tax
(Pending Discussion)

G. Extending Medicare Hospital Insurance coverage to state and local Employees.

Under current law, certain state and local employees hired prior to 1986 may elect to opt out of Medicare hospital insurance coverage. This election is repealed for years after September 30, 1995.

AOTA PRINCIPLES AS ADDRESSED IN HARKIN PROPOSAL

UNIVERSAL COVERAGE	-	NO (CHILDREN ONLY)
INSURANCE REFORM	-	YES (ALL PLANS)
COMPREHENSIVE BENEFITS WITH BROAD OT COVERAGE	-	YES (CHILDREN ONLY)
MENTAL HEALTH PARITY	-	YES (CHILDREN ONLY)
LONG TERM CARE	-	YES
PROVIDER PROTECTIONS	-	?

Harkin's "Kidcare" bill

STAFF DISCUSSION DRAFT -- NOT FOR RELEASE 8-26-94

SUMMARY OF POSSIBLE "DOWN PAYMENT" ALTERNATIVE

Recognizing that it does not appear possible to enact comprehensive health care reform this year, this proposal seeks to make an important, affordable down payment to comprehensive reform and universal coverage. First, it would make some basic improvements to the health care system that nearly all in the debate agree on (insurance market reforms, paperwork reduction, and an expansion of efforts to combat fraud, waste and abuse). Second, it would take a significant first step toward universal coverage by assuring that every child in America has affordable health care and by giving the self-employed a fairer break on the cost of their health insurance. Finally, it would begin to provide American families security against the costs of long-term care for the elderly and disabled.

These changes would be fully paid for by extending Medicare savings made in the 1993 reconciliation bill, a reduction in subsidy to wealthy older Americans for Medicare premiums and an increase in the cigarette tax.

Insurance Market Reforms

Health plans would be prohibited from denying, limiting, or conditioning coverage based on health status, claims experience, or medical history. Pre-existing condition exclusion periods would be limited to no more than six months and lifetime limits on benefits would be prohibited. In addition, policies would have to be guarantee renewable except in instances of non-payment of premiums or fraud or misrepresentation. (Mitchell/Dole)

Administrative Simplification/Paperwork Reduction

Changes would be made to reduce the up to $100 billion in costs added to the health care system by excessive numbers of forms and other red tape by moving to a uniform electronic system for records and claims. States would also be authorized to develop and implement "report cards" to assist consumers in evaluating health plans. (Mitchell/Dole)

Expanded Efforts to Combat Fraud and Abuse

These provisions would reduce the up to $100 billion lost each year to health care fraud and abuse by establishing an enhanced national anti-fraud program overseen by the Attorney General and the Secretary of Health and Human Services. It would provide for stiff new criminal and civil penalties targeted at a range of abusive and fraudulent practices, including fraudulent billings, bribery, embezzlement, patient abuse, and kickbacks.

It also provides for new incentives for private sector anti-fraud efforts by providing health plans and other third party payors a private right of action in cases where the federal government does not take action and allows for rewards to private citizens who provide information that leads to health care fraud convictions.

In addition, it provides, at no cost to the federal government, significant additional resources for combatting fraud by creating an account in which fines, penalties, and forfeitures derived from health care offenses would be deposited and drawn upon for implementation of the expanded efforts. (Mitchell/Dole)

Universal Coverage for American Children

Beginning in 1996, all children would have access to affordable health care. The 8-10 million uninsured children would be eligible for subsidies to enable to their families to afford coverage. Children in families with income up to 200 percent of poverty ($28,700 for family of 4) would be eligible for full subsidies. Subsidies would be phased out between 200 and 400 percent of poverty.

These children would receive private insurance coverage through an extension of the Federal Employees Health Benefit Plan (FEHBP). In order to operate under FEHBP, health plans would be required to offer a children's only policy with a benefit package similar to that provided in the Mitchell bill. No children would face copayments or deductibles for preventive care and there would be assistance for cost sharing for lower and moderate income families. In addition, the proposal includes the Dodd Amendment requiring that all health plans include no cost sharing for preventive services for pregnant women and children.

Premium subsidies could be applied toward purchase of family policy but benefit package for children must include all services included in children-only policy. To be eligible for a subsidy a child must not have been enrolled in a health plan offered by an employer during the 6-month period prior to an application for premium or cost-sharing assistance

In order to assure that families and businesses would not simply shift costs to the government, they could not drop dependent coverage only. States would be prohibited from lowering their Medicaid eligibility levels for children in order to shift costs on to this program.

Tax Parity for the Self-Employed

This provision would make health coverage more affordable to self employed Americans by giving them the same 100 percent tax deductibility for their health insurance costs provided to businesses, beginning in tax year 1996.

STAFF DISCUSSION DRAFT -- NOT FOR RELEASE 8-26-94

Capped Long-Term Care Program for Elderly and Disabled

Beginning January 1, 1996, a program to provide elderly and disabled Americans requiring long-term care assistance with the cost of home and community-based care. In many instances, these individuals can be kept out of more expensive nursing home care with less costly respite care for families and home care. The cost of this program would be capped. (Mitchell)

Financing

This package would cost approximately $240 billion over 10 years and would be fully paid for from 3 sources.

1) Extension of Medicare savings in 1993 reconciliation:

- Require the Part B premiums continue to be set to cover 25 percent of program costs. (approximately $30 billion)
- Extend requirement that private health insurance provided working elderly pay before Medicare. ($11.3 billion)
- Extend reduction in payment limit for home health care providers. ($6 billion)
- Extend certain reductions in payments to hospitals and doctors. (approximately $30 billion)

2) Increase share of Medicare Part B costs paid by wealthy program beneficiaries ($80,000 for individuals, $100,000 for couples) from 25% to 75%. ($35.8 billion)

3) Finance Committee approved increase in cigarette tax. $1.00 a pack beginning in 1995. ($135.6 billion)

** Staff are also exlporing options to open up the FEHBP to other Americans.

AOTA PRINCIPLES AS ADDRESSED IN ROWLAND-BILIRAKIS-COOPER

UNIVERSAL COVERAGE	-	NO
INSURANCE REFORM	-	YES
COMPREHENSIVE BENEFITS WITH BROAD OT COVERAGE	-	?
MENTAL HEALTH PARITY	-	?
LONG TERM CARE	-	NO
PROVIDER PROTECTIONS	-	NO

House: Rowland - Bilirakis - Cooper

THE BIPARTISAN HEALTH CARE REFORM ACT OF 1994

August 11, 1994

Enhancing Continuity in Coverage

Insurance Reforms

- Guaranteed portability, issue, and renewal of health care insurance.
- Prohibits discrimination based on health status, and bans preexisting condition exclusions.
- Assures choice of coverage through annual open enrollment period of at least 30 days.

Benefits

- Health plans must provide coverage within certain categories:

  (1) The standard package is approximately the actuarial value of the Blue Cross/Blue Shield Standard Option of the Federal Employee Health Benefits Plan offered to Members of Congress.

  (2) The high-deductible package includes the same types of benefits as the standard package but would cost about 20% less.

- The HHS Secretary with the National Association of Insurance Commissioners and the American Academy of Actuaries will develop model benefits packages with different cost sharing designs for different delivery systems so that consumers will be able to compare their benefit packages.

Fair Rating Practices

- Prohibits experience rating.
- Limits rating variations to differences in age, family size and geography. (Age variation is limited to 4:1 in 1997, phased down to 3:1 in 2000).

Access to Insurance Plans

- Employers must offer, but not pay for, at least two options for standard coverage (one must allow for unlimited choice of provider) and one high-deductible plan; Medisave accounts are optional.

Using the Market to Contain Costs

Cost Containment

- Voluntary Health Plan Purchasing Organizations (HPPOs) may be established by either state agencies or private entities. States will review and ensure that individuals and small businesses have access to a purchasing organization by the year 2000.

- Large employers (with more than 100 employees) and those small employers which pool together may self-insure. The size of the pool must be at least 100 individuals.

- Level contribution requirement such that employer contribution may not vary with price of premium.

- Medical malpractice reforms includes mandatory non-binding alternative dispute resolution; $250,000 cap on noneconomic damages.

- Administrative simplification and paperwork reduction: uniform streamlining of the electronic transmission of medical and billing information. Encourages uniform system and privacy protections.

- Antitrust: Clarifies confusing antitrust applications and avoids needless costly antitrust investigations. The Attorney General will develop and publish guidelines of federal antitrust laws with regard to health plans and provider arrangements.

- Fraud and Abuse: To reduce fraud and abuse, the Attorney General establishes an all-payer health care fraud and abuse control program.

- Streamlines billing for laboratory services.

- Preempts certain state anti-managed care laws and includes consumer and provider protection provisions.

Removing Financial Barriers to Access

Tax Deductibility for Individuals and Self-Employed

- For the self-employed, guaranteed tax deductibility phased in to 100% by 2000.

- New tax deductibility for individuals.

Medicaid Reform and Subsidies for Low-Income Individuals

- Subsidies would begin by covering those at 100% of poverty and would be phased up to 200% of poverty. Pregnant women and children would be eligible for subsidies up to 240% of poverty.

- AFDC and non-cash beneficiaries of Medicaid would be enrolled in the low-income subsidy program, mainstreaming most of the acute care portion of Medicaid.

- Expansion of benefits are subject to fail safe mechanism to ensure budget neutrality.

Quality

- Health plans will be held accountable for the quality of care they provide and for maintaining the health of the population they serve. Consumers will have comparative quality information to help make informed choices when choosing among health plans.

Improving Medicare

- o Expands private insurance coverage options for Medicare beneficiaries including managed care options.
- o Optional prescription drug benefit under managed care plans.
- o Reduces the rate of growth in program spending.

Expanding Access

- o Expands Community and Migrant Health Centers and encourages development of provider networks.
- o Creates Community Rural Health Networks (including all of the provisions of HR 4555, introduced by the bipartisan Rural Health Care Coalition).
- o Establishes services to develop regional emergency medical networks.
- o Provides financial incentives to increase health care providers in rural areas.

Enhancing Long-Term Care

Long-Term Care

- o Establishes federal standards for long-term care insurance.
- o Includes tax clarification of long-term care benefits.

Patient Right to Self-Determination

- o Acknowledges that individuals have the right to make decisions concerning medical care, including the right to accept or refuse medical or surgical treatment, as well as the right to formulate advance directives.

Strengthening and Preserving Veterans' Health Care System

- o Creates an investment fund to improve the existing VA health system.
- o Gives all veterans an option of selecting VA as health plan, with cost-free care for core veterans (service-connected and low-income individuals).

Report on Coverage

- o If by 2002 the Secretary determines less than 95% of Americans are covered with health insurance or less than 100% have affordable access to care, the Secretary must make recommendations to Congress to meet that goal.

Financing

- Five year cost of the plan is estimated to be approximately $140 billion (staff estimate).

- The plan is financed primarily by: savings in Medicare; savings in Medicaid; eliminating benefits for certain legal aliens whose financial sponsorship agreements have lapsed or whose sponsors have defaulted on the agreements; requiring federal retiree health benefits to meet private sector accounting rules; and coordinating auto insurance.

- The plan has a fail-safe mechanism to assure budget neutrality.