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The President's Comprehensive Health Reform Program

February 6, 1992

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Chapter 1

Overview

HIGHLIGHTS: The President's Plan For Comprehensive Health Care Reform

The President's Plan is a **comprehensive, market-based** reform that builds on the strengths of our current system to provide access to *affordable insurance* for all Americans.

- **The President's plan guarantees access to health insurance for *all* poor families** through a transferable health insurance tax credit (certificate)—available even to those too poor to file taxes—that is large enough to purchase a basic health package ($3,750 for a family).
- **The President's plan provides insurance security for all Americans.** The fear of "job lock"—where workers can't move to another job without losing access to insurance—is eliminated. Limits on the availability of insurance for those with "preexisting conditions" are eliminated.
- **The President's plan will *reduce the cost* of health insurance through major market reforms.** Smaller businesses and individuals would be pooled into larger groups—so they can receive the same favorable health coverage enjoyed by large employers. Millions of people who now can not find affordable insurance will be helped.
- **The President's plan provides new help to the middle class to pay for health care.** Up to $3,750 in health insurance costs can be deducted by families with incomes less than $80,000. Over 90 million Americans will receive new assistance for health costs.
- **The President's plan encourages the growth of coordinated care**—in private plans, Medicare and Medicaid. Laws limiting coordinated care would be prohibited—as would costly State mandated benefit laws. The comprehensive plan encourages individuals, employers and health providers to use coordinated care systems.
- **The President's plan will use the power of an informed marketplace to help control costs** by providing consumers with better information and by giving individuals the resources to choose the coverage that best meets their needs.
- **The President's plan would reduce administrative costs** through regulatory reforms that will streamline the current paperwork maze, and through market reforms that allow small employers to share—and thereby substantially reduce—administrative costs.
- **The President's plan includes major malpractice reform.** A comprehensive liability reform plan is proposed to reduce the costs of malpractice and the resulting defensive medicine that burdens the U.S. health system.
- **The President's plan would expand services in underserved areas.** Many inner city and rural areas have acute shortages of doctors and clinics. The President's budget expands funding for Community Health Centers, Migrant Health Centers and the National Health Service Corps to increase preventive care in these areas.

The President's Plan Does Not:

— include governmental price regulation or rationing of health care;
— burden small business with new and costly mandates that will stifle the creation of new jobs and be passed on in higher product costs and higher taxes for all Americans;
— require massive tax increases like "play or pay" and national health insurance;
— threaten poor older Americans with benefit reductions or premium increases.

The President's Plan builds on a system that provides the world's best health care. The plan provides all Americans access to affordable health care coverage through a transferrable health insurance credit (certificate)—available even to low-income Americans who do not file tax returns—that can be applied to the purchase of a basic health benefit package. To reduce the rapid growth of health spending, the plan makes radical reforms in the health insurance system and includes strong incentives for the development and expansion of coordinated care systems and other efficient arrangements for delivering high quality health care.

Summary Highlights

Expanding Access to Health Care (See Chapters 3 and 4)

Transferrable Health Insurance Credits (certificate) and Deductions—Benefitting Approximately 95 Million Americans—

- A transferrable health insurance credit (certificate) or tax deduction would be available to ensure access to affordable health care coverage for moderate and low-income families. About 95 million Americans would receive assistance. When fully implemented, families with incomes below the tax filing threshold, approximately the poverty line, would receive a credit of up to $3,750, sufficient to purchase basic health benefits. Similarly, individuals would receive $1,250 and two-person families $2,500. A health insurance credit (certificate) or deduction (also up to $3,750 per family) would be available to individuals, two-person, and larger families with annual incomes up to $50,000, $65,000 and $80,000, respectively.

Market Reform—

- *Basic Benefits.*—States would be required to develop a basic health insurance package equal to the value of the health insurance credit. This would enable low-income families to purchase adequate health care coverage.
- *Insurance Security.*—Workers changing jobs would no longer face concerns about "job lock"—the inability to change jobs for fear of losing access to insurance. Health insurers would be required to provide coverage to all employers requesting it. Coverage would be guaranteed, renewable, and preexisting condition limits would be eliminated.
- *Health Insurance Networks (HINs)—Pooled-Purchasing Power.*—When it comes to health insurance, small businesses do not have many of the advantages of large businesses. Large companies can self insure and avoid expensive benefit mandates and premium taxes. Large firms are sold coverage similar to that purchased by small firms, but at much lower prices. A new way of purchasing insurance, HINs would enable small firms to purchase low cost, high quality health insurance. HINs would enable small businesses to buy lower priced insurance by reducing administrative costs and by exempting insurance purchased from HINs from excessive State mandates, anti-managed care laws, and premium taxes. For the first time, groups like the National Federation of Independent Business, National Small Business United, and the U.S. Chamber of Commerce would be able to offer affordable health plans to their members nationwide or join with other groups to increase purchasing power in State or local markets.
- *Insurance Affordability.*—In the near term, premium costs for similar policies sold to firms in a single block of business could vary by no more than 50 percent. A health risk adjustment across insurers would be phased in—removing premium disparities and allowing for plan flexibility within a new insurance market driven by competition on quality and costs.

Containing Health Care Costs (See Chapter 5)

- *Malpractice Reform.*—The threat of malpractice litigation prompts physicians to order tests and perform procedures, enabling them to assert that every effort has

been made to provide the best health care. These defensive practices are extremely costly to the system. To address this, the President's plan would provide incentives to States to: (i) eliminate joint and several liability for non-economic damages, (ii) cap non-economic damages, (iii) eliminate rules that permit double recovery, (iv) require structured awards, (v) promote pretrial alternatives, and (vi) implement new procedures to improve quality of care. Also, standards of care, developed in conjunction with the medical community, would be explored as a means to remove physician uncertainty over malpractice litigation.

- *Improving Consumer Information.*—To assist individuals and employers in evaluating various health insurance policies, consumers would have access to information, that would provide information like that in "blue books" on the average cost of services and the quality of care provided by physicians, hospitals, clinical laboratories, and other health care providers. This will help control costs by providing consumers with comparative value information that will enable them to make more informed choices.

- *Reducing Administrative Costs.*—The President's plan will reduce administrative costs, which now total $43 billion a year, by more than 25 percent through electronic billing for providers, electronic benefit cards for policyholders, simplified utilization review, and insurance market reforms.

  Insurance law changes and market reforms will cut back the paperwork blizzard that confronts all insured Americans—and costs billions of dollars. Standardized claims procedures and other reforms will reduce administrative costs. For small employers, administrative costs may account for as much as 40 percent of the cost of insurance purchased. Marketing to and servicing small employer policies is costly. HINs, which unite many purchasers, would reduce the cost of insurance administration and premiums. These costs are usually under 10 percent for large businesses. Federally certified HINs would also be required to adhere to uniform claims processing procedures, a source of additional administrative savings.

- *Expanded Use of Coordinated Care*—
  - —In 1990, approximately 40 million Americans were enrolled in a coordinated care system—up from 10 million in 1980. The President's plan encourages broader use coordinated care including preferred provider organizations, point-of-service choice plans, case management, HMOs, and other forms of coordinated care.
  - —States would be encouraged to develop coordinated care systems and would be prohibited from having laws that hinder effective operation of these systems. Excessive State-mandated benefits—that increase the cost of insurance—would be prohibited.
  - —Medicare reforms would encourage increased coordinated care enrollment and increase incentives for coordinated care systems to contract with Medicare. The President's plan also would make it easier for beneficiaries of retiree group health benefit plans to be served by coordinated care systems.

- *Increased Flexibility for State Programs.*—States are encouraged to implement a coordinated care-based Medicaid program. They also would have the flexibility to redesign their entire health care systems.
  - —States could choose to combine current Medicaid funding with the new benefits provided through the health insurance credit (certificate) to develop a single unified health plan for their low-income residents.
  - —With the new Federal health insurance credit (certificate), all poor residents are guaranteed basic health coverage—without any further fiscal burden on the States. This will allow States to more effectively allocate their health resources for Medicaid and for the nonpoor population.

- *Cost-Effective Services are Expanded in Underserved Areas.*—The inner city and rural areas have acute shortages of doctors and clinics. The President's fiscal year 1993 Budget expands funding for Commu-

nity Health Centers, Migrant Health Centers, and the National Health Service Corps to expand preventive care in these areas.

- *Prevention.*—The President's fiscal year 1993 Budget includes $26.4 billion, an increase of nearly $4 billion (18 percent), for preventive health activities. Prevention funding has increased by more than $11 billion (74 percent) since 1989. The President's fiscal year 1993 Budget proposes increases of 18 percent for childhood immunizations and infant mortality reduction, a 27 percent increase for Head Start and Early Childhood Development, a 24 percent increase for breast and cervical cancer mortality prevention, and a 90 percent increase for childhood lead poisoning prevention.

Alternative Approaches (See Chapter 6)

The two alternative approaches to health care reform have fundamental structural weaknesses:

- *Canadian Model.*—In Canada neither providers nor consumers have incentives for efficiency; health care costs are growing faster than in the U.S.; patients endure long lines and wait for surgery and access to advanced technology; and, high quality care is rationed. A Canadian-style plan would require from $250 billion to $500 billion a year in new taxes. For quality care, many Canadians go to the U.S.

- *Play-or-Pay Model.*—"Play-or-pay" would hurt workers by increasing unemployment and forcing employers to cut wages to offset mandated costs. One study indicates that under "play-or-pay" between 400,000 to 700,000 jobs would be lost in the short-run, and up to 2 million jobs could be lost in the long-run. The "play-or-pay" system is structurally unsound and guaranteed to degenerate into national health insurance. Upon enactment, 59 million privately-insured Americans would fall into the public plan and the plan's instability would quickly force universal public coverage. Play-or-pay is a tax on low-wage workers and would result in millions of lost jobs. Finally, at least $37 billion per year in new and additional taxpayer-financed subsidies would be required to adequately fund the public plan.

Chapter 2

Principles for Reform: Building on American Strengths

Overview

- The cost growth of the U.S. health care system is unsustainable, both for individual Americans and for the economy as a whole.
- Even with rapidly increasing health spending, 13 percent of Americans do not have access to health insurance.
- Most federal health care support goes to the non-poor, the segment of society that least needs government assistance.
- Despite the shortcomings of the American system, it delivers the world's best quality care, and the world's most sophisticated health technology.
- Reform should preserve the strengths of the U.S. system while addressing its weaknesses. Reforms should not destroy its incentives for choice, quality, and innovation.
- The President's Principles for Reform establish guidelines for a comprehensive restructuring of a market-based health system.

Americans need and deserve adequate access to affordable high quality medical care. Health care in the United States has evolved into the world's most sophisticated and advanced system.

Our health care system has strengths and weaknesses. A clear understanding of both is essential in guiding policy development.

Principles for Reform

The President has determined that several principles should guide the development of a comprehensive approach to health reform. The reform *should:*

- Build on the strengths of an American health system that provides the highest quality health care in the world;
- Assure access to basic health insurance for Americans, and increase the affordability of such coverage;
- Promote consumer choice to ensure that the health care system continues to respond to the needs and concerns of Americans;
- Strengthen market incentives for providers and health plans to improve quality while controlling costs;
- Emphasize prevention and personal responsibility;
- Reduce abuse and wasteful excess;
- Meet the requirements of fiscal responsibility and budget discipline.

The approach *should not:*

- Force the American people to give up the choice and diversity that makes the American health system unique;
- Lead to comprehensive governmental price controls and rationing health care by government;
- Create new spending mandates for States and employers;
- Require a net increase in taxes; or
- Threaten older Americans with the prospect of either benefit cuts or premium increases.

These tests cannot be met by either "Canadian-style" or "Play-or-Pay" approaches to reform. Such approaches necessarily involve major tax increases, comprehensive governmental price controls, or rationing.

Understanding the Cost and Access Problems

Health care costs are increasing too fast and too many Americans have inadequate access to health care. The causes of the cost and access problems are complex. Unfortunately, simplistic proposals, such as reducing administrative costs to fund a universal access program, are unrealistic (Doherty, 1991).

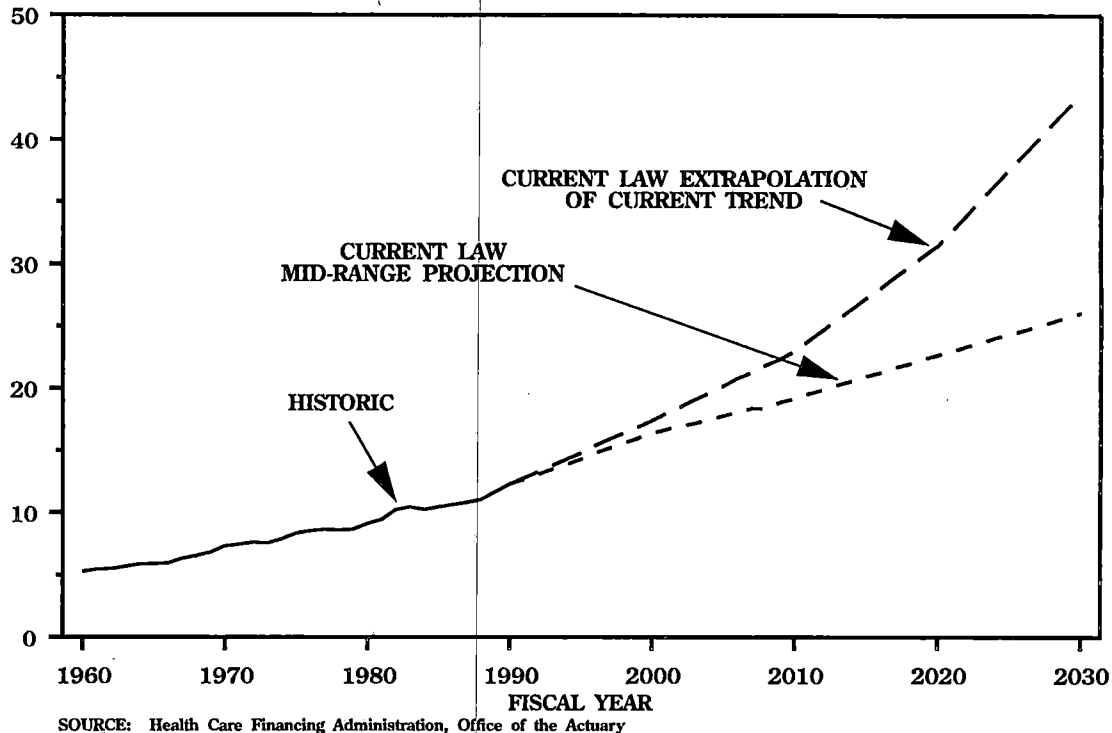
Moreover, the cost and access problems are not easily solved simultaneously. The political system tends to trade cost-control for access, and vice-versa. Addressing the access problem inescapably means re-allocating tens of billions of dollars each year. Addressing the cost problem requires correcting perverse incentives and market distortions—to encourage more efficient behavior by individuals, insurers, and health providers.

Unsustainable Cost Growth.—Currently, total health care expenditures are about 13 percent of the Gross Domestic Product (GDP)—up from less than 6 percent of GDP only three decades ago. If the current system continues unchanged, health care could consume over 16 percent of GDP by the year 2000, and between 27 and 43 percent of GDP by 2030 under mid-range and high-range projections (Sonnefeld et al., 1991).

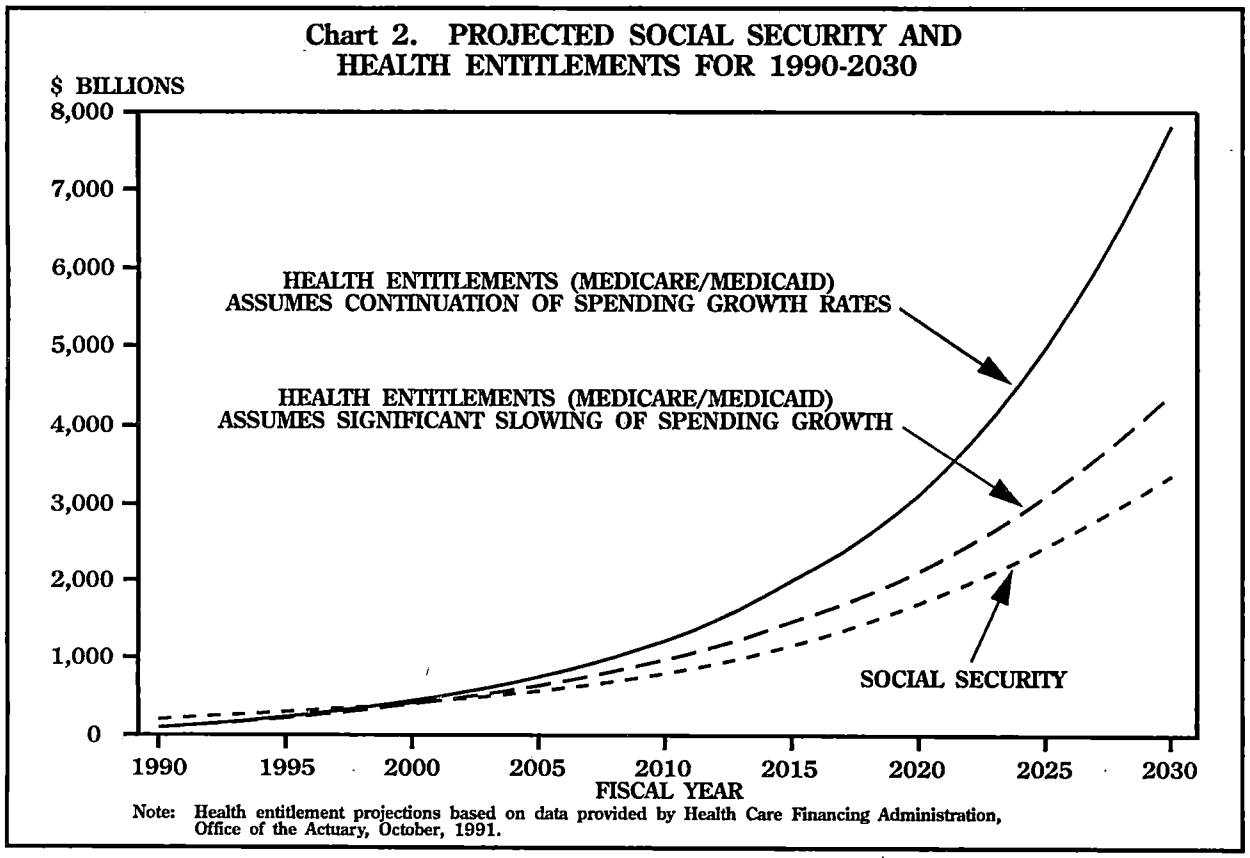
These costs are shouldered by everyone—individuals, business and government. The federal government is spending increasing proportions of the federal budget on mandatory health outlays. Before the year 2000, health entitlement programs (Medicare and Medicaid) will surpass Social Security as the single largest component of federal spending. Federal Medicaid spending alone has grown from $14 billion in 1980 to $37 billion in 1989 to a projected $84 billion in 1993. These figures reflect a 43 percent increase for last year alone, an increase of 227 percent since 1989, and an increase of 600 percent since 1980.

Medicare spending will have grown from $34 billion in 1980 to about $131 billion by 1993—an increase of nearly 300 percent. Unrestrained, Medicare will grow at an average rate of 12 percent per year from 1993

Chart 1. HEALTH SPENDING IS PROJECTED TO REACH 16.4% OF GDP BY 2000 -- RISING FROM 5.3% IN 1960



SOURCE: Health Care Financing Administration, Office of the Actuary



through 1997. By 2025, Medicare is expected to exceed 27 percent of the federal budget.

Even if it were possible to sustain health spending at nearly 30 cents of every dollar, it is difficult to imagine who would pay these enormous costs. Most individuals already feel that they are overburdened with health care costs. Businesses are spending increasing percentages of wages and other compensation on health care premiums—currently in excess of 100 percent of after-tax profits.

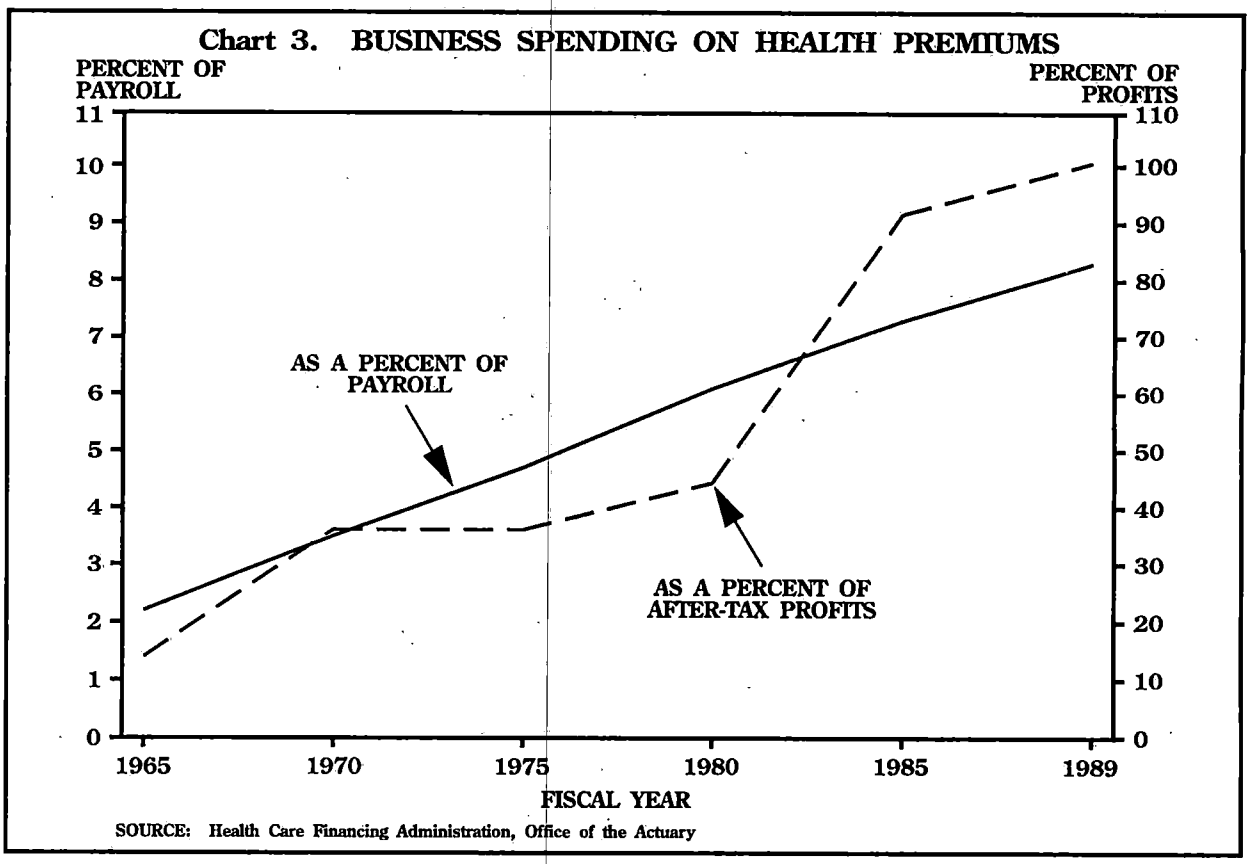
Clearly, health care costs must be contained, both in public programs and in the private sector. Neither individuals, business, nor government can afford to pay for the currently projected growth.

Inadequate Access Despite Increasing Spending.—Despite this rapid rise in health care spending, 13 percent of Americans—34.7 million—are without health care insurance.

Most of the uninsured are lower-income Americans—30 percent of the uninsured have incomes below the poverty level, and 32 percent have incomes between 100 and 200 percent of poverty (Needleman et al., 1990). Despite this, most of the massive federal spending on health care goes to the non-poor. In 1992, only 21 percent of total federal health care spending is estimated to be spent for the poor. Almost 90 percent of Medicare spending goes to individuals above the poverty level.

Uninsured Americans receive some health care, either by paying for it out-of-pocket, or in the form of "uncompensated" or "charity" care (Needleman et al., 1990). "Uncompensated" care is not free, in the sense that insured individuals must pay higher fees and thus higher premiums, and hospitals receive public (such as Medicare and Medicaid "disproportionate share" payments and non-profit tax treatment—now over $15 billion per year) and private (such as charitable contributions) subsidies to cover the costs.

The uninsured are more likely to receive health care in hospital emergency rooms, rather than in physicians' offices and clinics (NMES, 1987). This form of care can be harmful to the individual, who may only



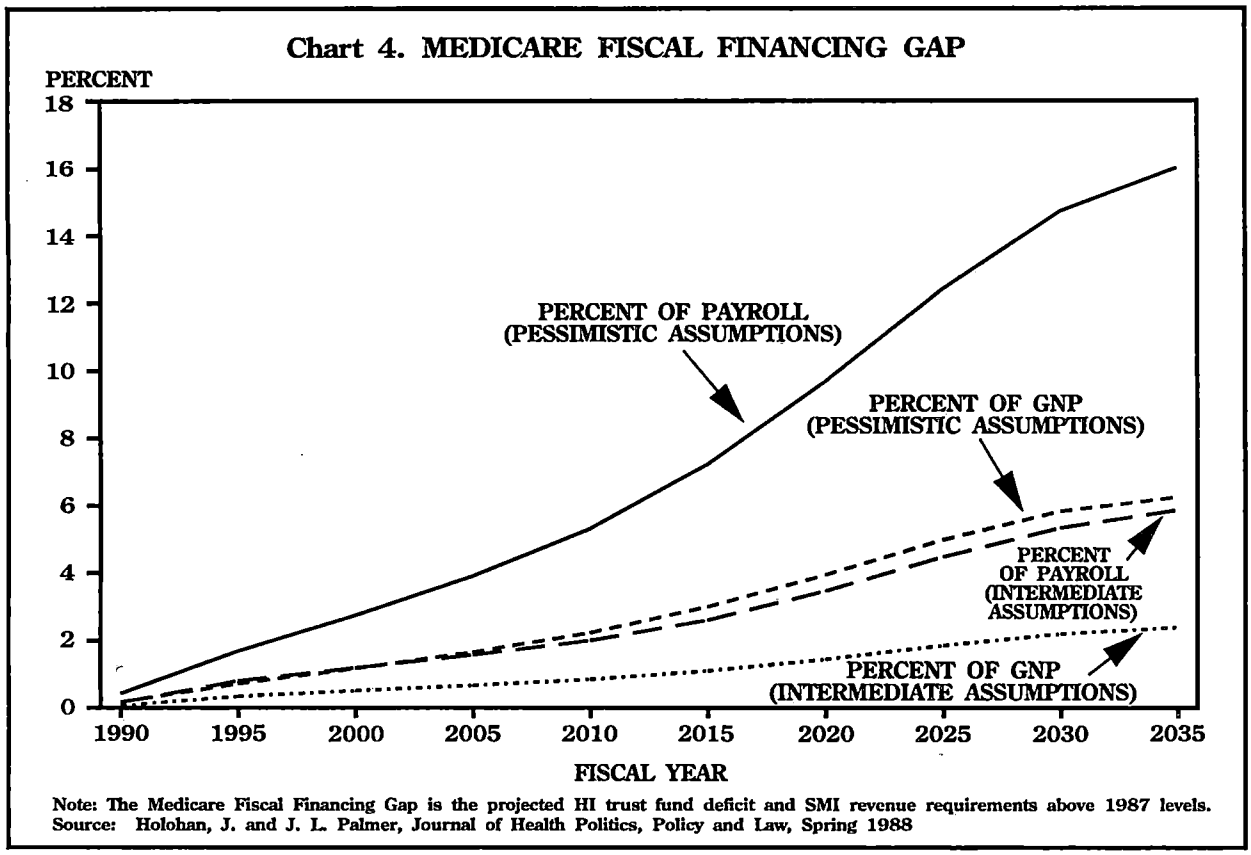
receive care for serious illnesses instead of coordinated, preventive care from a physician familiar with the patient. Emergency room care is also a more expensive and inefficient use of resources, since emergency room visits are much more costly than physician office visits.

No Easy Solution.—Rising health care expenditures are a function of many interrelated factors. These include: general inflation, population growth, relative aging of the population, growth in volume and intensity of medical care (HCFA, 1989), and "cost shifts" that re-allocate the costs of caring for the uninsured. The resulting medical inflation is consistently more than double the growth rate of the Consumer Price Index.

General inflation, population growth and relative aging necessarily occur. Other factors can be addressed, such as the growth in the intensity of medical services and of preventable illnesses. Despite increasing per capita U.S. costs, utilization as measured by hospital admissions, length of hospital stay, and medical visits per capita have been level or increased only slightly. This suggests that the intensity (e.g., more tests and procedures per hospital stay or per office visit) is the primary cause of spending growth. International comparisons confirm this conclusion (Schieber et al., 1991).

In addressing the growth in service intensity, it is difficult to know how much of the increase is due to advances in medical technology, and how much is attributable to excessive defensive medicine, poor health care management, and gaming of a public price-regulated system.

For preventable illnesses and conditions, though, the issues are more apparent. For example, at 13.8 per 100,000, the male homicide rate is more than 12 times that of Germany and 5 times that of Canada. More than 200,000 AIDS cases have been reported in the US. In 1989, the rate of incidence of AIDS was more than three times that of Canada and six times that of then-West Germany. And, there are about 375,000 drug-exposed babies in this country. This problem



is negligible in most other countries (Schwartz, 1991).

Rising costs are also the result of market distortions. Because medical treatment is largely in the hands of doctors and hospitals (who have financial and defensive incentives to provide more medical care) and not the consumer, consumer-based market discipline has been weak.

Under the current system, Americans with insurance are often overinsured and have few incentives to use medical care prudently. Instead, consumers tend to be risk-averse where health is concerned. Insulated from the real cost of medical treatment by employer and government subsidized insurance, Americans tend to over-consume health care. Moreover, because insurance itself is so highly subsidized for most Americans, they have little reason to prefer forms of coverage that are more efficient (e.g., coverage with higher cost sharing or coordinated care coverage)

The health care market is further distorted by limited consumer information about the treatments patients receive and the efficiency of their care. Consumers and large purchasers currently have few objective sources of information on which to base cost and quality comparisons.

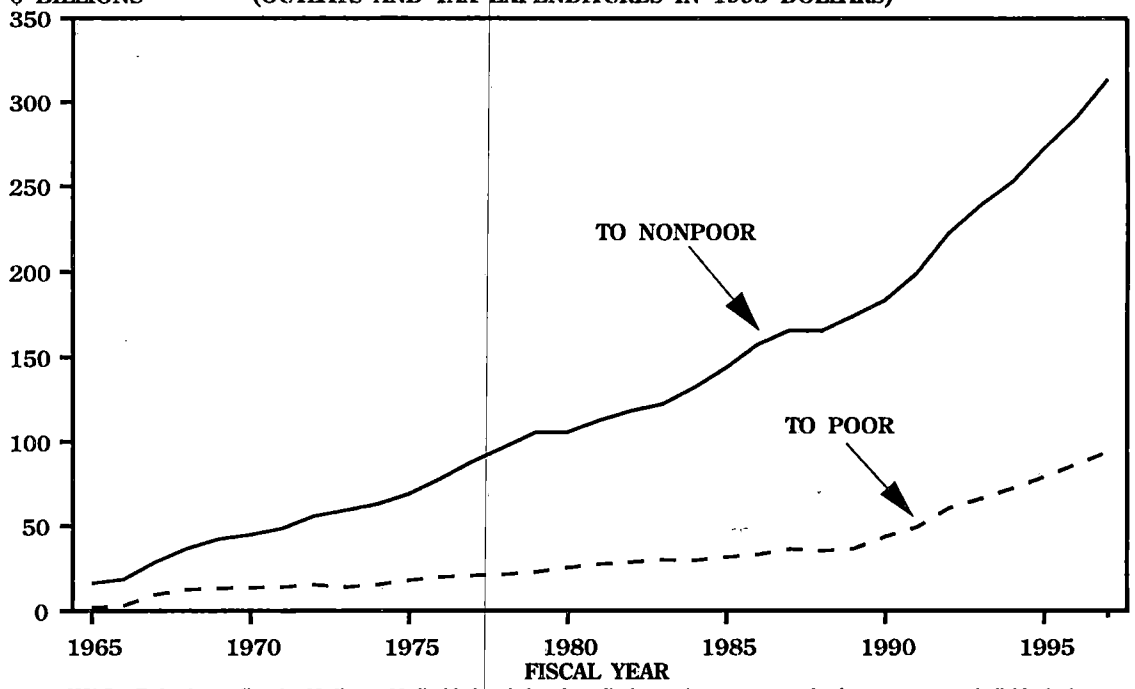
The problems of access and cost are inextricably linked. Access ultimately is an issue of affordability. Many low-income Americans need help to be able to afford coverage. Cost growth needs to be slowed to assure continued affordability for others. Thus, the access and cost problems must be addressed together in a comprehensive series of reforms. Only then can all Americans begin to enjoy efficient health care at affordable prices.

Building on American Strengths

Most Americans today have ready access to state-of-the-art medical care. Breakthrough treatments spread rapidly from our Nation's finest hospitals and laboratories and quickly become routinely available throughout the

Chart 5. FEDERAL HEALTH SPENDING

(OUTLAYS AND TAX EXPENDITURES IN 1993 DOLLARS)

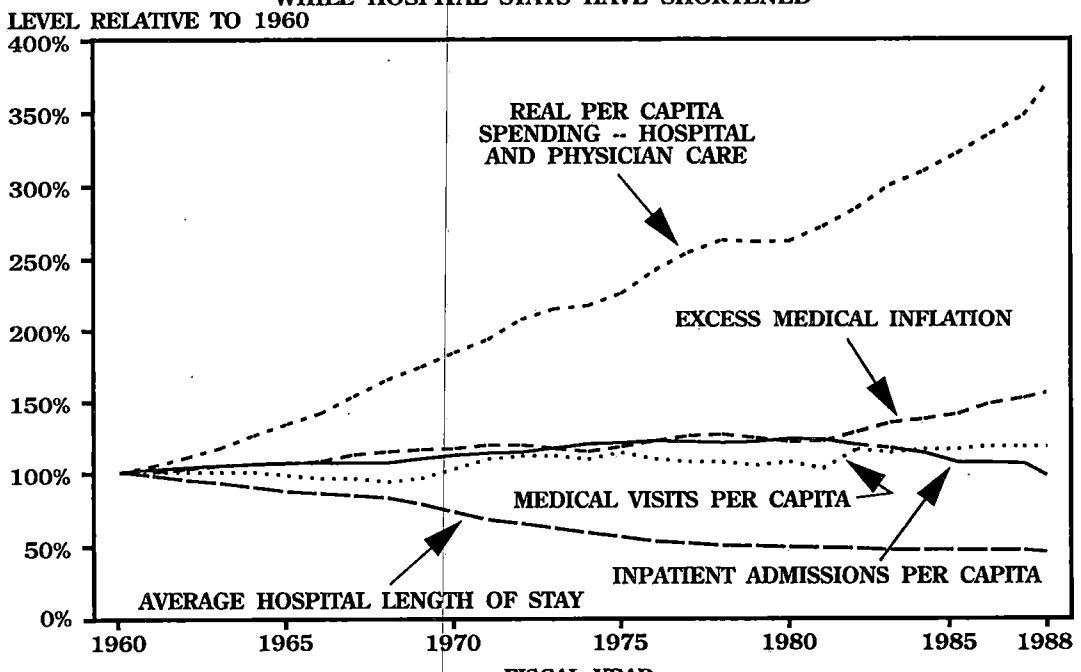


NOTE: Federal spending for Medicare, Medicaid, hospital and medical care for veterans, and other payments to individuals for health purposes; and tax expenditures for employment-provided health plans and for deductions of health expenses. Spending share to poor reflects percent of recipients with money incomes below poverty thresholds.

SOURCE: Census Bureau

Chart 6. MOST OF THE GROWTH IN REAL PER CAPITA SPENDING IS DUE TO SERVICE INTENSITY--MORE TESTS AND SERVICES ARE BEING PROVIDED PER ENCOUNTER

HOSPITAL ADMISSION AND PHYSICIAN VISIT RATES HAVE CHANGED LITTLE WHILE HOSPITAL STAYS HAVE SHORTENED



Sources: Utilization data from OECD, Health Care Financing Review, Annual Supplement, 1989; per capita spending data from Health Care Financing Administration, Office of the Actuary.

country. We must preserve this excellence in our efforts to solve our problems.

Vast improvements in health over the last few decades are unmistakable. Charts 7 and 8, for example, show dramatic improvements over the past 40 years in life expectancy and in mortality rates. Overall mortality rates have decreased from 840.5 deaths per 100,000 in 1950 to 535.5 per 100,000 in 1988. Mortality rates for heart disease and for cerebrovascular disease have declined by 46 percent and 66 percent respectively during this period.

Advances in medical treatment are so frequently reported that they seem almost routine. Today, Americans from all walks of life have ready access to these medical advances. (See Chart 12.)

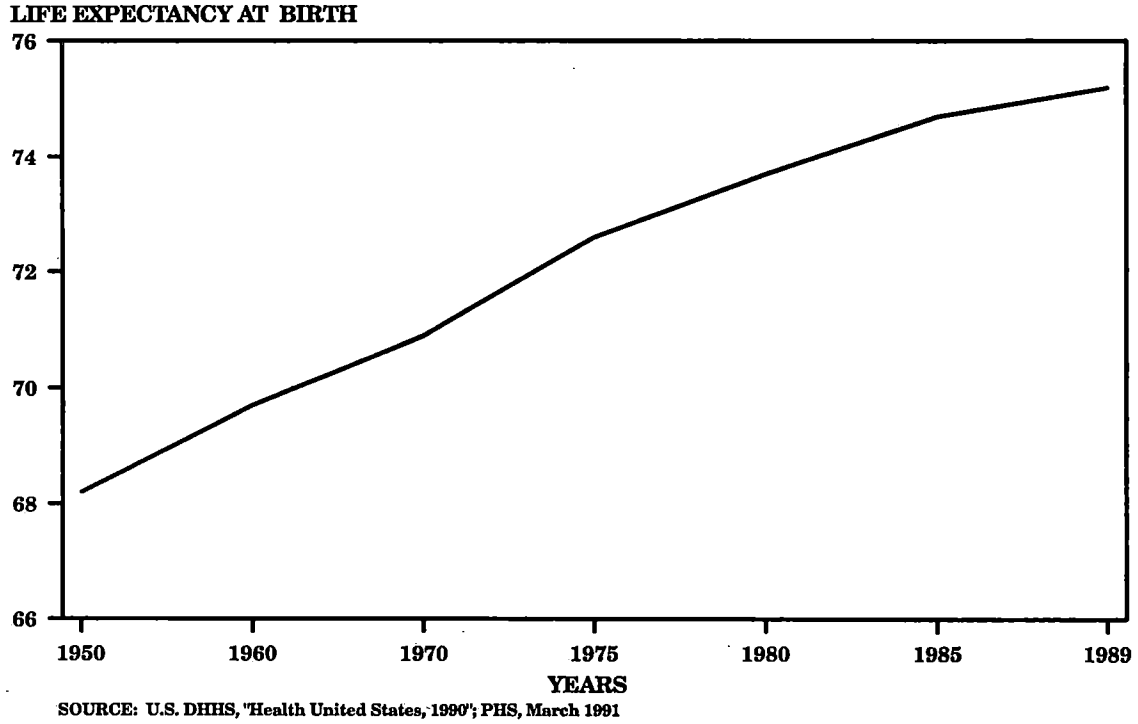
These trends neither reverse nor even plateau. Prevention and greater personal responsibility could increase average life expectancy from about 73.8 years to 77.6 years (Hahn et al., 1990). At the same time, new drug regimens and technologies offer the promise of lowering deaths due to major killers such as heart disease and cancer.

This success is based on several key features of the U.S. health care system.

Choice.—Individuals and families are free to choose their own physician and hospital and an increasing number of Americans are able to choose among a variety of health plans. This, in turn, encourages physicians, hospitals, and health plans to compete to provide better health care at a lower cost. As a result, our health care system reflects the needs and concerns of ordinary Americans as expressed in the choices they make. This dynamic should be nourished and strengthened.

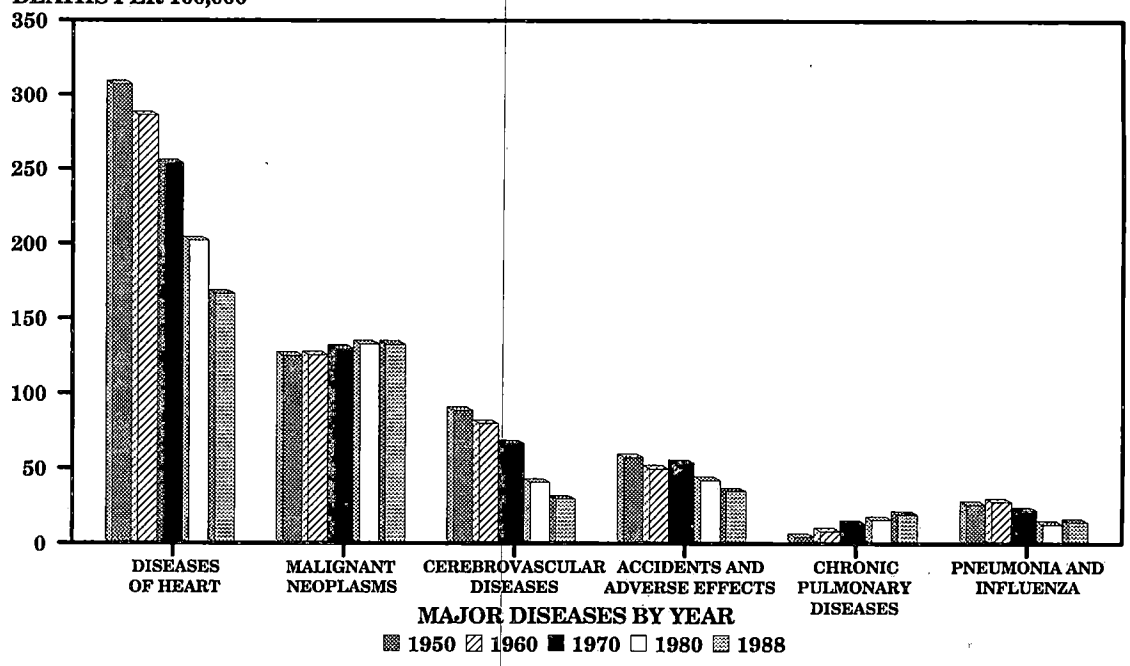
Diversity and Flexibility.—Choice and the open competition by providers for patient care also assures diversity and flexibility in the financing, organization and delivery of care. The last two decades have witnessed unparalleled innovation in the organization and management of health care in the United States. The most important development is the growth of coordinated care. Health maintenance organi-

Chart 7. LIFE EXPECTANCY IN THE U.S.



SOURCE: U.S. DHHS, "Health United States, 1990"; PHS, March 1991

Chart 8. MORTALITY RATES FOR SELECTED CONDITIONS, 1950-88



SOURCE: US DHHS, National Center for Health Statistics, "Health USA, 1990"

zations (HMOs) and preferred provider organizations (PPOs) now serve over 40 million Americans. These health plans combine the financing and delivery of health care and integrate quality management across the entire continuum of care—from prevention to care for chronic illnesses. Through competition, coordinated care plans are driven to respond to consumer needs leading to better quality care at lower costs.

Skilled Medical Professionals.—U.S. physicians and health professionals are the best educated and most skilled health care work force in the world. U.S. Hospitals and medical schools are world leaders for particular specialties and treatments.

Caring Volunteers.—Hundreds of thousands of groups and organizations engaging millions of volunteers assist in providing quality health care.

Health care volunteers improve access to health services and help to control health care costs. These volunteers provide such services as: working at community health clinics; caring for AIDS patients and their families; participating in drug abuse prevention, education, and rehabilitation; delivering meals to the homebound; providing hospice care; and assisting victims of debilitating diseases and supporting their families.

Biomedical Research.—The U.S. leads the world in biomedical research. America's continued dominance of the competition for Nobel prizes reflects that pre-eminence. Advances in biomedical research over the past four decades have improved the quality of health care while saving billions in health care costs. With an increasingly thorough understanding of basic disease mechanisms, researchers are likely to achieve additional breakthroughs within the next twenty years.

Federal investment in biomedical and applied behavioral research has increased as a proportion of GDP from 0.12 percent in 1970 to 0.16 percent in 1992. U.S. public and private funding provides the lion's share (Chart 10) of the funding for such research worldwide.

The Success of American Health Care—Examples

Cancer.—Deaths from childhood cancers have been reduced 38 percent since 1973, with almost two-thirds of children with cancer surviving beyond five years. There has been astonishing progress against Hodgkin's disease, with a 50 percent reduction in deaths, and against testicular cancer with a 60 percent reduction in deaths.

Heart attacks.—In the early 1960s, almost a million Americans a year died from heart attacks. Today, deaths from heart attacks have been dramatically reduced to less than half that number due to better prevention and better treatment. Major advances in treatment include therapy to dissolve blood clots that cause heart attacks and balloon angioplasty to relieve chest pain during convalescence and beyond. Patients are now commonly discharged after 8–10 days, and return to full activity within 4–6 weeks.

Hypertension.—High blood pressure affects 58 million Americans and can lead to heart disease and stroke. Since the National High Blood Pressure Education Program was launched in 1972, age-adjusted stroke mortality in the U.S. has declined by more than 50 percent. Recommendations from a recent study of hypertension in the elderly could further prevent 6 strokes and 11 major cardiovascular events a year per 1,000 seniors treated. Cost savings could total one-half billion dollars a year.

Diabetic Retinopathy.—Damage to the blood vessels of the retina from diabetes accounts for approximately 12 percent of the new cases of blindness each year. Until the late 1960s this condition was untreatable. Within the last two decades, laser surgery has been widely adopted as an effective treatment. By the year 2000, $2.8 billion dollars will be saved and 279,000 years of vision preserved as a result of this advance.

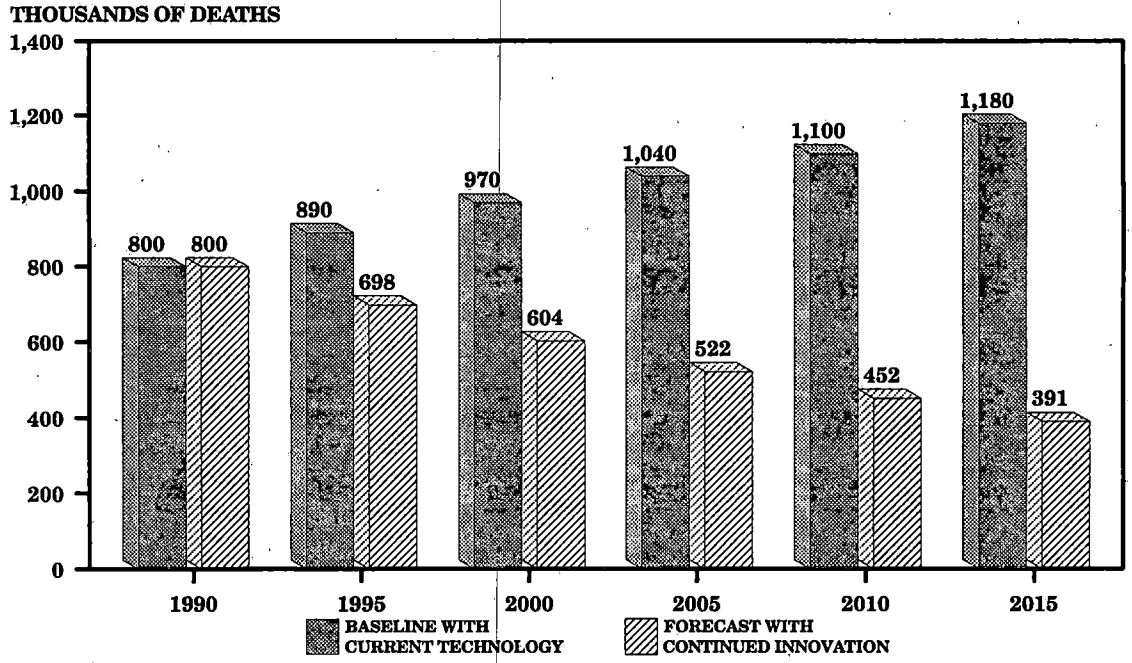
Paralysis due to Spinal Cord Injury.—This year 10,000 Americans—most of them young—will suffer a spinal cord injury, often resulting in life-long paralysis. Today, many patients recover thanks to a recently discovered treatment that involves high dose methylprednisolone therapy.

Technology.—Similarly, new technologies developed by the U.S. drug and medical device companies have grown exponentially over the last three decades. This innovation has improved the quality of health care for Americans and has strengthened our nation's international economic competitiveness. The U.S. accounts for nearly half of the $65 billion dollar global market for medical devices. Medical equipment exports have grown about 20 percent per year since 1985. In 1991, exports of such products reached nearly $7 billion.

A comparison with other prosperous Western nations—Canada and Germany—in Chart 12 presents some astonishing implications of the unparalleled access that Americans enjoy to sophisticated diagnostic and therapeutic technology. A difference in access to advanced technology is often the critical difference between health and disability, life and death.

Quality Assurance.—Finally, leadership in the development and implementation of new methods for assuring quality care has been a hallmark of health service delivery in the United States for over a decade. Peer review, practice guidelines, research on patient outcomes, and other activities mean that appropriate interventions are applied correctly to the individual's clinical condition.

Chart 9. PREDICTED DEATHS FROM HEART DISEASE WITH AND WITHOUT CONTINUED INNOVATION



NOTE: With aging of the population, deaths from heart disease would increase over the next three decades. But this increase can be dramatically reversed with continued technological innovation.

SOURCE: Ruth Brown, et al., "The Value of Pharmaceuticals," Batelle, 1991

Potential Future Breakthroughs in Medical Treatment

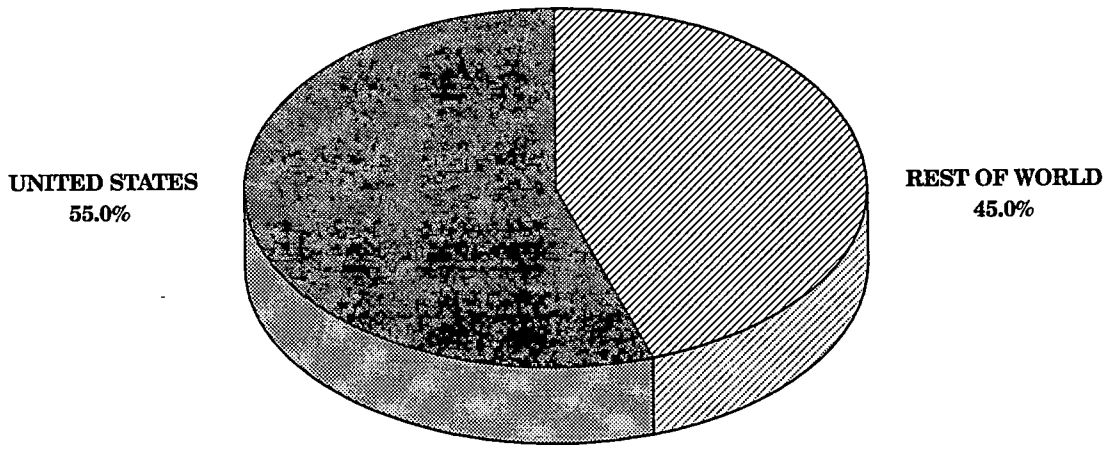
Cancer.—Despite recent progress, more than 500,000 Americans will die of cancer in 1992. There is, however, a new feeling of optimism among researchers. Clinical trials using a new drug, taxol, in women with breast cancer have shown very high response rates. Another new approach, use of chemotherapy before surgery can change an inoperable tumor to one that can be removed surgically. And there is potential for major advances in gene therapy and anti-cancer vaccines during the next 10 to 20 years

Alzheimer's Disease.—Alzheimer's Disease (AD) affects an estimated four million people in the U.S. at a cost of $90 billion a year. Aging of the population could result in a five-fold increase in the disease over the next fifty years. At present, there is no treatment. In the last 12 months, however, three major breakthroughs have occurred that give promise that research into the causes of AD will soon yield definitive results. This, in turn, is likely to lead to new concepts for developing treatments.

Cystic Fibrosis.—Over 30,000 children and young adults suffer from cystic fibrosis (CF). Discovery of the CF gene in 1989 led to a new understanding of the disease. Recently, researchers successfully used a cold virus to implant a normal human CF gene into the lungs of live animals. This advance is likely to lead to an effective gene therapy in the foreseeable future.

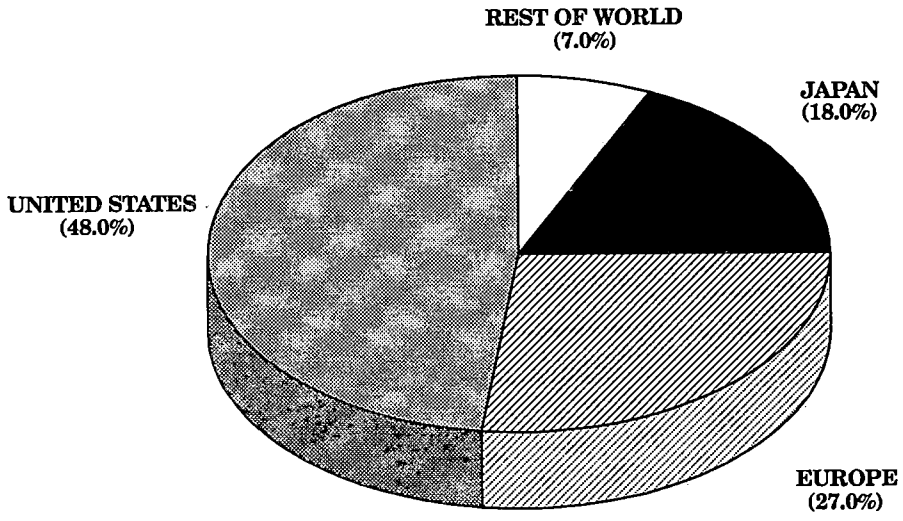
Diabetes.—Despite insulin, millions of diabetics are at risk of disabling complications. Transplanting pancreatic islet cells could "cure" the disease preventing these complications. Preliminary studies have successfully demonstrated that enclosing the transplanted cells in an artificial covering blocks rejection of the transplant by immune attack. A real cure for diabetes may be just a matter of time.

Chart 10. FUNDING FOR HEALTH CARE RESEARCH AND DEVELOPMENT, 1990



SOURCE: US DHHS/PHS/Office of International Health

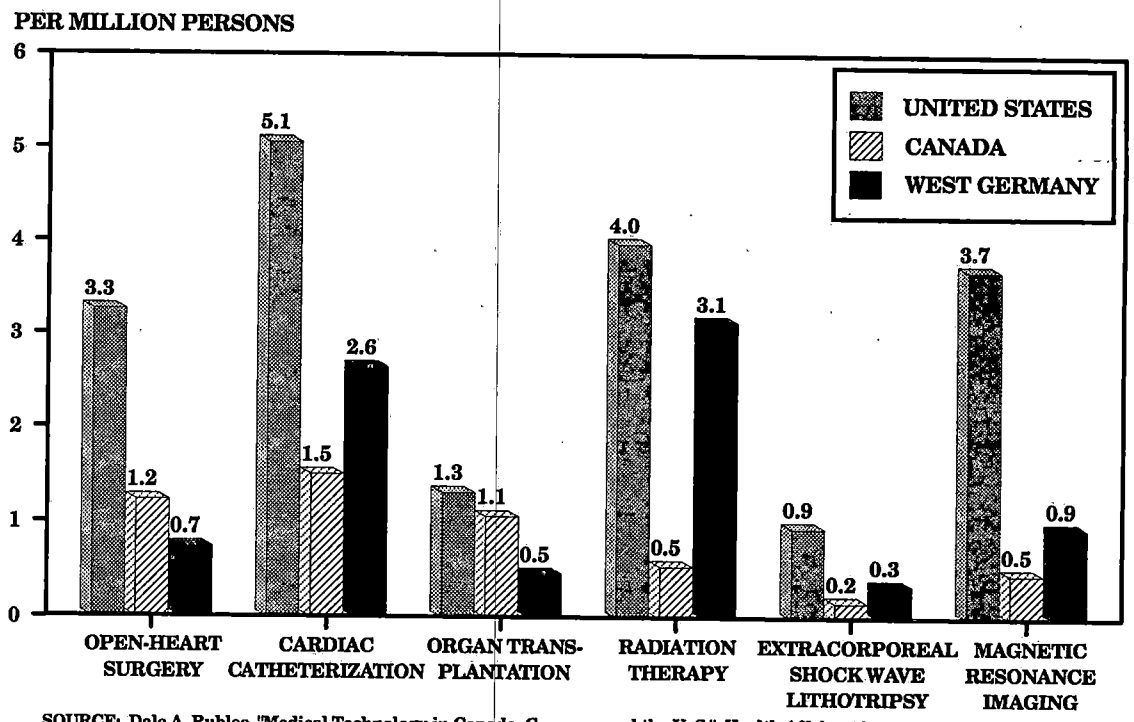
Chart 11. PRODUCTION OF MEDICAL EQUIPMENT
UNITED STATES AND THE WORLD, 1991



SOURCE: Medicine & Health, January 27, 1991

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Chart 12. COMPARATIVE AVAILABILITY OF SELECTED MEDICAL TECHNOLOGIES



SOURCE: Dale A. Rublee, "Medical Technology in Canada, Germany and the U. S." Health Affairs, 1989

Chapter 3

Expanding Access and Increasing Affordability Through Market Reform

Overview

The President's proposal for reform of the health insurance market will make coverage more secure, available, and affordable for millions of Americans.

- Everyone—young and old, healthy and sick—will benefit from the assurance of the availability of affordable health insurance regardless of future changes in their health.
- Workers will be able to change jobs without fear that insurance coverage will be denied due to a preexisting illness.
- Premium costs will be reduced by as much as 20 percent for at least 70 million workers and their dependents affected by small group reforms.
- Five million Americans currently without health insurance will have insurance as a result of these market reforms.

The market reform proposal has four major components. These components will:

- Assure availability and security of coverage. Insurers would offer coverage without regard to health status. Coverage would be renewable, and preexisting condition limits would be eliminated. Employers would provide information and facilitate access to group coverage to all employees and dependents, but would not be required to administer or contribute to the cost of coverage. Further, colleges and universities would provide continued access to group coverage to recent graduates and other students for six months after leaving school.
- Assure affordability of coverage for individuals and small businesses through broad risk pooling. Insurers would participate in broad pooling arrangements to spread health risks evenly across insurers and thereby allow insurers to charge uniform premiums for the sick and the healthy. On an interim basis, pending phased implementation of this new system, insurers would be subject to limits on their ability to vary premiums.
- Encourage group purchasing of health insurance by small businesses to give them the same cost advantage enjoyed by larger businesses. Small businesses could pool their purchasing power through Health Insurance Networks (HINs). This will help small businesses negotiate discounts and save on overhead and marketing costs. Moreover, the Employee Retirement Income Security Act (ERISA) preemption that allows larger self-insured firms to avoid cost-increasing State laws will be extended to small businesses purchasing coverage through HINs. For the first time national and regional small business associations and other groups will also be able to establish inter- and intra-State HINs to better assist their membership.
- Give health plans increased flexibility to control costs. Health plans would be protected from mandated benefit and "anticooridnated care" laws that hinder designing cost-effective benefit packages to meet individual and family needs and drive up costs. Health plans would also be protected from laws and regulations that hinder innovative cost control measures, such as utilization review and selective contracting.

An important benefit of these reforms is strengthening significantly competition among health plans. In today's environment, health plans can gain a significant premium cost advantage by avoiding high risk individuals and groups. Under the Administration's reform

proposal, such "risk avoidance" will be stopped. As a result, competition will focus on price, value, and quality, leading to long-term gains in efficiency and improvements in quality.

Strengths and Weaknesses of the Current System

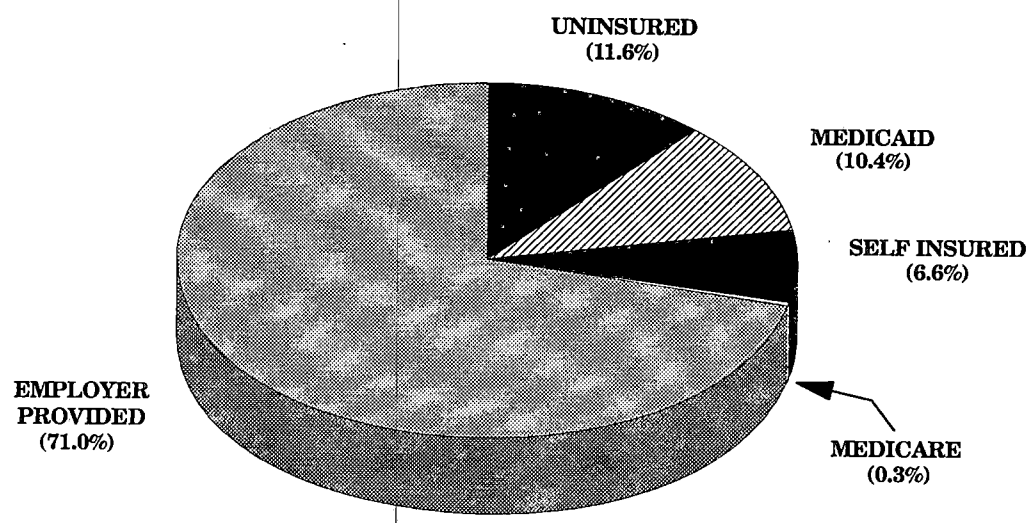
153 million working age Americans and their dependents—62 percent of the total population—are covered primarily through private health insurance. Most of these are covered through employment. This system has worked well because employment can be a stable basis for risk-pooling, particularly for medium and large firms and because substantial administrative savings and economies of scale are possible through employment-based group coverage.

Special Problems for Small Business.—While generally successful, there are significant problems with the current system, especially for small group and individual coverage. Workers at small firms are much more likely to be uninsured than workers at medium and large firms.

This disparity in coverage reflects three main problems. First, many small businesses cannot afford to provide costly fringe benefits. Second, health insurance is more costly for small businesses due to (i) higher overhead and marketing costs and (ii) costs resulting from State mandated benefit laws and premium taxes which generally do not apply to self-insured coverage ("ERISA exempt" from State insurance laws) typically provided by larger businesses. Finally, the market for health insurance for small business is in turmoil due to risk selection.

Erosion of Risk Pooling.—For people with serious illness, the cost of medical care can easily consume a substantial share of family income. With broad risk pooling, through insurance, the costs of illness are spread across a broad pool of premium payers, making costs more uniform, thus more affordable. The value of risk pooling is particularly great because spending on health care is highly skewed. At any given time, most of the population is healthy, and has little need for medical care. However, a small percent of the population is

Chart 13. INSURANCE COVERAGE OF THE POPULATION UNDER 65



SOURCE: Agency for Health Care Policy and Research, NMES, 1987

Table 3–1. **Number of Uninsured Workers and Dependents By Establishment Size—1987**

(Source: AHCPR, 1991)

Establishment Size	Number of Workers and Dependents	Percent of Workers and Dependents	Number Uninsured	Percent Uninsured	Percent of All Working Uninsured
Less than 25	74.2 m	44	17.2 m	23.1	68
26–100	34.6 m	21	4.3 m	12.3	17
Greater than 100	59.2 m	35	3.9 m	6.6	15
Totals	168.0 m	100	25.4 m	15.1	100

Note: Interventions affecting groups below a threshold, such as a hundred workers, will generally affect all *firms* below the threshold, as well as workers in establishments below that threshold, where firms have establishments in one or more States that fall below the threshold. Even limiting to the strict "firm"-based definition of size it is estimated that about 70 million workers and their dependents fall below a size of 100.)

seriously ill, and requires extremely costly care. The top 5 percent of the population in terms of health care use (i.e., the 95th percentile) have per capita health expenditures ($7,100) 26 times greater than costs ($270) for people at the midpoint of the population in terms of health care use (i.e., the 50th percentile).

Insurance risk pooling is valuable for everyone because even those who are healthy today may develop a serious illness at some point in their life. However, *risk selection* can undermine insurance as a pooling mechanism. Risk selection occurs whenever a particular pool has a skewed selection of risks. Such a pool will have a higher or lower average per capita cost when compared with other pools.

Risk selection is extremely difficult to prevent. This is because healthy and sick people have different needs for health insurance and choose different health plans to meet these needs. Generally, healthy people are attracted to leaner benefit packages (higher cost sharing, fewer covered benefits) because they expect that they will not have a need for more extensive coverage. In contrast, sicker people prefer richer benefit packages because of their expected needs. Moreover, certain features of coordinated care, such as a greater emphasis on preventive care, could be more attractive to the healthy. As a result, sick and healthy people will

Table 3–2. **Distribution of Per Capita Health Spending By Age and Within Age Categories, 1987**

(Source: AHCPR, 1991)
(In dollars)

Age	Mean	25th Percentile	50th Percentile	75th Percentile	95th Percentile
0–6 years	1,133	50	180	600	3,800
7–18 years	643	15	120	400	2,500
19–24 years	839	0	150	550	4,000
25–54 years	1,238	50	260	860	5,500
55–64 years	2,469	160	570	1600	11,424
Greater than 65 years	4,551	330	960	3,500	22,528
Total	1,591	50	270	1,000	7,100

sort themselves into different plans, even without any effort at selective marketing by insurers. The result will be that sick people will face high premiums due to the non-random distribution of health risks.

Risk selection is especially likely in the market for small group because a single small business cannot serve as a stable risk pool. One or two sick workers can greatly increase average per employee health benefit costs. Insurers originally combined many small businesses into a single risk pool and charged all members of the insured group a uniform (or age-adjusted) premium that did not vary based on health risk. This approach helped to make coverage affordable for individuals with chronic illnesses.

However, in today's market, some insurers have developed strategies for attracting low risk groups, while leaving higher-risk groups without coverage or with unacceptably high premiums. Favorable risk selection provides an opportunity to make a profit by offering low premiums to attract healthy groups while discontinuing coverage (or increasing premiums to a prohibitive level) once a group becomes more costly. Some insurers are also using medical information (health screening) to exclude higher-risk groups or individuals from coverage. Some insurers exclude preexisting medical conditions from coverage. In some cases, even individuals with relatively mild health problems have been denied coverage.

As some insurers succeed in attracting low-risk groups and avoiding high-risk groups, other insurers face an upward premium spiral, and must risk select to keep up with competitive pressures. Similar—possibly even more severe—problems affect the market for individual non-group coverage.

These problems are increasingly common. Moreover, there appears to be no natural end to current trends. Thus, if left unchecked, broad risk pooling seems likely to unravel in the small group and individual coverage markets. If this were to happen, health insurance would become unaffordable for many Americans—especially those most in need of coverage.

Assuring Availability of Coverage

The President's reform proposal contains several initiatives to assure that health insurance coverage is readily available. These reforms apply broadly to all private health insurance coverage regardless of group size and to coverage provided by employers who self-insure.

Prohibition on Exclusion from Coverage Due to Health Status.—All insurers wishing to sell group health insurance in a State would be required as a condition of doing business to (i) accept every employer group in the State that applies for coverage and (ii) provide coverage to individuals within an employer group. In addition, all employers would be prohibited from excluding any individual from health insurance coverage for reasons of health status. Finally, any insurer selling coverage to individuals receiving health insurance tax credits would be prohibited from excluding any credit recipient from coverage.

Guaranteed Renewability.—Insurers wishing to sell group coverage in a State would be required to renew coverage for a group except in the case of nonpayment of premiums, fraud, or misrepresentation.

Portable Access.—Under the proposal, workers would be able to change jobs without loss of coverage due to a preexisting coverage exclusion. Currently, some health insurance does not cover costs related to any illness or disease diagnosed prior to the initial date of coverage. As a result, many working Americans with chronic illnesses have been afraid to change jobs for fear that the insurance provided at their new job would no longer cover their medical expenses.

The use of preexisting condition exclusions would be eliminated. This will assure that all workers can change jobs without losing access.

Access to Group Coverage for Workers and Dependents.—All employers would be required to provide information on affordable basic health insurance plans available in their respective States. This information is to be prepared and provided by State insurance commissioners. This will expand access to plans that provide individual and family coverage to all employees—but employers would not be re-

quired to administer a health plan or make any contribution towards the cost of health coverage. States would assist employers by making available information regarding the availability and cost of "basic" coverage from various health plans. Employers would be required only to arrange for deduction of premiums from paychecks if employees so requested, but would have no other administrative burden. Health insurance networks—group purchasing arrangements for small employers—would facilitate this process and it is anticipated that most small employers would join a HIN (see below).

Access to Group Coverage for College Graduates.—To help fill a significant uninsured gap for new work force entrants, all colleges and universities that provide group coverage to students would be required to offer extended group coverage for new graduates and other students for six months after they leave undergraduate and graduate programs. The college or university need not make any contribution toward the cost of coverage under such a plan.

Assuring Access to Coverage for Individuals and Families Receiving Health Insurance Tax Credits (certificates).—Each State would define a "basic" benefit package or a series of packages with an estimated actuarial value equal to the value of the health tax credit. A number of benefits packages are provided as illustrative examples (*See* Table 3–3).

Any health plan in a given State could offer the State-defined "basic" benefit package to credit recipients and to others. To ensure that credit recipients have a variety of plans available, if no insurers offer the "basic plan" the State insurance commissioner could require two or more health plans with a substantial market share to offer the "basic" benefit plan. Health plans could charge a market price for the "basic" benefit package.

The State and Federal Governments would implement outreach programs with the goal of securing 100 percent participation among credit eligibles. Broader participation would help prevent unnecessary and costly emergency care by encouraging primary and preventative care.

Table 3–3. **Basic Benefit Plan Examples for Approximate Amount of the Full Health Insurance Tax Credit in 1993**

(Plans are illustrative only—States will design benefits)

"Coordinated" Fee-For-Service Plans

Plan A—Unlimited inpatient hospital, inpatient physician care, prescription drug coverage, 3 ambulatory physician visits and associated diagnostic services with a $10 co-pay per visit.

Plan B—Unlimited inpatient hospital, inpatient physician care, and 5 ambulatory physician visits and associated diagnostic services with a $10 co-pay per visit.

Plan C—Unlimited inpatient hospital, inpatient physician care, 10 ambulatory physician visits and associated diagnostic services with a $10 co-pay per visit.

Plan D—Inpatient hospital up to 15 days, inpatient physician, lab, emergency room, and ambulatory physician visits and associated diagnostic services covered for $5 fee per visit for the first three physician visits, then a 10 percent co-pay up to a $500 out-of-pocket limit.

Plan E—Includes all services under Plan D, but with a 20 percent co-pay on physician visits after 3 visits.

Plan F—Includes all services and co-payment under Plan E, but would offer prescription drug coverage.

Model HMO Benefit Plan

Plan G—Unlimited inpatient hospital and inpatient physician services, emergency room, and unlimited ambulatory physician visits with associated diagnostic services (subject to a $10 copayment), prenatal care, and prescription drugs (subject to a $5 copayment).

In cases where a hospital emergency room is an individual's first point of contact with the system, rotating assignment would be used to enroll an uninsured credit-eligible individual to a specific health plan if the individual were unable to make a choice. So for example, a homeless person entering the hospital and having no preference for any carrier would be assigned to an insurer by rotation and the credit would automatically flow to the insurer.

Assuring Affordability of Coverage Through Risk-Pooling

As noted above, broad risk pooling is essential if health insurance is to be affordable for the sick as well as for the healthy. The President's market reform proposal provides both interim and longer-term solutions. Transition measures, including "premium bands" would be implemented immediately to stabilize the small group market pending full implementation of longer-term measures.

In the near term, premium bands will spread risks within an insurer's pool by limiting the difference in premiums that an insurer may charge to groups with different health risks. This will make coverage less costly in the near term for higher risk groups. However, premium bands may be unstable in the longer term. Because an insurer would be unable to vary premiums to reflect fully actual differences in expected health care costs, healthy enrollees would have incentives to shift to other insurers that have fewer sick people in their pools.

Health risk pooling would assure affordable coverage over the long term both for small groups (under 100 employees) and for individuals and families receiving health insurance tax credits. Under this approach, health plans insuring a sicker than average population would receive a net transfer from the risk pool while other insurers will be net payers into the pool. This will assure stable risk pooling over the long-term and will level the competitive playing field among insurers to focus competition on efficiency and quality.

The health risk pooling approach would be implemented immediately for tax credit recipients and would be phased-in over a five year period for small group coverage. Delayed implementation in the small group market is appropriate to permit an orderly transition and to avoid undue disruption of existing arrangements. Immediate implementation of health risk pooling would, however, be possible for credit recipients since this is a new market.

Transition Measures for Small Group Coverage.—These transition measures would apply to all insurance provided to small businesses employing fewer than 100 workers. The premium standards (or "bands") limit variation in premiums within each insurance company's overall set of offerings. They would not constrain premium variation between insurers. The premium standards would be temporary and would be phased-out with full implementation of a system to equalize risk among insurers.

- *Premium Standards Across and Within Demographic Categories.*—Insurers could vary premiums by age. This means that younger workers would not be forced to subsidize older workers (who typically have higher income and higher health risks). But, insurers would be limited in their ability to vary premiums based on health status or prior use of care. Premiums could not differ by more than 50 percent within age/sex categories in the first year decreasing to 35 percent by the third year.

- *Rate of Increase Standard for Renewal Premiums.*—Insurers could not increase premiums excessively for groups with deteriorating health status or claims experience. The maximum percent increase in renewal premiums would be set at 5 percent plus the percent change in the "base premium rate." The "base premium rate" is the lowest premium the insurer could have charged under the relevant block of business for a group with similar demographic characteristics, excluding factors related to health status, claims experience, industry, occupation, or duration of coverage.

- *Premium Standards Across "Blocks of Business".*—Premiums could vary by up to 20 percent across different blocks of business. A carrier may establish different blocks of business: (i) for business acquired

from another carrier, (ii) for business obtained through a distinct system of marketing (e.g., brokers vs. associations), and (iii) for business obtained through different associations (for example, HINS). Carriers could establish three different blocks of business for each of the three reasons, for a total of nine different blocks of business.

- *Enforcement.*—An independent actuary would certify compliance. Failure to have a valid certification would trigger a violation. The State enforcement agency could conduct an investigation to verify certifications.

States could also implement a prospective reinsurance or risk allocation system on an interim basis to pool risks among insurers.

- Under a *prospective reinsurance* model, an insurer could obtain optional reinsurance for any group or newly eligible group member. The primary insurer would be liable for an individual's health costs up to a threshold amount. Above the threshold, the reinsurance program would be responsible for most of the cost. The program would be funded by reinsurance premiums and an assessment on all small group insurers.
- Under *risk allocation,* each insurance carrier would have a quota of assigned risks based on the carrier's market share. Insurers could initially refuse to provide coverage based on health risk. However, the rejected group or individual would have a right to select any insurer from an assigned risk list maintained by the State provided that the insurer's allotment has not been filled.

Health Risk Pools.—Each State would implement two broad health risk pools: one for small group coverage and another for coverage provided to individuals and families receiving transferrable health insurance tax credits. These pools would spread risk broadly across all health plans providing such coverage within a State.

Under this system, health plans that cover a sicker than average population would receive a net payment from the pool, while other health plans would be net payers into the pool. Payments from and to the pool would be based on the difference between the expected health care costs for the entire covered population and the expected health care costs for the population covered by the insurer.

As a result, insurers would no longer have an incentive to deny coverage to individuals with chronic disease. Moreover, insurers would be able to provide coverage at a near uniform premium for the sick and the healthy. The health risk pool would have this effect because a health plan that enrolls an individual with a high-cost chronic illness will receive a transfer of funds from the pool equal to the difference between the expected health care costs for the individual involved and the average expected cost. This moves the system back toward a flexible community rate—where choice in plans is maintained, but risk is truly pooled.

A number of methods have been developed for measuring expected health care costs based on the health characteristics of the population involved. These methods include the Diagnostic Cost Group system developed at Boston University and the Ambulatory Care Group system developed at Johns Hopkins. Other systems are available for use by the States. The Department of Health and Human Services would fund research to refine these systems and to develop improved systems for adjusting for health risk. The Department would also provide technical support to assist States in establishing the risk pools.

As is true for any system that varies payment according to health status, some degree of overreporting is possible, but such overreporting would not have an adverse effect on the pooling system unless some insurers were more successful at it than others. If necessary, to prevent this outcome, a random sample audit of insurance claims and other records could be used to verify the accuracy of health risk assignments.

The health risk pools for small group coverage and for credit recipients would be similar in most respects. Participation would be required for all health plans providing coverage to small groups and to credit recipients. If an individual purchases the basic benefit package, the insurance company re-

ceives the credit plus or minus an amount related to the individual's age (and possibly gender). These adjustments mitigate the problem of adverse selection for the basic benefit packages.

Amounts received by an insurance company would also be subject to health status adjustments. On an annual basis, each credit recipient would be assigned to a health status category. Each health category would have a corresponding weight based on expected health care costs defined relative to the population average. Each insurer would calculate an average weight for all credit recipients covered by the insurer. Insurers with an average weight greater than the statewide average would receive net transfers from the pool, while insurers with an average weight less than the statewide average would be required to make contributions to the pool.

States would implement pools for credit recipients simultaneously with federal implementation of the transferable health tax credit system. Implementation of health risk pools for small group coverage would occur over a five-year period on a phased-in basis, starting in the third year after enactment of the reform proposal. Transition measures, including premium limits, would apply in the small group market in the interval.

Encouraging Group Purchasing For Small Employers: Health Insurance Networks

The President's reform proposal will help reduce insurance costs for small businesses by encouraging group purchasing. Group purchasing can reduce health insurance costs by as much as 16 percent through efficiencies of scale, lower administrative costs, and through pooling of purchasing power that helps small businesses negotiate better rates with insurers.

Cleveland's Council of Smaller Enterprises (COSE) operates a successful health insurance group purchasing program for small firms. While COSE has been successful, surprisingly little of this type of group purchasing is going on nationwide. The reforms described in the preceding sections will spur group purchasing by protecting against some of the abusive practices that have daunted some local purchasing groups. Additional assistance is provided as well to encourage rapid formation of group purchasing arrangements.

ERISA Reform/Incentives for Group Purchasing.—The federal preemption of State regulation of self-insured health benefit plans under ERISA that benefits virtually all large employers would be extended to small businesses that purchase coverage on a group basis through a Health Insurance Network (HIN). This would protect against (i) State mandated benefit laws that require firms to provide certain costly services, (ii) excessive State health insurance premium taxes, (iii) and State anti-coordinated care laws. These laws typically increase premium costs by 2 to 5 percent. HINs could also still self-insure, but in this case, enhanced insurance State solvency and increased Department of Labor standards would apply to ensure the economic stability of the plans.

Functions.—HINs could contract with insurers to provide coverage to members or could self-insure subject to enhanced State solvency

Table 3–4. **Savings From Small Market Reforms: Administrative and Bargaining Effects**

(Expressed as percent of total premium, by firm size)

Firm Size Claims	Total Savings
<4	15.9
5–9	13.1
10–19	10.9
20–49	8.5
50–99	6.0

regulation (if State solvency standards are insufficient, Department of Labor solvency standards would operate as a backup oversight system). All federally approved HINs would be required to offer at least one coordinated care option and to use a standard claims form.

Organization.—HINs would be structured as non-profit voluntary membership organizations with a board of directors elected by the membership. HINs would be registered and qualified, as applicable, by a State agency or by the Department of Labor. There would be no limit on the number of HINs that could be established in a given area. HINs could be established along the lines of professional societies, industry, or trade associations and would be subject to all of the market reforms listed in the preceding sections. By buying coverage through a HIN, small businesses would be able to achieve more effective purchasing power in the market, thereby helping reduce the cost of insurance to their employees.

HINs will provide the mechanism for pooling large numbers of individuals and employees of small firms, an advantage that is now only available to large companies. These plans have not grown in the past because of State laws. To allow for federal preemption, plans had to "self insure". Small groups have difficulty raising capital to self insure risk. This system allows "imputed ERISA exemptions"—small firms can join together without self-insuring, and have insurers carry the risk.

Intrastate and Regional Pooling.—The State or Federal government could certify an HIN. For example, Pennsylvania (or the Federal government) could certify an HIN of 1,000 small employers who pooled market power to negotiate with local providers in Philadelphia, or the Federal government could certify a similar HIN for the Philadelphia area (PA, NJ, and DE) that would pool market power in the entire region.

Multi State Pooling.—HINs would allow for the first time, multi State pooling of small firms. Groups like NFIB, National Small Business United and The Chamber of Commerce (or any other group) could offer the same basic plans to members nationwide. In the past, State barriers have prevented such plans. This will simplify marketing and administration and sharply reduce costs.

Increasing Flexibility for Health Plans

States would no longer be allowed to mandate benefits that unduly limit flexibility for health plans, thereby increasing health care costs and restrict coordinated care.

State Mandated Benefits.—Many State laws require insurers to cover certain optional or ancillary services. These mandated benefits drive up premium costs up by at least 3 to 5 percent.

Provisions that Restrict Coordinated Care.—Some State laws impose restrictions which prevent the development of coordinated care—and the competitive pressure it imposes on fee-for-service providers. Anti-managed care laws include:

- *Restrictions on reimbursement rates or selective contracting:* Laws that restrict the ability of a carrier to negotiate reimbursement rates with providers or contract selectively with a limited number of providers.
- *Restrictions on differential financial incentives:* Laws that limit the financial incentives that a health benefit plan may require a beneficiary to pay when a non-plan provider is used on a non-emergency basis.
- *Restrictions on utilization review:* Laws that (a) prohibit utilization review of any or all treatments and conditions, (b) require that such review be made by an in-State physician or by a physician in a particular specialty, (c) require the use of specified standards of health care practice in such reviews, or require the disclosure of the specific criteria used in such reviews, or (d) require payment to providers for the expense of responding to utilization review requests.

Federal/State Relationships

Most of the reforms described in the preceding section would be implemented by the States. Thus, the responsibility for regulating health insurance would remain primarily with the States. However, federal legislation would be amended to provide States with clear

incentives to enact laws that will achieve national goals.In many cases, as with HIN certification and oversight, there would be backup federal certification and oversight procedures.

Under this approach, after an initial period to allow State action, if a State's health insurance laws do not meet prescribed federal guidelines, then insurance sold in-State would be certified through a federal back-up mechanism.

Other reforms would be implemented directly by Federal Government through amendment of the Federal Employee Retirement Income Security Act (ERISA) or through other appropriate legislation. Certification of HINs would fall into this category.

As stated above, federally certified HINs would be protected from State mandated benefit laws and State premium taxes in the same manner as an ERISA-qualified self-insured plan. Federally certified HINs would, however, be subject to additional State requirements to assure solvency. States could provide an alternative process for certification of HINs. If State laws and State premium taxes were excessive, a HIN could apply to the Department of Labor for federal certification—pre-empting State law. As a result, State would be encouraged to facilitate market pooling and access to coverage for small business—or risk losing their traditional insurance oversight and regulatory role to a federal backup system.

Chapter 4

Expanding Access Through Tax Measures to Help People Pay for Insurance: Health Insurance Tax Credit and Deduction

Overview

The cornerstone of the President's plan to increase access to health insurance is a new transferable tax credit and deduction designed to help most of the Nation's uninsured obtain health insurance. The plan places the highest priority on providing health insurance for low-income individuals, but also would provide substantial benefits to middle-income individuals who enjoy little or no employer contributions for health insurance and to self-employed individuals.

Policy Background

Current tax law provides substantial benefits to individuals whose employers contribute to their health care insurance costs. The entire amount of the employer's contribution is excluded from taxable income and from the FICA wage base.

Self-employed individuals are able to deduct 25 percent of their premium payments. And all taxpayers are able to deduct out-of-pocket medical expenses and premium payments to the extent that these expenses exceed 7.5 percent of adjusted gross income; however, this deduction is of limited value to most taxpayers because few have medical expenses significantly in excess of the AGI threshold.

Other federal programs—including Medicare and Medicaid—provide health insurance coverage directly to eligible groups including the elderly, disabled, and certain low-income individuals. However, many low income individuals—including many unemployed individuals and the working uninsured—do not qualify for any of these benefits and do not receive any direct or indirect Federal contribution to their health insurance.

Overall, there are estimated to be 34.7 million Americans without health insurance (CPS, March 1991). Lack of coverage has a number of adverse consequences. Health may be at risk because of reduced access to primary and preventive care. Moreover, uninsured people often seek medical care in hospital emergency rooms, which is costly and inefficient. The cost of providing care to the uninsured produces large cost-shifting within the health care system, increasing costs for the insured—by up to 15 percent for some services. For these and other reasons, expanding insurance coverage is an important goal for the Nation.

Analysts have suggested a variety of options as means of expanding insurance coverage. These options include national health insurance (see Chapter 6, section A), and a "play or pay" mandate to require employers

95 Million Americans Will Benefit

To make health insurance more affordable, the President's plan includes:

- A tax credit of up to $3,750 for low-income families;
- A tax deduction of up to $3,750 for middle-income families;
- An increase to 100 percent in the deduction for health insurance available to self-employed individuals.

to provide coverage or to pay a tax (see Chapter 6, section B). Both of these alternatives will lead to higher costs for American taxpayers, rationing of care, and inefficient delivery in an unstable system. The President's proposal instead relies on significant reforms of the health insurance market, a new transferable health insurance tax credit for low-income families, and a new health insurance tax deduction for middle-income families.

The President's plan will promote individual choice. With a system of health insurance tax credits and deductions, low- and middle-income families will be free to choose among a variety of health plans with increased availability due to the market reforms. This helps ensure that coverage meets individual and family needs.

Moreover, providing choice is a critical prerequisite of competition in any market system—and competition among health plans is the best way of assuring continuous improvements in quality of care, service, and cost-effectiveness. None of the alternative options for expanding insurance coverage promote choice or enhance competition. Indeed, they generally have the opposite effect. Other disadvantages are detailed more fully in Chapter 6.

Tax Credits and Deductions for Low-Income and Middle-Income Individuals

Low- and middle-income persons who are not covered by other federally subsidized health insurance programs will be eligible for a tax credit or deduction for the purchase of insurance.

Eligibility.—Eligibility for the credit or the deduction is related to income and extends up to a modified adjusted gross income of—

- $50,000 for single persons
- $65,000 for persons filing as heads of households, and
- $80,000 for married persons filing jointly.

These income levels will be increased to account for inflation.

Individuals who receive other federal support (e.g., covered by Medicare, Medicaid, CHAMPUS, and selected other federal health programs) would not be eligible for the credit. The transferable tax credit would replace the supplemental earned income tax credit available under current law for certain low-income taxpayers who contribute toward the purchase of health insurance coverage for their children.

Amount.—The maximum amount of the credit is $1,250 for single persons, $2,500 for married couples and other two-person families, and $3,750 for families of three or more. These credit amounts would be sufficient to purchase a basic health insurance benefits package (See Table 3–3). The amount of the credit would phase down to a minimum at increasing income levels.

Individuals, couples, and families may also elect to claim a deduction instead of the credit. The deduction will be available to persons without regard to whether they itemize or claim the standard deduction and will be equal to $1,250 for single persons, $2,500 for married couples and other two-person families, and $3,750 for families of three or more.

Both the credit and deduction amounts will be increased to account for inflation. Applicable credit and deduction amounts will be reduced by the amount of any contribution made by the employer to the employee's health plan. Individuals with employer contributions exceeding the applicable credit or deduction amount will receive neither the credit nor the deduction.

As noted above, the amount of the tax credit would vary based on modified adjusted gross income in relation to the tax filing threshold. The tax filing threshold is the sum of the standard and taxpayer and dependent exemptions and approximates the poverty level. Modified adjusted gross income equals the sum of adjusted gross income, plus nontaxable Social Security payments, Railroad Retirement payments, and tax-exempt interest.

The tax credit would be implemented over a five-year period. When fully implemented—

- All eligible individuals, married couples, or families with incomes below the tax threshold (100 percent of poverty) will re-

ceive the maximum credit (e.g., to $1,250, for individuals, $2,500 for married couples, and $3750 for families).

- All eligible individuals, married couples, or families with incomes above the tax threshold will receive a partial credit, decreasing to 10 percent of the maximum credit (e.g., to $125 for individuals, $250 for married couples, and $375 for families) at 150 percent of the tax threshold.
- All eligible individuals, married couples, or families with incomes above 150 percent of the tax threshold, will receive the greater of the minimum credit or the deduction of up to $3,750 as described above.

As noted previously, individuals, married couples, and families with incomes above $50,000, $65,000, and $80,000, respectively, would be ineligible for either the credit or the deduction. Also, as noted previously, individuals, couples and families could take the health insurance deduction instead of the credit. Moreover, the amount of the credit and the deduction would be phased out over the range of $40,000 to $50,000 for single persons, $55,000 to $65,000 for married couples and other two-person families, and $70,000 to $80,000 for families of three or more. The tax credit and deduction would cost about $35 billion in 1997 when fully phased-in.

Administration.—For filers, credits and deductions could be claimed on the tax return at the end of the year in the usual manner used for other credits and deductions.

Alternatively, low-income credit recipients could receive a transferable credit certificate during the year by applying to a governmental office. States may select a State agency, such as the Employment Service or contract with the Social Security Administration to certify applicants' eligibility and to notify the Internal Revenue Service of the issuance of the advance credit.

This mechanism would immediately qualify the individual or family for assistance in purchasing health insurance; people would not have to wait until they file their tax returns to benefit. Transferable credit holders would transfer the credit to an employer or insurer who provides health insurance in payment for coverage. The insurance provider will then reconcile the amount of the advance credit on their tax return.

Credits would be used to purchase a "basic" benefit package (or other health plans of their choice). States would ensure that insurance companies would make basic benefit plans available (See Chapter 3).

Tax Credits and Deductions for Self-Employed Individuals

The self-employed would be entitled to deduct 100 percent of the cost of their health insurance premiums or receive the applicable credit, whichever is greater.

Using the Tax Credit/Deduction to Purchase Insurance

The market reforms described in Chapter 3 would apply to help assure that coverage is both available and affordable for individuals and families receiving health insurance tax credits. Specifically, guaranteed issue, guaranteed renewability, and elimination of preexisting condition exclusions would all apply. Moreover, broad based health risk pooling would apply to insurance sold to credit recipients to ensure affordability of coverage for recipients with chronic illnesses. Finally, credit recipients would be able to buy low cost coverage through health insurance networks or HINs.

The initial credit amounts of $1,250, $2,500, and $3,750 for individuals, couples and families were selected to cover the cost of an efficiently-run health plan that provides "basic" services. Each State would define a basic benefit plan or plans that could be purchased for the approximate amount of the credit. Any insurer in the State could offer basic benefits to credit recipients. Credit recipients would be able to buy coverage other than the State-defined basic benefit package if such other coverage would better suits their needs.

Achieving the Goal of Expanded Access

The health insurance tax credit and deduction will help millions of low- and middle-income families afford health insurance. When fully implemented, approximately 86 percent of all individuals not receiving Federal medical

support have income in the range of eligibility for a credit or deduction; the remaining 14 percent are higher-income individuals or families.

- Individuals who have employment based coverage, but who pay much of the cost themselves, would receive a substantial new deduction or credit.

A total of 95 million individuals would benefit from the health insurance tax credit and deduction when the President's program is fully phased in.

- About 25 million low-income individuals would receive the maximum credit (adjusted for any employer contributions).
- Approximately 13 million individuals with incomes between 100 percent and 150 percent of the tax filing threshold would receive a partial credit or deduction.
- Finally, about 57 million middle-income individuals would receive a partial credit or deduction. Of these, 51 million would receive a deduction.

Self-employed workers would also be helped. In 1993, 3.1 million self-employed taxpayers currently buying health insurance would benefit from the increase in the deduction available to the self-employed. Still more self-employed individuals will benefit because they qualify for the health insurance tax credit. And, the insurance market reforms discussed in Chapter 3 will reduce the cost of health insurance for self-employed individuals at all income levels.

After five years, 29 million Americans will become newly covered. The number of uninsured will be decreased from 34.1 million to 4.9 million—or less than 1.8 percent of the total population. Twenty-four million Americans will gain coverage primarily as a result of the new health insurance tax credits and deductions. And, by reducing premium costs substantially, the health insurance market reforms and other cost-containment reforms will encourage employers to expand coverage voluntarily to an additional five million Americans.

Table 4–1. **Effect of Overall Reform Proposal on the Number of Uninsured Americans**

(People in millions; projected to population)

Income Level	Below 100 Percent of Poverty [1]	Between 100 and 150 Percent of Poverty [1]	Totals	As Percent of Total Population
Current Law Uninsured	15.4	5.7	34.1	12.8%
Covered Through Tax Credits and Deductions	14.9	5.0	24.1	9.1%
Covered Through Market and Other Reforms	0.4	0.6	5.0	1.9%
Total Newly Covered	15.3	5.6	29.2	11.0%
Remaining Uninsured	0.1	0.2	[2]4.9	1.8%

[1] Poverty here is the income level at which individuals, couples, and families must begin paying income taxes.
[2] Many of the 4.9 million remaining uninsured are eligible for a credit or deduction.

Chapter 5

Making the System More Cost-Effective

A. Overview

Over the past several decades, per capita health care costs in the United States have increased more than 4 percent per year faster than general inflation. Since 1960, real per capita health spending has grown as a share of GDP from 5.3 percent in 1960 to an estimated 13.1 percent in 1991. If current trends were to continue, total health spending could reach 26.1 percent to 43.7 percent of GDP by 2030 under alternative assumptions (Waldo et al., 1991). Clearly, these trends are unsustainable if the United States is to improve its economic base and standard of living.

This rapid growth reflects a number of factors that cannot easily be changed or controlled: the demographics of the U.S. population, the labor-intensive nature of health care services, and the introduction of beneficial—but highly costly—new technology. Other causes of rising health care costs—market failures in health care and health insurance—can and should be addressed through enhanced competition.

Currently, the mix of health services provided is not necessarily that which fully informed consumers would purchase under optimal conditions and services are not produced at minimum cost. A key issue is the role of insurance. While health insurance has important benefits—it protects individuals and families from unexpected high health care costs and it reduces financial barriers to care—traditional fee-for-service insurance with low cost-sharing stimulates over-utilization of services. The reason is straightforward: with insurance paying most of the cost, health care is perceived to be a free good for patients and demand for medical care increases above optimal levels. Moreover, insulated from the cost of care, consumers have little reason to shop for the best price.

More efficient forms of health insurance coverage are available. These include fee for-service coverage with modest cost sharing and coordinated care coverage, where the health plan strives to buy the best package of health care at the lowest cost on behalf of plan enrollees. Due to distortions in the health insurance market, however, demand has been relatively weak for these more efficient forms of coverage.

There are three principal distortions in the market for health insurance which support inefficient forms of coverage: (i) government subsidies which reduce consumer sensitivity to cost, (ii) opportunities for favorable risk selection—or "cream-skimming"—which can give inefficient health plans an unfair cost advantage, and (iii) limited consumer information regarding the quality of care in competing health plans which can lead consumers to mistake higher price (or more intensive service delivery) for better care or superior outcomes.

There are other weaknesses in our current system as well. Substantial consumer and provider uncertainty exists regarding the effectiveness of a broad range of alternative diagnostic and therapeutic procedures. Moreover, prevention often is neglected resulting in needless illness and greater cost. Finally, our current legal system increases health care costs by fostering "defensive medicine" and excessive litigation costs.

Against this background, the outlines of a comprehensive reform strategy become apparent. The key initiative is to shift health care delivery to a more market-based, competitive system. Other critical elements include reducing administrative costs, coordinated care initiatives, more prudent purchasing of care (particularly through public programs), prevention, and malpractice reforms.

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Each of these elements move the system toward greater efficiency. Together, these elements form the building blocks of a more fully integrated market-based system.

Strengthening Competition

The President's reform proposal has three main elements which will strengthen competition. These elements will lead to greater efficiency and a more equitable allocation of resources. The nature of competition will shift. Providers and the mix of services will be chosen based more on price relative to quality and meaningful outcomes.

Changes in Tax Policy.—The President's Plan contains two changes in tax policy that make health care moare widely available and affordable: (i) a transferable tax credit for low-income individuals and families, and (ii) a deduction for self-paid health premiums of up to $1250/$3750 for middle income individuals and families.

The transferable tax credit is a crucial reform. For the first time, government assistance for low-income individuals and families will be provided through tax credits rather than through a publicly administered health insurance program. Reliance on tax credits will allow increased consumer choice. Tax credits to low-income individuals will permit them to shop among plans and coverage options. Moreover, because the credit is set as a fixed dollar amount rather than as a percent of premium costs, consumers will be cost-sensitive and purchase additional coverage only when the benefits of such coverage at the margin outweigh competing goods and services.

Consumers affected by the tax credit and the capped deduction can be expected to be more cost-conscious. Restoring marginal cost sensitivity in this way could result in a 5 percent one-time reduction in health care costs for those affected (Chernick, Holmer, and Weinberg, 1987). This estimate is consistent with other studies which indicate one-time savings of between 2 percent and 13 percent (EBRI, 1989).

While these reforms will directly affect only a portion of the population, a broader spillover effect seems likely. Employers are likely to provide more efficient forms of insurance coverage to all employees—not just those directly affected by the change in tax policy. Because coverage does not correlate highly with income (Taylor and Wilensky, 1985), this spillover effect is plausible.

Non-medical areas will experience spillover benefits as well. By subsidizing health insurance for low-income workers, the tax credit will encourage re-entry into the work force—particularly for Medicaid recipients who may fear losing insurance coverage if they resume employment. Broader health insurance should also lead to productivity gains from improved health status for the uninsured unemployed/working poor.

Insurance Market Reforms.—The insurance market reforms will help make competition more effective as a means of encouraging greater efficiency. The market reforms will effectively block "cream skimming" or favorable risk selection. This will cause competitors to focus on cost-containment and quality. Group purchasing through Health Insurance Networks ("HINs") will also give small businesses greater market "clout." And, preemption of State-mandated benefit and anti-managed care laws will give health plans new flexibility to respond to market pressures for greater efficiency and cost savings.

Improved Information.—Comparative cost and quality information would be made available to purchasers through a new series of State and local initiatives. Providing this information is a critical element for a pro-competition reform strategy. Comparative information for individual and institutional purchasers will enable purchasers to shift demand towards high-value health plans and providers. This, in turn, will provide powerful incentives for plans and providers to compete by controlling costs while improving quality. Even a minority of well-informed consumers can influence other consumers and the direction of the market (Pauly, 1978). Plans and providers that demonstrate equivalent or superior outcomes at lower cost would gain a competitive edge. Service utilization and costs could be cut appreciably with no deterioration in outcomes.

Funding will increase for outcomes research. This research will better define the safety and effectiveness of key medical and surgical

procedures and will facilitate more appropriate use of costly technologies. Funding also will increase for efforts to develop practice guidelines for practitioners. By specifying a "best practice" approach for specific conditions, guidelines can help prevent unnecessary or potentially harmful care.

Administrative Savings

Some administrative costs (e.g., spending on utilization review) can result in net savings by identifying and preventing costly, unneeded, and potentially dangerous care. The U.S. leads the world in health care quality assurance. Quality assurance increases administrative costs, but adds important value for consumers.

Nonetheless, there are areas where overhead costs in the U.S. are excessive and savings are possible. One area of concern is administrative and marketing costs for health insurance sold to small businesses. Overhead costs can be as high as 40 percent of total premiums for small businesses compared with less than 6 percent for large businesses. Another area of concern relates to the high cost of paperwork associated with billings and claims forms.

Under the Administration's proposal, group purchasing arrangements, or Health Insurance Networks, for small businesses will help reduce administrative and marketing costs. And market reforms will reduce overhead costs by prohibiting insurers from refusing coverage to particular individuals in a group due to their health status and by discouraging frequent changes of insurers.

The Secretary of Health and Human Services is leading a number of initiatives to streamline administrative procedures. These include accelerated development of data standards for electronic claims processing, and encouragement of electronic medical records for insurance enrollees.

Coordinated Care

The President's reform proposal would encourage greater use of coordinated care arrangements through increased enrollment in public programs—Medicare and Medicaid—and eliminate State laws that hir der developing these arrangements.

"Coordinated care" refers to a diverse—and still evolving—set of alternative delivery models introduced over the last two decades. Examples include Health Maintenance Organizations (HMOs) and Preferred Provider Organizations (PPOs). Coordinated care plans offer the potential of: lower cost, improved outcomes through better quality assurance, and expanded consumer choice among health service delivery options. Coordinated care systems closely integrate the financing and delivery of health care. Unlike fee-for-service medicine, clinical decisions are coordinated across the full continuum of care.

Accumulating evidence presented in subsection B shows direct savings from coordinated care as high as 30 percent. Other studies show significant "spillover" savings: as coordinated care systems gain market share in local markets, fee-for-service costs are reduced as providers are forced to compete more vigorously. And, it is important to

Table 5–1. **Savings From Small Market Reforms: Administrative and Bargaining Effects**

(Expressed as percent of total premium, by firm size)

Firm Size Claims	Total Administration Savings	Total Savings with Bargaining Effects
Fewer than 4	12.6	15.9
5–9	10.6	13.1
10–19	9.1	10.9
20–49	7.4	8.5
50–99	5.5	6.0

stress that the cost containment potential of coordinated care is dynamic. Further savings are likely as management systems improve and as better techniques for delivering medical care are developed.

Prudent Purchasing in Public Programs

Expenditures for both Medicare and Medicaid programs have continued to grow at double digit rates. Medicare baseline growth for fiscal year 1992 is projected at 11.8 percent; expenditures under Medicaid have increased at nearly 25 percent on average over the last four years, making it the fastest growing domestic program. Prudent purchasing and other measures to improve efficiency could reduce growth in Medicare costs. Medicaid cost growth would be slowed by encouraging greater reliance on coordinated care and by providing States with greater flexibility. These savings will be achieved with no reduction in benefits for program recipients.

The Administration also supports measures to stop abuses in the current system. For example, payment for physician self-referrals would be prohibited under the Medicare and Medicaid programs. Physicians and other providers increasingly refer patients for tests or to diagnostic centers in which they hold some financial stake—a clear conflict of interest. Recent evidence indicates these "self-referral" arrangements can increase costs per episode by as much as 400–700 percent (Florida Cost Containment Board, 1991; Hillman et al., 1990).

Prevention

Prevention is a "win-win" investment. Health care costs can be cut while improving well-being and increasing worker productivity. Healthy behaviors can prevent between 40 and 70 percent of all premature deaths, a third of all cases of acute disability, and two-thirds of all chronic disability. Accordingly, the President's plan focuses on prevention efforts which have maximum return on investment. Specific initiatives include increased funding for: (i) vaccine research and other research targeted at preventing specific diseases; (ii) screening programs such as blood lead level testing, pap smears, mammograms, and blood cholesterol testing; and (iii) health promotion activities, such as campaigns to reduce smoking, increase seat belt use, or encourage early prenatal care for low-income women.

Medical Professional Liability Reform

Medical malpractice reform is a key element of health system reform. Malpractice premiums more than doubled from approximately $2.7 billion in 1984 to $5.6 billion in 1989. And, the threat of malpractice forces doctors to practice "defensive medicine"—ordering unnecessary tests and procedures simply as documentation to protect against litigation. Defensive medicine costs are estimated at about $21 billion a year. The current system also involves lengthy delays and excessive litigation costs.

To address these problems, the Administration is proposing comprehensive reform. States would be encouraged to reform medical malpractice litigation by: (i) capping the amount of allowable non-economic damages; (ii) eliminating joint and several liability for non-economic damages; (iii) eliminating the collateral source rule that allows for double recovery; (iv) requiring structured payments for malpractice awards, as opposed to lump sum payments; (v) promoting pretrial alternative dispute resolution to encourage reasonable settlements; and (vi) implementing procedures to enhance quality of care. These reforms would also be applied to Federal courts, and alternative means of resolving medical malpractice claims would be piloted within the Federal Employees Health Benefits Program.

In addition, the President's reform proposal supports amending State and federal rules of civil procedure to provide that a party who refuses to engage in alternative dispute resolution and who loses at trial must pay the other party's attorneys' fees. Finally, the Department of Justice will provide additional guidance concerning the application of the antitrust laws to certain aspects of the health care system.

Practice guidelines and standards of care have assumed growing importance in providing quality assurance. Such guidelines and standards also may play an important role in reducing defensive medicine. Their implica-

tions for malpractice litigation will be the focus of scrutiny by the Secretary of Health and Human Services.

Overall System Effects

Each of the individual elements will encourage greater efficiencies and a more fair allocation of resources across the U.S. health care system.

Tax policy changes, health insurance market reform, and greater availability of comparative value information will together generate increased cost sensitivity and increased consumer shopping across all income and occupational groups. Suppliers can be expected to respond with more affordable benefit packages and a more efficient mix of services. For example, use of cost-sharing and coordinated care plans could increase. As coordinated care plans achieve greater premium cost advantages, more individuals would switch to these plans from fee-for-service coverage. And, coordinated care plans would have incentives to increase savings by making provider networks more selective and by reducing marginally useful care, including cost-increasing technologies.

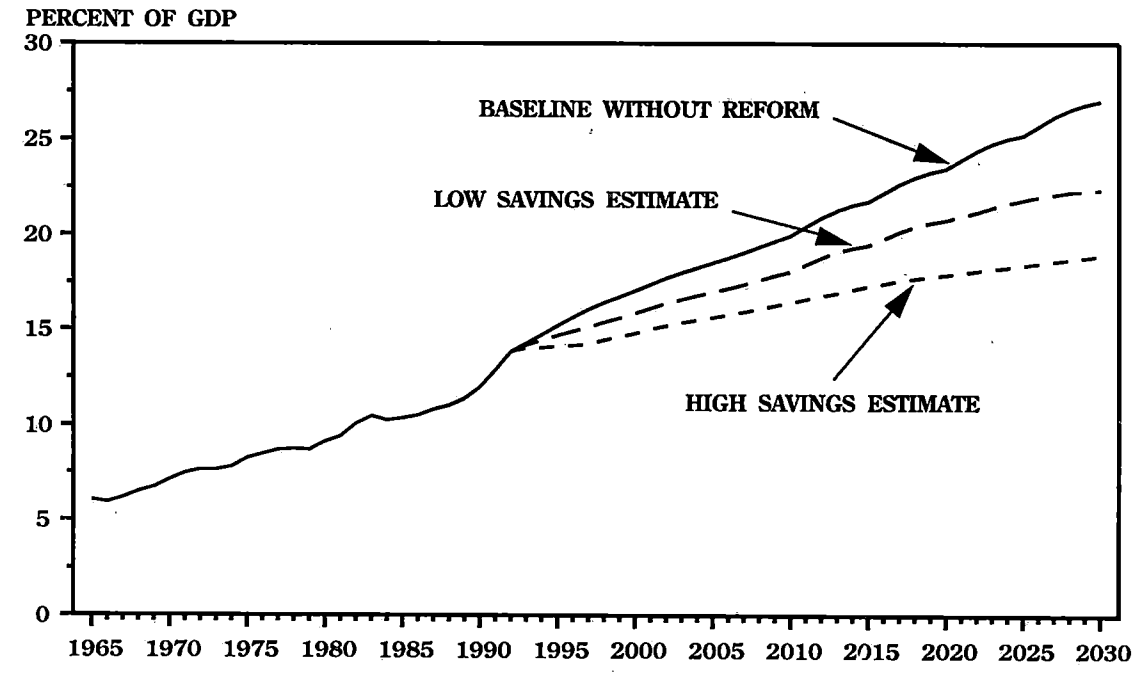
Increased use of coordinated care by Medicare and Medicaid would reinforce these market shifts. Public and private activity combined could make coordinated care plans the dominant system. The market power enjoyed by coordinated care approaches would further mean that norms of care (and consumer and physician expectations) would increasingly be established by this sector.

Projected Savings Estimates

The President's health care reform proposals can reduce the rise in health expenditures. The individual savings estimates, both static and ongoing, are presented in Chart 14. By 1997, total health expenditures could be cut by 6 to 14 percent if the proposals are adopted.

In dollar terms, projected system-wide savings through 1997 would total $394 billion. Projected estimates of cumulative savings

Chart 14. IMPACT OF HEALTH REFORMS ON PROJECTED U.S. HEALTH SPENDING



SOURCE: Office of Management and Budget

through the end of the decade total nearly a trillion dollars—$954 billion.

Over the longer term running into the next century, many of the President's proposed reforms can be expected to reduce the growth rate of real per capita medical expenses.

As shown in Chart 14, the long-term rate of growth in the Nation's health care costs can be cut from 10 to 19 percent. A lower growth rate in per capita costs, will eventually restrain the share of medical costs in the total economy. By 2030, the share of GDP devoted to health care will be 4 to 8 percentage points lower. Instead of 27 percent (the middle range projected estimate), it could be 19 percent.

Summary

Health care savings are to be achieved through implementation of the following reforms:

- Incentives for coordinated care;
- Making information available to consumers;
- Increases for prevention programs and higher levels of personal responsbility;
- Malpractice reforms;
- Reductions in administrative costs;
- Increased efficiency, reduction in waste, and increased cost-effectiveness of publicly funded programs.

The combination of these reforms will yield public sector savings that would be sufficient to offset the new health insurance tax credit and deduction.

B. Encouraging Coordinated Care

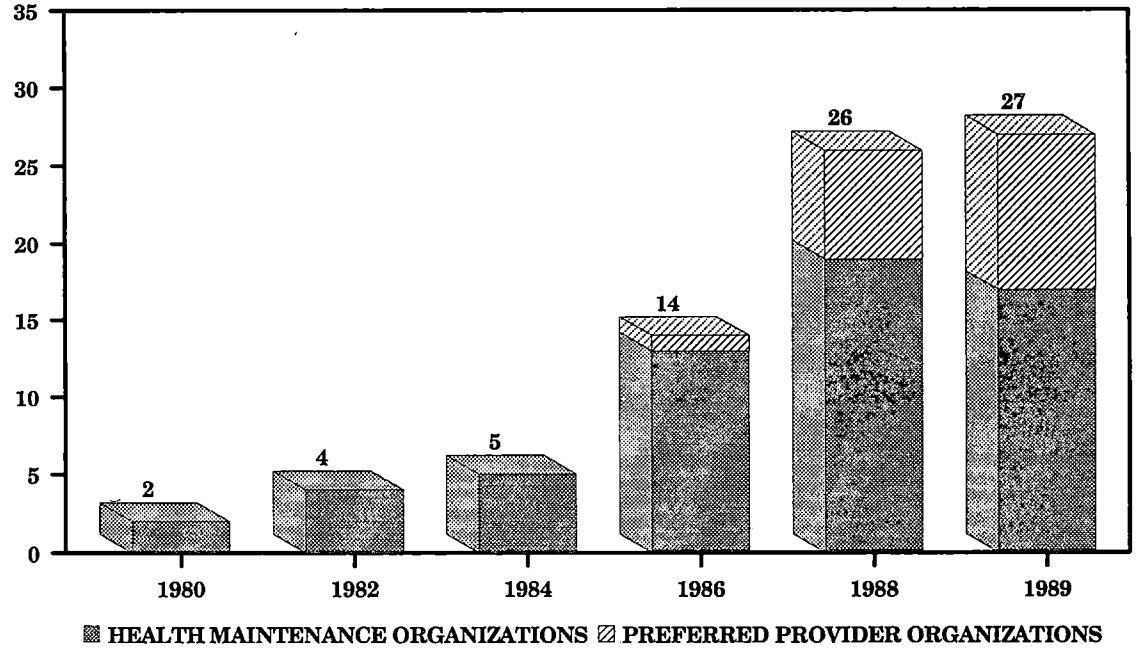
Overview

Rapid increases in health care costs have focused attention on the inflationary incentives inherent in fee-for-service and cost-based reimbursement, which traditionally have characterized American medicine. Under fee-for-service arrangements, physicians and other providers have incentives to perform more, not fewer, services, because practitioners receive higher levels of income by providing additional care. Many of these extra services offer little or no additional health benefit. Moreover, under these systems, health care delivery is often fragmented, with patients receiving services from different providers without any means of coordination.

In the past decade, health care delivery in the United States has been moving away from fee-for-service medicine toward "coordinated care" plans. The term refers to a diverse—and still evolving—set of delivery models that integrate the financing and delivery of care and alter the incentives for both providers and consumers of care. As Chart 15 indicates, by 1989, some 27 percent of workers in medium and large firms received care through a coordinated care arrangement as opposed to less than 2 percent in 1980. The trend is based on the realization that coordinated care systems offer better incentives for appropriate, less costly, high-quality health care.

- Coordinated care plans redirect incentives. The organization is placed at financial risk for the entire continuum of patient care.
- As a result, coordinated care plans have incentives to organize their systems and deliver care in the most efficient manner possible. Selective contracting to obtain discounts, exclusive use of providers, and provider payment incentives are approaches utilized to improve efficiency.
- Importantly, there are also incentives to ensure that the plans deliver high quality care:
  - —Unlike fee-for-service medicine, the plans are responsible for the entire episode of any illness and for the future welfare of the patient. Thus, plans have incentives to keep patients healthy and

Chart 15. COORDINATED CARE ENROLLMENT IN MEDIUM AND LARGE FIRMS



SOURCE: Interstudy, BLS Annual Survey

to ensure the most rapid and complete recovery from illness.

—An important byproduct is that plans have incentives to offer preventive services.

—Moreover, plans must maintain high standards of quality because plans compete for patients and patients can choose to enroll elsewhere.

Coordinated care plans employ a variety of mechanisms to ensure high quality care and coordination of services. These include utilization review to determine whether services are medically necessary and appropriate, pre-admission certification, second surgical opinions, patient case management, and the use of primary care physicians as coordinators and managers of care.

- Coordinated care plans are "win-win" organizations for providers and consumers. Consumers can receive high quality care with additional benefits such as preventive services. Efficiency gains can mean better returns for providers and lower premiums for consumers.

Models of Care

An array of coordinated care plans currently exist. A popular example is the preferred provider organization (PPO), in which a network or panel of providers contracts with the entity. Many consumers have favored PPOs because they allow greater freedom of choice in selecting providers. Typically, providers are reimbursed for services based on a negotiated fee schedule. Providers generally accept lower fees in exchange for directed access to increased numbers of patients. Utilization review programs ensure that physicians do not offset lower fees with inappropriately increased volume. Consumers may choose a provider outside the PPO network, but face additional out-of-pocket payments.

A second example is point-of-service (POS) plans that utilize a network of participating practitioners. Beneficiaries select a primary care physician, who makes all referrals for specialty care. If individuals seek care from a participating provider, they incur little or no additional costs. Individuals opting

to seek care outside the plan face higher deductibles and copayments.

A third well-known example is the health maintenance organization (HMO), in which a defined, comprehensive set of health services is provided to an enrolled group of individuals. The organization assumes financial risk for part or all of the group's health care. In the "group model" HMO, a physician group contracts with the entity at financial risk. Under the "staff model" HMO, physicians are employees of the HMO.

Perhaps not surprisingly, other countries such as Canada and the United Kingdom are now emulating the characteristics of coordinated care arrangements:

- The United Kingdom has recently implemented the most thorough reform of its system since its founding, by installing elements of market responsiveness by providers, especially by HMO-like private physician groups;
- Canadians are experimenting with "Health Service Organizations" which are similar to HMOs in concept but which do not always have the prepaid, locked-in enrollment features that can increase efficiency.

Evidence: Cost and Quality

Evidence indicates that coordinated care plans offer health care to enrollees that is as good as, or superior to that of fee-for-service medicine. Studies have generally shown comparable quality based on assessments of medical records between fee-for-service medicine and HMOs (Cunningham and Williamson, 1980; Luft, 1981). In addition, studies have shown that beneficiary satisfaction is very high in Medicare HMOs and equal to that found in Medicare as a whole (Rossiter, 1989). Moreover, Medicare HMOs offered more supplemental benefits, including preventive services, for a lower premium than that of traditional Medigap policies (which pay deductibles and co-payments not covered by Medicare). In general, HMOs have been able to reduce hospitalization and increase the use of primary care. A lower number of hospital patient days for coordinated care plans versus traditional fee-for-service results in substantial savings while ensuring quality care.

A number of studies indicate cost savings associated with the use of coordinated care (Luft, 1980; Luft, 1981; Manning et al., 1984, 1987; McCaffree et al., 1976; Luft, 1978; Roemer and Shonick, 1973; Wolinsky, 1980)—as high as 30 percent (Luft, 1981). Other studies (Dowd, 1986; Robinson, 1991; Rossiter, 1989; Scheffler et al., 1988; Welch, 1990) have shown "spillover" cost-savings into the fee-for-service sector as coordinated care plans increase their market share in an area and stimulate competition among a variety of plans, thereby driving down costs.

Evidence regarding cost savings from coordinated care is ongoing, in part because of the newness of plans and their changing organizational nature. Further savings are likely as management systems improve and as better techniques for delivering medical care are developed.

While there has been debate about whether some of the savings associated with HMOs can be attributed to favorable selection (i.e., healthier people enrolling in HMOs), the Rand Health Insurance Experiment (Manning et al., 1984) demonstrated that HMOs provide significant potential savings over fee-for-service medicine. Assessment of health outcomes between the HMO group and the traditional fee-for-service group showed no difference. In this multi-year demonstration in which individuals were randomly-selected into an HMO, reported savings over 5 years were as high as 25 percent, compared to patients randomly selected into fee-for-service arrangements.

Trends in Enrollment

Private Sector Growth.—The shift toward coordinated care over the past decade has been clear. As Chart 15 illustrates, in 1989 over 27 percent of all employees in medium and large firms receive care through HMOs or PPOs. The most significant growth has occurred in those coordinated care plans that offer consumers substantial flexibility to choose their own physicians.

Public Programs.—Enrollment in public programs has been less robust. *Medicare* began

to enter into fixed price contracts ("risk contracts") with HMOs in the mid-1980s. However, HMO enrollment has stalled since 1986, with risk enrollees only increasing from 1.0 to 1.3 million beneficiaries. Only 3 percent of Medicare beneficiaries currently are enrolled in alternative plans, in striking contrast with the under 65 population.

- The most serious problem is that the elderly have typically not used HMOs during their nonelderly years and have some reluctance to become involved in a new delivery system during a time when they can expect to become heavy users of health care. As more individuals with experience in coordinated care plans turn 65, this problem will diminish.
- A second problem is that HMOs have a limited ability to offer seniors a more attractive benefit package than what is offered by FFS Medicare. This is especially true for seniors (about 40 percent) who have employer-based supplemental benefits. These supplemental benefits can overlap with HMO-based benefits under Medicare coverage. Moreover, HMOs cannot offer cash rebates to seniors because they are prohibited from doing so by anti-kickback provisions. Nor can they lower Part B premiums.
- A third problem is that HMOs compete with a large, government program that has near monopsony power in most market areas. Medicare purchases FFS care for most of its beneficiaries and obtains deep price discounts due to its large market share. These price discounts may overwhelm potential savings that HMOs can obtain from discounts and better control over utilization.
- A fourth problem has been that HMOs are paid only 95 percent of comparable FFS costs (because of presumed efficiencies). Nevertheless, HMOs face marketing and enrollment costs unlike government. They further face greater financial risk on average due to full prospectivity, relatively small numbers of enrollees, and an Average Annual Per Capita Cost (AAPCC) payment methodology which currently fails to predict resource use and can fluctuate substantially year-to-year.
- A final problem is that until 1992, the only coordinated care option available to the elderly has been HMOs, a structure that is too rigid and inflexible for many Americans. As more flexible options become available, this could dramatically change their interest in coordinated care.

For *Medicaid,* HMOs have had legislative authority to enter into contracts with State agencies since 1967. However, Congress adopted measures in the 1980s inhibiting HMO contracting with Medicaid.

Current law authorizes use of new forms of alternative delivery arrangements, such as primary-care case management (with an appointed physician or other primary care provider serving as a gatekeeper to specialist and inpatient services) and health insuring organizations (a fiscal intermediary that functions much like the insurance portion of an HMO by providing strong utilization controls). This meant States had a variety of alternatives for testing the cost-effectiveness of Medicaid recipients into coordinated care plans.

By 1991, nearly two and one-half million Medicaid recipients across 28 States received care under coordinated care arrangements (Hadley and Langwell, 1991; Wilensky and Rossiter, 1991). Nevertheless, these gains in enrollment still account for less than 10 percent of Medicaid recipients nationally.

Increasing Incentives

The President's reform proposal emphasizes greater use of coordinated care arrangements through increased enrollment in the private sector and through public programs.

In the private sector, millions of Americans eligible for the transferable tax credit (certificate) would have the choice of enrolling in coordinated care plans offered within their State. Because of efficiencies of care provided by HMOs and other alternative delivery arrangements, premiums offered by these plans would be expected to be very competitive relative to traditional fee-for-service plans. From a quality and continuity of care perspective, plans could provide more primary/preventive and comprehensive benefits relative to fee-for-service plans.

Medicare and Medicaid.—Through the public programs, incentives for coordinated care will be pursued more aggressively. As Chart 16 demonstrates, the percent of Medicare and Medicaid recipients currently enrolled in coordinated care programs lags significantly behind private sector enrollment. Medicaid initiatives will be encouraged through increased State flexibility and federal matching rates that are based on a per capita basis—discussed in greater length in section G of this chapter.

Medicare is discussed in more detail here. HCFA will initiate a two-pronged approach because the only coordinated care alternative currently is the HMO option. Medicare will:

- create new options, as alternatives to the most structured form of coordinated care (HMOs), that would provide beneficiaries with greater provider choice while introducing them to the benefits of coordinated care; and
- take steps to strengthen the existing HMO option.

A summary of the individual initiatives are listed in the table below.

Creating New Options.—New options, such as Point of Service (POS) and Employer POS would be initiated. Under current law, a beneficiary who wants to receive benefits through an HMO must enroll with that plan. Beneficiaries enrolling in HMOs with risk contracts are required to receive all of the Medicare covered services through the HMO.

In recent years, employers have moved toward health plans where individuals make a choice at the point of service of whether to receive care through the plan's network of providers or outside that network. These plans have been popular with employees and have achieved the desired results of moving a significant percentage of services into the preferred provider network.

Under POS, HCFA would enter into multi-year contracts with POS contractors to create comprehensive preferred provider networks (primary care physicians, specialists, hospitals, labs, etc.) for beneficiaries not enrolled in

Chart 16. PUBLIC PROGRAMS LAG IN COORDINATED CARE

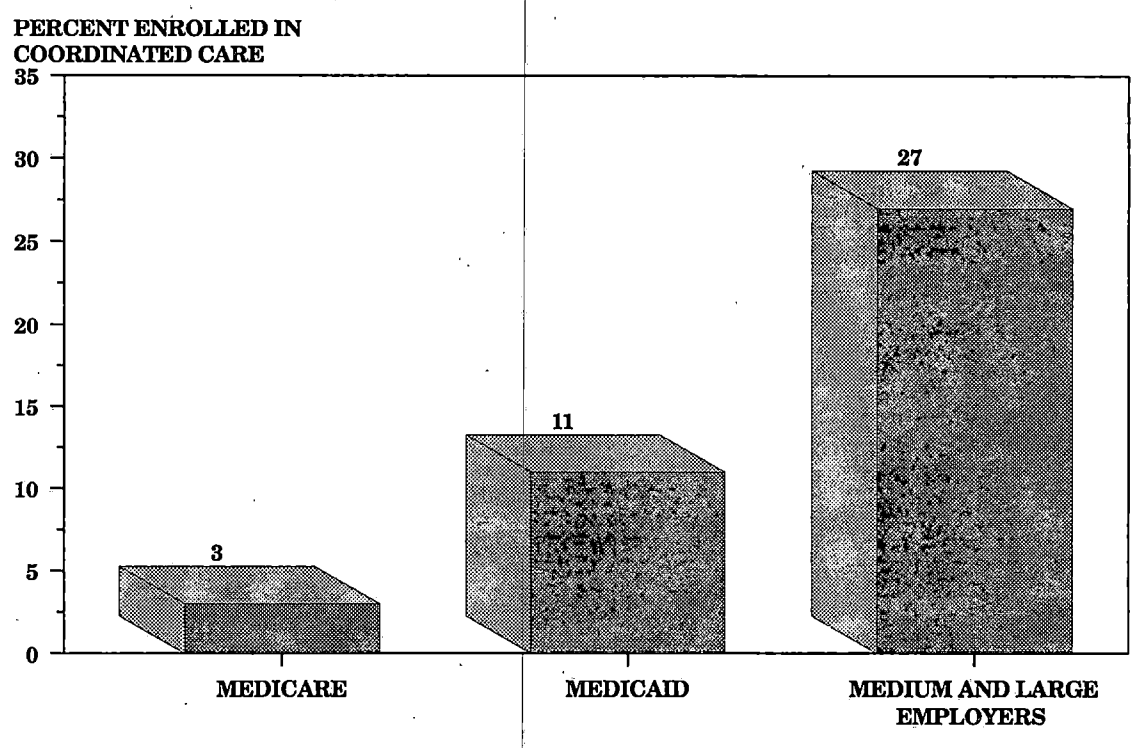


Table 5–2. **Summary of Medicare Corodinated Care Initiatives**

General Approach	Initiative	Features/Comments
Create New Options	Point-of-Service	multi-year contracts preferred provider networks negotiated discounts
	Employer	union/employer-sponsored plan
	Point-of-service	provide medical review/utilization review coordination of services/benefits
	Case Management	high cost/chronic cases voluntary plan of care medical/utilization review
Strengthen Risk-Based Program.	100 Percent AAPCC	2 options: (1) increase AAPCC payment (2) outlier payments/beneficiary rebates
	Reform AAPCC Methodology	(1) use USPCC to update rates in high penetration areas (2) experiment with competitive bidding approaches
	Increased Flexibility	(1) large group contracts (2) multi-year contracts (3) continuous open enrollment (4) comparative information materials
	Refine Current AAPCC Methodology	(1) working aged adjustor (2) health status adjustor
	Reform Cost Contract Options	advantage: introduces beneficiaries to plan option disadvantages: poor incentives for efficiency would over time phase-out
	Strengthen Oversight	expand sanction authority for: (1) prohibited marketing practices (2) illegal marketing material (3) non-compliance with quality review

risk plans. POS contractors would negotiate discounts for combined Part A and Part B payments for high cost/high volume surgical procedures. They would also negotiate other discounts from providers and suppliers. POS physicians would have incentives to make referrals only within the POS network.

For employer POS, HCFA would contract with employer or union-sponsored plans to provide medical review/utilization review (MR/UR) for Medicare covered services for retirees. This would enable employers and joint union/management Taft-Hartley trusts to coordinate benefits to retirees through the same administrative structure used to coordinate care for active employees and/or under-65 retirees.

Strengthening Existing Risk-Based Program.—For the longer run, the more significant initiative will be to strengthen the existing coordinated care program. The President's plan will initiate several actions that will increase investment in the current program.

For example, one important approach will increase payments to HMOs with risk contracts. This could either be done by (i) directly increasing payments from 95 to 100 percent of the AAPCC or by (ii) indirectly increasing payments to 100 percent through a combination of payments through an outlier pool and provision of beneficiary rebates.

Under the first option, the additional 5 percent AAPCC payment could encourage entry into the Medicare market of HMOs that currently are not participating. Existing plans could use the additional 5 percent to improve their competitive edge against Medigap plans by offering additional benefits or providing rebates to beneficiaries.

Under the second option, Medicare would make additional payments to HMOs through an outlier pool for a portion of the costs of high cost cases above a predetermined threshold. For example, if Medicare paid for 60 percent of the costs for cases that exceeded $61,000 in 1993, payments to HMOs would increase on average by 2.5 percent.

In addition to outlier payments, Medicare could provide rebates to beneficiaries enrolled in HMOs as a concrete sign of the support of the risk contract program. The rebate could equal 30 percent of the Part B premium.

A second general approach to strengthen the current program will be through reform of the current AAPCC payment methodology. Although the AAPCC methodology is accurate in predicting the costs for an HMO's total enrollment, its predictive power in regard to individual enrollees is extremely low.

Even though enrollment in risk plans as a percent of total Medicare enrollment is low, in some counties enrollment is greater than 25 percent. Over the past few years the increases in the AAPCCs for these counties has lagged behind the national average increase (USPCC). For example, while the national average increase in rates for the past three years was 22.6 percent, in one county with 34 percent enrollment the increase was 15.5 percent. In another county with 27 percent enrollment the AAPCC actually decreased over the past three years.

Several options are available such as (i) recomputing the rates for high penetration areas based on the growth in the USPCC rather than changes in the geographic factor, and (ii) experimenting with competitive bidding to establish payment rates.

Several other initiatives to strengthen the current risk-based program are not detailed here but are summarized in the table above.

Anti-Coordinated Care Laws

Currently, many State-based laws and regulations discourage greater use of coordinated care arrangements. Examples of these barriers include restrictions on reimbursement rates, restrictions on selective contracting for providers and services, restrictions against certain financial incentives arrangements, and utilization review activity. The President's plan would protect health plans from anti-coordinated care laws and regulations.

Second, federal waivers are currently applied to demonstrating and evaluating new coordinated care approaches, in effect designating them as exceptions to mainstream health care policies and practices. Under the President's Plan, these waivers of exception would be "flipped." States would have to apply for exceptions to coordinated care policies instead.

C. Providing Comparative Value Information for Health Purchasing

Background

Providing useful information for purchasing health care is a critical element for a pro-competition health reform strategy. Informed consumer choices should guide the delivery of medical care. In a market of coordinated care organizations, consumer choice could be exercised through selection of a health plan in which to enroll. With traditional fee-for-service coverage, consumer choice would be exercised through decisions about providers and procedures.

People now routinely make many decisions about insurance coverage and medical care. Strengthening competition through the tax credit and through health market reforms will encourage more direct comparisons with costs and outcomes—that is, assessing the value of their health care dollar.

Currently, meaningful information about comparative costs and outcomes is not routinely available to consumers. Consequently, consumers are unable to assess the value of their health care dollars by making comparisons of costs and outcomes across health

care providers and health plans. This lack of consumer information has potentially harmful effects on consumers and the Nation. Anecdotal information is unreliable.

As a result, consumers and purchasers of care often do not know what they are buying. In the absence of information, consumers are apt to rely on higher price or more intensive service delivery as proxies for quality. Thus, limited consumer information can insulate providers from competition and can lead to excessive prices and inefficient delivery of care.

Wider availability of cost and outcomes information will strengthen incentives for efficiency, especially when coupled with changes in government subsidies for insurance. Health plans that demonstrate equivalent (or superior outcomes) at lower premium cost would gain a competitive edge. Similarly, people want to know, for example, if Hospital A provides better care than Hospital B and would choose accordingly, if they could. Because consumers tend to mistake higher cost or more intensive service delivery as proxies for better quality, service utilization—and costs—could be cut appreciably with no deterioration if consumer choices were guided by valid cost in quality and quality information.

Through concerted public/private sector action, it should be possible to implement information systems that would enable health care purchasers to make meaningful comparisons of cost and quality between health plans and health care providers. The long-run potential to control costs while improving quality is substantial. Even a minority of well-informed consumers can influence other consumers and the direction of the market (Pauly, 1978). With better information, health plans that manage cost-increasing technologies could pass the savings on to purchasers. Cost-increasing technologies would be utilized only if consumers believe that the resulting improvement in health outweighs the added cost.

Comparative value information can change consumer decision making. For example, Washington Consumers' Checkbook, a magazine published by a nonprofit organization, illustrates that consumer's use of information changes market behavior. The Federal Employee Health Benefits Plan (FEHB) makes consumer choice relatively easy, and this is something of a model for improved consumer involvement. Since 1979, Washington Consumers' Checkbook has prepared an annual guide to federal plans in the Washington, D.C. area. The guide compares plan benefits, special features such as dental coverage or customer service, eligibility, premiums, and out-of-pocket costs, and draws conclusions on values. The results of the comparisons have influenced market share during each federal employee open season. For example, during the 1980 enrollment period, a plan that was ranked highly in terms of benefits relative to costs increased its Washington D.C. enrollment by 120 percent, compared with less than a 20 percent increase nationally.

More sophisticated prototype systems for comparing costs and quality are available as well. The Pennsylvania Health Care Cost Containment Council publishes information about what hospitals charge and comparisons of mortality rates for every hospital in the State.

This information allows consumers to learn, for example, that two hospitals within 40 miles of each another charge very different prices for the same procedure. For coronary artery bypass surgery, one hospital charged $17,490 while the other charged $28,059 in 1989.

The Council also calculates actual mortality rates and projected mortality rates following hospital stays for hospitals that take into account age and sickness when admitted, two of the many variables that determine how sick a population a hospital treats. This data shows that for the same two hospitals, the lower cost hospital had a lower mortality rate than expected and the higher cost hospital had a higher than expected mortality rate.

To encourage greater employee support for selective contracting and to provide hospitals with stronger incentives to improve quality while controlling costs, a group of major employers in Cleveland, Ohio, is sponsoring the Cleveland Health Quality Choice (CHQC) project. CHQC is developing a state-of-the-art system for measuring and comparing the quality of care in Cleveland-area hospitals.

The system will include a survey to measure perceptions of quality from the patient's standpoint and a system for measuring quality from a clinical standpoint. Patient outcomes (e.g., death and complications) in hospital intensive care units and for selected medical and surgical admissions will be monitored with detailed clinical adjustments to account for differences in severity of illness.

CHQC hopes to be producing quality reports on a routine basis starting in 1992. CHQC expects that participating employers would use this information to guide their health purchasing decisions. Employers would share this information with their employees to encourage use of the selected providers. While it will be several years before the full impact of the program can be assessed, and the Cleveland group must overcome many hurdles, use of outcomes data to compare quality is growing in its popularity and its impact.

Other systems for measuring outcomes have been developed as well. A consortium of HMOs is working with leading researchers from RAND corporation to develop indicators of quality that could guide consumers in selecting between competing HMOs. The MedisGroups system is routinely used by over 500 hospitals nationwide to monitor quality. And, the Health Care Financing Administration will begin to implement the Uniform Clinical Data Set (UCDS) system to monitor the quality of hospital care provided to Medicare patients in the Nation's hospitals.

Proposal

Under the Administration's proposal, each State would implement programs to help make comparative value information more readily available for health care purchasers. This initiative would be included as part of the health insurance market reform proposal.

States could develop information systems directly, as Pennsylvania has done, or could delegate this responsibility to private sector groups. States could give preference to local health care purchasing coalitions, such as the Cleveland Quality Health Choice coalition.

Within one year of enactment, States would develop and make broadly available information regarding average prices and costs for common health care services. Information could include mean and median prices and a measure of the variability across and within market areas. This information could be especially useful for large purchasers of care for preferred provider arrangements and negotiated discounts. Sufficiently discrete definitions (e.g., utilizing standardized professional codes like CPT–4 codes) of a broad range of representative services could be developed to permit meaningful comparisons.

Within five years, States would develop systems to provide comparative quality and outcomes data for health care purchasers and for consumers choosing health plans and hospitals.

The Federal Government would implement these information systems directly in the case of inaction by the State and would charge a user fee to defray the cost.

The Secretary of Health and Human Services (HHS) would develop prototype systems, such as Medicare's Uniform Clinical Data Set (UCDS), to facilitate data gathering and comparisons of outcomes. There would be an emphasis on experimentation to test different methods for gathering and analyzing outcomes and quality information. HHS would fund evaluations to determine the most cost effective methods (e.g., those methods that yield the most useful information at lowest cost).

When appropriate, national standards could be established to facilitate uniform data gathering that would facilitate analysis and comparisons across the Nation.

D. Encouraging Personal Responsibility and Prevention

Personal Responsibility

Reform of the U.S. health care system can neither be fully effective nor complete until there are basic changes in how Americans view responsibility for their own health. Individuals must choose, for example, to improve eating habits and increase exercise; to reduce consumption of alcohol and tobacco; to end substance abuse; to avoid the high risk behavior that spreads HIV; to seek the necessary medical examinations and vaccinations; to seek early prenatal care; to wear seat belts and take other necessary precautions; and to learn to resolve conflicts without resort to violence. Personal decisions about how to live may have the most important effect on the Nation's health and the cost of caring.

About half of the 2.2 million deaths which occur in the U.S. every year are potentially preventable, as are many of the illnesses that afflict millions of Americans. Many of the "risk factors" for these diseases involve freely-made individual choices. Better control of fewer than 10 factors—such as diet, prenatal care, exercise, the use of tobacco, alcohol and illegal drugs, and the use of seat belts—could prevent between 40 and 70 percent of all premature deaths, a third of all cases of acute disability, and two-thirds of all cases of chronic disability. Since the preservation of individual choice is a cornerstone of American democracy, disease and injury prevention must become individual as well as national priorities. In this, the Nation must encourage a culture of character, which actively promotes responsible behavior and the adoption of lifestyles that are conducive to good health.

Benefits of Taking Responsibility for Health.—Personal behavior can have a dramatic effect on the quality and length of life. Regardless of access and costs, families and individuals are and will remain our first line of defense in preventing illness. Indeed, any strategy for constraining costs must include a plan to reduce the need for medical intervention. The average American could live almost four years longer if currently available preventive measures were followed fully.

Public and private efforts to promote healthy behavior have already achieved dramatic results:

Smoking.—The Nation has witnessed a dramatic change in behavior as the incidence of one of the leading contributors to preventable deaths, smoking, has declined from 40 percent in adults in 1965 to 28 percent in 1990. This change was brought about through a combination of actions by individuals, private industry, health providers, and all levels of government.

Traffic Accidents.—Increased use of safety belts, declines in drunk driving, and better vehicle crashworthiness have cut the traffic fatality rate by 50 percent since 1973. If the traffic fatality rate had remained at the 1973 level, an additional 40,000 lives would have been lost in 1991 alone.

One of the most important factors in reducing the traffic fatality rate has been the growing use of seat belts and child safety seats. As shown in the accompanying chart, simply accepting the personal responsibility for using these safety devices has saved many lives. As people increase their use of seat belts, child safety seats, and air bags, the Nation will see more lives saved every year. Air bags will be installed in an estimated 90 percent of all new cars sold in the United States by 1995.

Heart Disease and Stroke.—During the 1980s, death rates declined for two of the leading causes of death among Americans: heart disease and stroke. Much of this progress is attributable to changes in behavior. The more than 40 percent decline in heart disease mortality since 1970 reflects dramatic increases in high blood pressure detection and control, the decline in cigarette smoking, and increasing awareness of the role of blood cholesterol and dietary fat. Stroke death rates, which have dropped by more than 50 percent in the same period, also reflect gains in hypertension control and reductions in smoking.

Investing in Prevention

Prevention is an important element of an increased emphasis on personal responsibility. Preventive practices are, by and large, simple, inexpensive and effective. Prevention makes sense for a number of reasons. Many preventive interventions are proven to be *cost effective.* And prevention is a good investment for the market place, resulting in fewer productive days lost and in reduced morbidity and cost to the health care system.

Costs of Preventable Health Problems.—There is ample research estimating the costs of illness and disability, in terms of diminished longevity, productivity foregone, and money spent treating illness and disability. These costs are particularly sobering when the illness or condition could have been prevented.

Prevention is Cost Effective.—In 1987, primary prevention and health promotion accounted for less than 5 percent of overall health care spending, yet there is mounting evidence that prevention is cost-effective.

Investing in Our Economic Future.—Disease prevention presents the opportunity to dramatically cut health care costs, prevent the premature onset of disease and disability, and help all Americans achieve healthier, more productive lives. Although the emphasis on prevention has led to overall health improvements, the U.S. is still burdened by preventable illness, injury, and disability. Injury now costs the U.S. well over $100 billion annually; cancer, over $70 billion; and cardiovascular disease, $135 billion.

Directions for Prevention.—In recognition of the clear advantages of aggressive prevention activities, the government is supporting and enhancing prevention programs with known benefit, and, through demonstrations, testing interventions for their efficacy and efficiency. The Federal Government spent over $8

Table 5–3. **Preventable Health Costs**

Health Problem	Years of Life Lost	Costs (in millions of dollars)
Cardiovascular Disease	15,000,000	135,000 (1985 $)
Alcohol Abuse	3,140,178	7,672 (1980 $)
Smoking	534,870	4,509 (1980 $)
High Blood Pressure	319,499	6,289 (1980 $)
Cholesterol	159,333	7,655 (1980 $)
Glucose Intolerance (Diabetes Mellitus)	133,627	5,239 (1980 $)
Cancer	18,000,000	72,000 (1985 $)
Injury	2,300,000	180,000 (1988 $)

Table 5–4. **Return on Investments in Prevention**

Preventive Activity	Savings per Dollar Spent	Total Savings per Year (in millions of dollars)
Immunization:		
Measles, Mumps, Rubella	14.40	0
Polio	10.00	400 (1990 $)
Hib	—	—
Prenatal Care	3.40	—
Universal Breast Cancer Screening (30 percent women age 65–74)	—	3,538 (2020 $)
Hypertension Screening and Effective Followup	—	80,000 (1986 $)

Note: "—" means not available.

Table 5–5. **Social Costs of Preventable Risks**

Disease or Condition	Preventable Risk Factors	Lives Lost (1988)
Heart Disease	Tobacco use, obesity, elevated blood pressure, elevated cholesterol, sedentary lifestyle.	765,156
Cancer	Tobacco use, improper diet, alcohol abuse, environmental exposures.	485,048
Cerebrovascular Disease	Tobacco use, elevated blood pressure, elevated cholesterol, sedentary lifestyle.	150,517
Unintentional Injuries	Safety belt nonuse, alcohol abuse, home hazards	97,100
Chronic Lung Disease	Tobacco use, environmental exposures	82,853

billion for prevention in fiscal year 1992. This will rise to nearly $9 billion in fiscal year 1993. These programs fall into three basic categories: (i) measures to help vulnerable populations at high risk of preventable disease, (ii) measures to make primary care more readily available to disadvantaged or geographically isolated Americans, and (iii) measures to encourage healthier lifestyles.

Helping Vulnerable Populations

Table 5–6 describes the substantial funding increases proposed in the President's fiscal year 1993 budget for prevention programs.

- *Childhood Immunizations.*—Childhood immunizations are among the most cost-effective prevention activities. A $1 investment in Measles-Mumps-Rubella (MMR) vaccine may return $14 in averted medical care costs. Other routinely administered

Table 5–6. **The Budget Provides Substantial Increases for Programs Focused on Prevention and the Next Generation**

(Obligations in millions of dollars)

Initiative	1989 Actual	1992 Enacted	1993 Proposed	Percent Change: 1992 to 1993	Percent Change: 1989 to 1993
CDC Childhood Immunization	141	297	349	+18%	+148%
Infant Mortality Reduction	5,681	7,950	9,365	+18%	+65%
(Healthy Start)	—	64	143	+123%	N/A
Women, Infants, and Children Nutrition Assistance (WIC)	1,929	2,600	2,840	+9%	+47%
Head Start	1,235	2,202	2,802	+27%	+127%
Access to Primary Health Care Services	4,184	6,334	7,643	+21%	+83%
(Community/Migrant Health Centers)	482	594	684	+15%	+42%
(National Health Service Corps)	48	100	120	+19%	+150%
Nutrition Education	138	152	178	+17%	+23%
Breast and Cervical Cancer Mortality Prevention	—	416	515	+24%	N/A
Smoking Cessation	78	106	111	+5%	+42%
Physical Fitness and Diet	68	100	102	+2%	+50%
Injury Prevention	1,482	1,862	2,026	+9%	+37%
Family Planning	333	461	498	+8%	+50%
CDC Lead Poisoning Prevention	—	21	40	+90%	N/A
Tuberculosis Control	21	32	66	+106%	+214%

vaccines such as Diphtheria-Tetanus-Pertussis (DTP) and Oral Polio are reported to have similarly high rates of return. Through coordinated efforts at all levels of government and the private sector, the Nation has achieved a 98 percent immunization rate for children entering school.

The President's initiative will increase federal support to target efforts toward raising immunization levels in inner cities and other areas where health returns on these activities are certain to be high.

- *Healthy Start/Infant Mortality Prevention.*—The Nation's infant mortality rate continues to decline, having reached its lowest level ever (9.1 deaths per 1,000 live births) in 1990. But while the overall infant mortality rate continues to decline, mortality for African-American infants remains twice that for white infants—demonstrating the need for more intensely targeted assistance.

  Additional investment in prenatal care and nutritional assistance targeted to low-income women also continues to yield high returns. Overall, nearly 25 percent of all women and nearly 40 percent of African-American and Hispanic women do not begin prenatal care during their first trimester of pregnancy, the most crucial time for prenatal care. Investment in prenatal care can yield significant returns: each dollar invested in prenatal care for high-risk women might save $3 in treatment costs.

  The President's initiative proposes over $9.3 billion for all federal activities to reduce infant mortality, including $143 million for Healthy Start, an important program that targets federal resources to 15 areas with exceptionally high rates of infant mortality.

- *Women, Infants, and Children Nutrition Assistance (WIC).*—The proposal continues the President's strong commitment to WIC with the largest one-year increase ever proposed for the program, $240 million (9 percent), for a total of $2.84 billion—sufficient funds for full participation by eligible pregnant women and infants. A recent evaluation of the Special Supplemental Food Program for Women, Infants, and Children (WIC) found that for each dollar spent on nutritionally at-risk pregnant women and infants, Medicaid spending fell by between $1.92 and $4.21 during the first 60 days after birth.

- *Head Start/Early Childhood Development.*—Head Start provides a range of comprehensive early childhood development services, including education, nutrition, health and other social services. Children who enroll in Head Start experience immediate gains in cognitive growth, social development, and health status. For every dollar invested, Head Start may eventually save $6 in averted costs associated with special education, crime, and income support.

  The President's initiative contains the largest single-year funding increase in the history of Head Start, proposing an additional $600 million for a total of $2.8 billion. With the Administration's proposal, Head Start will serve an estimated 157,206 more children in 1993. This unprecedented increase in Head Start supports participation of all eligible and interested disadvantaged children for one year, complementing the 36 States (plus the District of Columbia) which also support pre-school programs.

  The President's initiative also proposes $850 million for the child care and development block grant, which was part of the child care legislation that the President proposed and subsequently signed in 1990. Low-income families receive vouchers they can use with the child care provider of their choice; block grant funds provide additional early childhood development services for pre-school age children.

  The proposal further includes $6 million for a new initiative in HHS to use local schools as a way to bring primary health care services to children from low-income families who might not already have access to these services. These "Ready to Learn" grants will enable community health centers and local schools in selected low-income communities to provide health outreach services through local schools.

- *Lead Poisoning Prevention.*—Lead poisoning is the most common environmental disease of young children, disproportionately affecting poor, minority children in the inner cities. Yet childhood lead poisoning is preventable through detection and abatement. This initiative includes $40 million to support about 30 Statewide lead poisoning screening and referral programs.

  In addition, the Department of Housing and Urban Development (HUD) will continue assisting low- and moderate-income private residential property owners abate lead-based paint by providing grants to States and localities. HUD's public housing modernization program will continue lead-based paint testing and abatement activity in public housing. Approximately $50 million will be spent on these activities in 1993.

Expanding Cost-Effective Primary Care

- *Access to Primary Health Care/Expanding Community Health Centers.*—Comprehensive primary health care services include diagnosis and treatment as well as education designed to encourage healthy behavior. Continued investment in improving access to primary health care is important to many communities and can yield sizable returns. Increased access in low-income communities can improve overall health status and reduce the use of emergency services.

  To put primary health care services within the reach of people who do not currently have adequate access, the President's 1993 initiative includes an additional $1.3 billion for programs supporting primary and preventive health care.

  The initiative also contains $120 million for the National Health Service Corps (NHSC). This 19 percent increase will enable the NHSC to expand the program and train additional physicians to provide health services in low income and underserved areas, increasing the availability of primary case—particularly in low-income underserved areas.

- *Breast and Cervical Cancer.*—Despite increasing federal investment in breast and cervical cancer screening, NIH predicts that over 45,000 women are expected to die from these two diseases in 1993. The key to successful treatment of breast and cervical cancer remains early detection. The sooner treatment can begin, the greater the chance of survival.

  The President's initiative will invest $515 million for screening through the Medicare program and through the Public Health Service. This investment will focus resources on screening low-income, high-risk women in age groups for which screening is recommended.

- *HIV/AIDS Funding.*—Under the President's initiative, total federal HIV/AIDS funding increases by 13 percent, to $4.9 billion.

- *Tuberculosis Control.*—The Nation has made great strides toward eliminating tuberculosis (TB). The disease has been curable and preventable for almost four decades. The long-term decline in TB morbidity enjoyed by the United States ended, however, in 1984.

  The President's Plan attacks the recent growth of TB levels head on. The initiative includes a 106 percent increase over 1992 for CDC Tuberculosis Control Grants.

Promoting Lifestyle Changes

- *Smoking Cessation.*—Smoking during pregnancy retards fetal growth, reduces birthweight, and doubles the risk of having a low-birthweight baby. Studies have shown a 25–50 percent higher rate of fetal and infant deaths among women who smoke during pregnancy compared with those who do not. Each dollar invested in smoking cessation for pregnant women may yield as much as $6 in averted costs for neonatal intensive care and extended care for low-birthweight infants. Beyond the damage tobacco use during pregnancy may cause, smoking is also a factor in the deaths of over 400,000 Americans every single year.

  The President's initiative expands smoking cessation education activities for specific at-risk populations, including minority and low-income pregnant women.

- *Injury Prevention.*—Every one percent increase in seat belt use saves more than 160 lives per year. If the U.S. were to increase the national average of seat belt use from the 1990 rate of 48 percent to the Administration's goal of 70 percent by the end of 1992, 3,800 lives could be saved annually and 100,000 injuries could be prevented—yielding potential economic benefits of $2.5 billion.

  The initiative increases funding for injury prevention to almost $2 billion, a 9 percent increase over 1992. These funds will be used primarily within the Department of Transportation (DOT) for aviation, rail, highway, marine, and pipeline and hazardous material transportation safety. An estimated 50,000 lives are lost annually in incidents in the transportation sector. The initiative also includes increased emphasis on reducing drunk driving and increasing occupant protection.

- *Family Planning.*—Evidence attributes reductions in infant mortality achieved over the last 20 years in part to effective family planning. Recognizing the importance of these services, the President's initiative contains an additional $37 million for HHS family planning grants and federal Medicaid payments, an increase of 8 percent.

- *Physical Fitness and Diet.*—The President's initiative for 1993 increases funding for health education, disease prevention, and physical fitness activities. It also focuses on bringing health promotion and disease prevention activities to older Americans. The Administration on Aging will provide more health risk assessments, nutritional counseling, group exercise programs and other health promotion activities. These activities can improve the health and quality of life of older Americans and allow many older people to receive these services regularly.

In summary, to confront the problems of access to health care and the continued escalation in health care costs, efforts are underway to address the problems of the uninsured and the underinsured and to tackle the country's growing health care expenditures. No matter what path is ultimately chosen, it is clear that prevention will play a critical role in the future health of Americans. It is also apparent that prevention can only be accomplished in partnership among individuals, the business community, and government.

E. Malpractice and Antitrust Reform: Changing Incentives for Provider Behavior

Our legal system distorts health care delivery in America. These distortions derive in part from perverse incentives that encourage malpractice litigation. Unnecessary and costly defensive medicine has increased. Fear of antitrust liability has helped produce an often inefficient and duplicative distribution of sophisticated services and equipment. Finally, the quality of health care is diminished by the reluctance of professional review boards and hospitals to discipline poorly performing physicians because of potential antitrust liability.

Proposal

In May 1991, the President proposed the "Health Care Liability Reform and Quality of Care Improvement Act" to address the costs of malpractice insurance, the transaction costs of malpractice litigation, and the length of malpractice dispute resolution proceedings, and to reduce the incidence of malpractice through increasing the quality of care.

The Administration's reform package includes proposals that encourage States to:

- Cap the amount of allowable non-economic damages. In the 26 States that have limited total damages, malpractice rates have declined significantly;

- Eliminate joint and several liability for noneconomic damages;
- Eliminate the collateral source rule that allows for double recovery;
- Require structured payments for malpractice awards, as opposed to lump sum payments;
- Promote pretrial alternative dispute resolution, including mediation and pretrial screening panels, to encourage reasonable settlements;
- Implement procedures to enhance the quality of care.

Additionally, at the Federal level the Administration proposes to apply these tort reforms to Federal courts to begin a pilot program in the Federal Employees Health Benefits Program that offers alternative dispute resolution; and to improve the quality of medical care through enhanced effectiveness research and improved peer review.

The proposed Act is based on three principles:

- Medical malpractice reform should seek both improved quality of care for patients and lower litigation costs.
- Legal reforms should reduce the incentives for physicians to practice unnecessary defensive medicine or to abandon practice in inner city and rural areas.
- Incentives for states to act are preferable to Federal preemption of current state law. Federal preemption should be used only selectively and narrowly.

The elements outlined below supplement this proposal. They address three areas: (i) the delay associated with malpractice litigation, (ii) the increasingly common practice of engaging in unnecessary defensive medicine, and (iii) the effects of our antitrust laws on costs and the quality of care activities.

Medical Malpractice Reforms

The costs associated with malpractice litigation have contributed to the rapid growth of health care spending. These costs include the direct costs of insurance, litigation, and settlements. Perhaps most importantly, however, our malpractice system creates incentives for physicians to engage in defensive medicine—excessive tests, failure to delegate certain tasks to other qualified professionals, and in general a more elaborate style of care than is necessary for the provision of sound medical care.

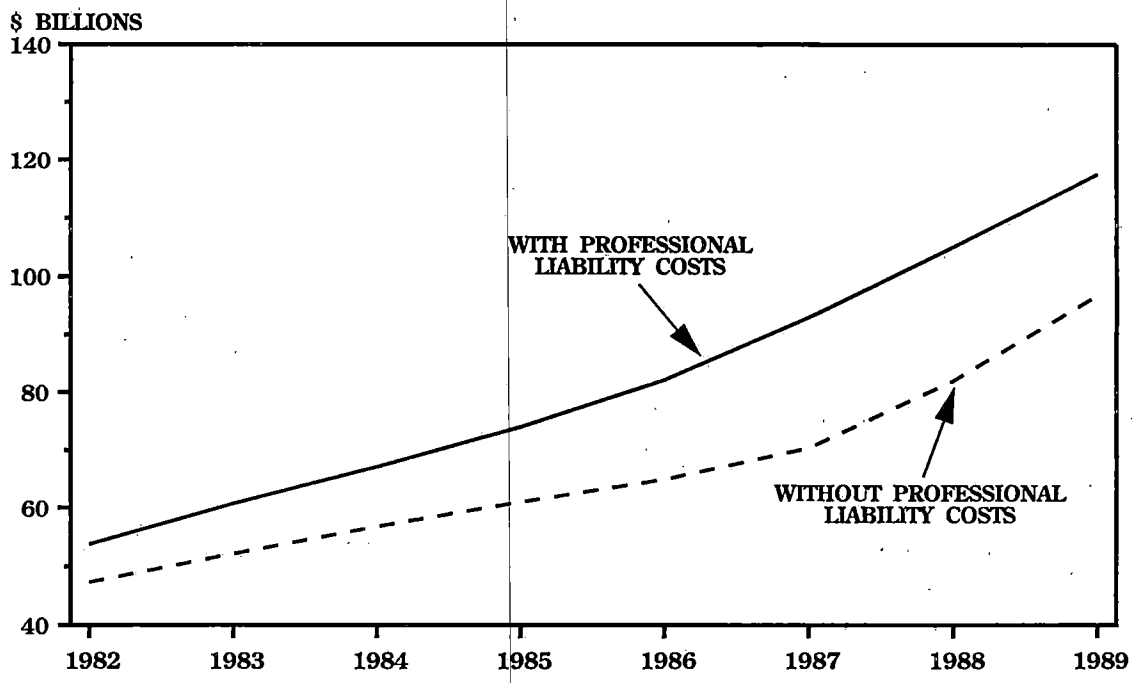
In 1989, defensive medicine accounted for an estimated $20.7 billion, 17.6 percent of total physician expenditures (Moser and Musacchio, 1991). In addition, of all medical practice growth components, professional liability premiums exhibited the fastest annual percentage growth between 1982 and 1989—increasing 15.1 percent annually (AMA Socioeconomic Monitoring System, 1982; 1989). Charts 17 and 18 present increases in professional liability premiums relative to other physician practice costs and impact on total physician service expenditures over time.

Often, unnecessary defensive medicine may result from a misperception on the part of providers of the real potential for liability. A recent study found that physicians in New York State tend to overestimate the risk of being sued by a factor of three (Harvard Medical Practice Study, 1990). For that reason, efforts should be made to communicate the true level of liability risk to providers.

Not all unnecessary defensive medicine is attributable to fear of liability. In some cases, as in fee-for-service medicine, health care providers may have a strong economic incentive to engage in such activity. The fear of liability, however, does result in an increase in the degree and kind of diagnostic testing, the reluctance to delegate certain basic functions, and the abandonment of care for some high risk patients or in high risk areas of treatment such as obstetrics. Based on a 1984 study, 41.8 percent of physicians made at least one change in their practice patterns in response to risk of malpractice liability. The average physician increased record keeping costs by 2.9 percent, prescribed 3.2 percent more tests and treatment procedures, increased follow-up visits by 2.6 percent, and spent 2.4 percent more time with patients (Reynolds et al., 1987).

In addition to the monetary costs associated with medical malpractice litigation, there are

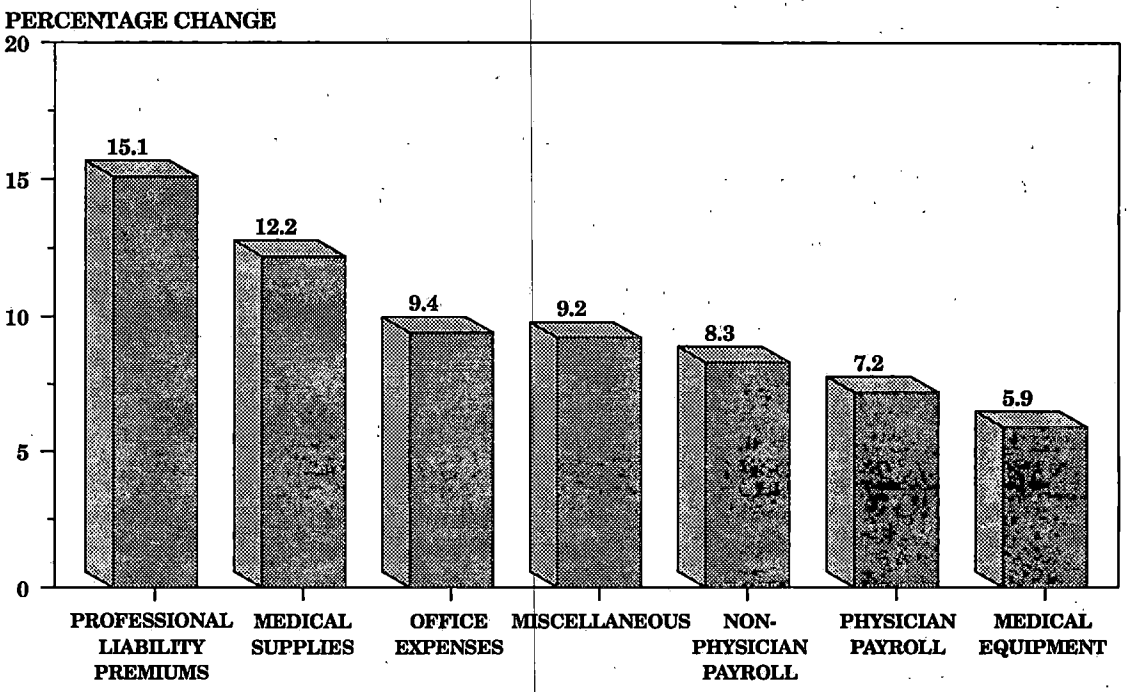
Chart 17. PROFESSIONAL LIABILITY COSTS AS A PORTION OF TOTAL PHYSICIAN SERVICE EXPENDITURES



SOURCE: Expenditures including professional liability costs, HCFA; expenditures excluding professional liability costs, AMA

Chart 18. GROWTH IN MEDICAL PRACTICE COST COMPONENTS

(AVERAGE ANNUAL PERCENTAGE CHANGE, 1982 TO 1989)



SOURCE: AMA Socioeconomic Monitoring System, 1983 and 1989 core surveys

other costs that cannot be quantified. Both providers and patients suffer from the protracted process of litigation. Patients who ultimately gain a recovery must wait years to recover the damages due them. Physicians are often as troubled by the process of litigation as its results.

Collectively, these monetary and emotional costs erode one of the most important aspects of health care, the doctor—patient relationship. What should be a cooperative relationship marked by trust between the doctor and patient is sometimes wary and somewhat adversarial. Reduced communication may undercut the patient's confidence in the physician and breed passivity in a patient, leading to a decrease in patient information about treatment.

Reform of the medical malpractice system offers the prospect of not only reducing monetary costs but, as importantly, helping to restore patient confidence in the medical system and provider confidence in our legal system.

Beyond the provisions in the Health Care Liability Reform and Quality of Care Improvement Act the Administration endorses the following approaches to reduce the delay of malpractice dispute resolution, reduce the amount of unnecessary defensive medicine, and clarify the application of antitrust laws in the provision of health care:

Alternative Dispute Resolution (ADR).— The desire of physicians to avoid malpractice litigation extends beyond the issue of liability and the perception that outcomes are unpredictable. Removing malpractice suits from the adversarial forum of the courtroom offers at least three benefits. It will lessen the sense of confrontation of the dispute. In many, if not most, cases it will speed resolution of the dispute. And, it will vest resolution of often complex medical issues in a person or persons who will likely have more experience with medical issues than the typical member of a jury.

The Administration supports two approaches to persuade or require parties to use ADR and seeks to work with Congress to consider two other approaches that would remove the dispute from a traditional trial setting altogether.

Encouraging the Use of ADR Through Party Choice. The Administration supports amending state and Federal rules of civil procedure to permit either party to litigation to make an offer to use ADR. If the party refusing to engage in ADR loses at trial, that party must pay the others attorney's fees. This change in the rules will provide a strong incentive for parties to consider seriously the desire of the other party to resolve the dispute without the necessity of a full trial.

State Contract Law. The Administration seeks to encourage agreements between patients and providers, made prior to the delivery of health care services, to use out-of-court dispute resolution mechanisms if a dispute arises. It is unclear, however, whether such contracts are valid in all states. The President's plan proposes to permit contracts between patients and providers that require non-binding arbitration before a lawsuit can be filed notwithstanding conflicting state law.

Promising Areas for Innovation. Although the proposals discussed below address the issue of delay and the merit of increasing the expertise of those who decide malpractice cases, each has its shortcomings and critics. The Administration believes, however, that it is important that these issues become an integral part of the debate on reforming our malpractice system. The Administration will cooperate with Congress, state legislatures, medical associations, and others to explore whether such proposals can remedy the problems of the current system.

- *Mandatory ADR for Federal Beneficiaries.* Several malpractice reform proposals would make the receipt of Federal health care benefits implied consent to enter into ADR if a dispute arises out of the health care provided. The added cost of health care resulting from the shortcomings of our malpractice litigation system is directly reflected in the cost of these programs to the treasury. The Federal government thus has a legitimate interest in finding ways, such as ADR, to reduce those costs.

- *Mandatory ADR for All Claimants.* To avoid the judgment of lay juries and the delay inherent in our current civil justice system, some have called for taking medical malpractice cases out of the courts entirely. The American Medical Association, for example, has proposed that every state create an administrative tribunal to hear medical malpractice claims with courts permitted only appellate review. Although the theoretical benefits of such a system are obvious, serious questions of constitutionality, practicality, and increasing bureaucracy must be resolved before any large-scale proposal moves forward.

Offers of Settlement.—The Administration also proposes to permit either party to a malpractice action to make a formal offer of settlement. This provision has been discussed for application in other areas of civil justice in need of reform, such as product liability. In effect, the provision makes Rule 68 of the Rules of Civil Procedure available to plaintiffs as well as defendants.

Standards of Care.—Medical associations, authors, and commentators have attempted to provide guidance to physicians on appropriate standards of medical care. It is the tort system, however, through the judgments of lay juries, that too often defines the standards of care physicians must meet. The precedential value of the jury's determination and the uncertainty generated in gray areas, can effect profoundly provider behavior.

Variation is inherent in case-by-case determinations by different juries. This translates into a perceived lack of predictability in our medical malpractice litigation system. This uncertainty and the role of lay persons in determining what is adequate medical care has encouraged overly cautious behavior and some resentment of the litigation system in the medical community.

In recent years, there has been increased interest in the development of guidelines or standards of care as references for physicians by medical groups, insurers, and legislators. The debate has centered on who would develop such standards, the degree of specificity required to make the standards useful, the degree of flexibility necessary to reflect the individuality of patients and circumstances, and what use and legal force, if any, should be given to such guidelines or standards.

The Omnibus Budget Reconciliation Act of 1989, Public Law 101–239, established the Agency for Health Care Policy and Research within the Public Health Service to promulgate guidelines and standards of quality and other "performance measures." No provision was made for giving any legal effect to such standards in litigation, however.

The Secretary of Health and Human Services will intensify his efforts to develop these guidelines and standards. The Secretary will also consult with experts in the field, including providers, medical associations, legal scholars and others, to study the feasibility and desirability of giving some legal force to such guidelines. The Secretary's study should include a discussion of the process for forming such guidelines or standards, and the degree to which the guidelines would have to be specific and/or take into account variations in practice geographically, because of resources, or the age and condition of the patient.

The Administration believes that practice guidelines and standards offer great promise in reducing the level of unnecessary defensive medicine without compromising the quality of medical care. Physicians knowledgeable about the practice guidelines and standards can look to them in determining the adequacy of care provided to their patients.

Guidelines and standards of care could offer the added benefit of enhancing the value of alternative dispute mechanisms. As alternative dispute resolution is increasingly used, practice guidelines and standards of care will heighten confidence that the mediator or arbitrator will reflect accurately the behavior of a jury if the case proceeds to trial. Thus, parties will be better positioned to judge the consequences of rejecting the proposed determination.

Antitrust Law

In addition to the issues of medical liability and dispute resolution, antitrust issues bring law and medicine together. For instance, professional peer review has always reflected

a tension between the necessity to weed out those who do not meet the standards of the profession and the possibility that such review could be used unfairly and illegally to limit competition in the profession. With the emergence of new methods of health care delivery, like HMOs and PPOs, and increasingly sophisticated and costly technology, confusion about the proper application of the antitrust laws in the health care field has grown.

The Administration proposes a series of steps to assure that the new emphasis on quality of care is not undermined by concerns of unwarranted allegations of collusion, that concerns of antitrust liability do not chill the evolution of a more organized and efficient health care delivery system, and that the cost of health care is not raised unnecessarily because of duplication of costly technology and services.

The President's initiative includes legislation to address the issue of the unnecessary duplication of technology and the provision of guidance by the Federal government on the issue of the application of the Federal antitrust laws to peer review and managed care issues.

Medical Technology.—Much of the increased cost of health care has resulted from the high costs associated with advanced technology. Often expensive equipment is duplicated by competing health care organizations because of concern over the application of the antitrust laws to the sharing of equipment and services. As a result, the acquisition of expensive technology may far exceed what is needed. To reduce the costs of high technology equipment and services, the Administration will again urge Congress to pass the joint production venture legislation, S. 1163, transmitted by the Departments of Justice and Commerce on April 29, 1991.

Peer Review Activities.—State disciplinary boards and hospital medical staffs often review physicians qualifications to determine whether a license or hospital privileges for the physician should be limited, denied, or revoked. Presumably, the goal is to ensure an appropriate level of quality of care. Often, however, the physician whose privileges are curtailed will sue the reviewing physicians and witnesses on the grounds that the review is really a veiled attempt to limit competition.

Some commentators suggest that the creation of certain safe harbors for actions limiting physician privileges can avoid litigation costs and the chilling effect of potential litigation without unduly limiting competition. The Administration does not believe changes in substantive law are necessary. Rather, the Department of Justice will provide enhanced guidance for state peer review boards and hospitals with respect to actions to deny, revoke, or suspend the license of privileges of any physician.

PPOs, HMOs and Other Pooling Arrangements of Providers.—The emergence of managed care is creating new issues in health care. For instance, if physicians in an area band together to form a PPO, thus fostering price reductions and managed care, it may be alleged that they are nonetheless reducing the number of competitors for physician services in the marketplace. At the same time, diligent enforcement of the antitrust laws is necessary to prevent price fixing and illegal tie-ins in the provision of health care. Reducing the fear of liability for certain beneficial activities while maintaining the deterrent effect of the antitrust laws for traditional anticompetitive endeavors is the challenge for antitrust enforcement agencies, particularly the Department of Justice and the Federal Trade Commission.

The Administration will clarify the antitrust standards that apply to provider pooling arrangements such as PPOs and HMOs. Additionally, the Department of Justice will increase its enforcement efforts against those in the health care industry who boycott such provider organizations. Together with the efforts of the Federal Trade Commission, the actions of the Department should provide the guidance that these evolving entities need to prosper.

F. Reducing Administrative and Paperwork Costs

Overview

Recent studies suggest that paperwork savings of $67 to $100 billion a year would be possible if the United States shifted to a Canadian-style national health insurance program (GAO, 1991; Woolhandler and Himmelstein, 1991). A critical review of available information by OMB indicates that potential savings are much lower, at most $31 to $49 billion (Director Darman, October 1991, Testimony, House Ways and Means Committee). Other analyses have concluded that any administrative savings under a nationalized health plan would be more than offset by an increase in benefit costs. One analysis estimated total savings in administrative costs in the United States under a Canadian-style system would be $47 billion; however, these administrative efficiencies of a common benefit package would be less than the $78 billion increase in benefit costs that would come with the common package (Sheils and Young, 1991).

Moreover, simple administrative cost comparisons are misleading because they fail to capture the value added by effective administrative measures. The United States spends between $2 billion and $4 billion a year on various quality assurance programs, measures that improve health care and reduce costly and potentially dangerous inappropriate care. And, as a recent study points out, delays in treatment under the Canadian system lead to "hidden" costs of up to 0.6 percent of GDP—or more than $34 billion dollars a year if translated to the United States (Danzon, 1991).

Nonetheless, significant administrative savings are possible while maintaining choice and diversity for our citizens. Moreover, paperwork burdens, hassles, and confusion associated with obtaining health care can be reduced. The reform proposal contains five initiatives to accomplish these goals:

- Electronic billing using standardized formats will dramatically reduce paperwork and reduce administrative costs.
- Shifting from costly case-by-case medical review to pattern of care review will reduce the "hassle" factor for physicians, focus review efforts on problem areas, and improve quality.
- Use of electronic cards for billing and eligibility determinations will reduce paperwork and confusion for consumers at the point of service.
- Development of computerized medical record systems will reduce paperwork burdens for providers while improving quality.
- Market reforms will reduce administrative costs in the small group market by up to $9 billion a year by providing efficiencies of scale through group purchasing for small businesses (HINs) and by eliminating medical underwriting costs.

These reforms will bring the administration, billing, and record-keeping in our health care system into the twenty-first century, through a system-wide movement to automation and more standardized billing, claims adjudication, eligibility determination, and clinical information. The effective implementation of market pooling mechanisms will consolidate consumers into more streamlined, better managed groups that have more leverage in the health market.

Background

Health care overhead is a diverse category that embraces a wide range of activities including: claims processing costs for insurers, billing costs for providers, utilization review, quality assurance, maintenance of enrollment and eligibility records, premium collection, marketing costs, and profit. Public and private insurance and billing costs totalled almost $80 billion in 1991, or about 12.2 percent of total personal health spending. Insurance administration accounts for $43.6 while provider billing costs account for the remaining $36.2 billion.

Of the total of $43.6 billion for insurance administration in 1991, $32.8 billion is for private insurance, $5.7 in federal costs, and $5.0 billion in State and local costs. The bulk of this spending (77.5 percent) is for

Table 5–7. **Insurance Administration and Provider Billing Costs in the U.S., 1991**

(Source: HCFA, OMB staff estimates)

	Cost in Billions of Dollars	As Percent of Total Administration	As Percent of Total Personal Health Spending
Insurance Administration	$43.6	54.6%	6.7%
Hospital Billing Costs	$17.1	21.5%	2.6%
Physician Billing Costs	$10.4	13.0%	1.6%
Billing Costs for Other Providers	$8.7	10.9%	1.3%
Total Insurance and Billing Costs	$79.8	100.0%	12.2%

claims processing, quality assurance, and general administration. Marketing costs and profits total $6.0 billion while taxes paid by private insurers account for the remaining $3.7 billion.

Insurance administration costs have increased from 5.3 percent of total personal health spending in 1965 to 6.7 percent in 1991. This change primarily reflects an increase in insurance coverage during the interval. Out-of-pocket spending, as a percent of total personal health spending, decreased from 55.9 percent in 1960 to 23.3 percent in 1990 (Levit et al, 1991). With this decrease, administrative costs were bound to increase.

Private insurance administrative costs vary substantially with firm size as a percentage of benefit payments, ranging from up to 40 percent of benefit costs for very small firms to under 6 percent for very large firms. This disparity in costs reflects the fact that large businesses enjoy efficiencies of scale in the purchase and administration of insurance benefits. Risk premiums are lower for large groups coverage because benefit costs are much more predictable. Commissions for brokers also are higher for very small firms due to the retail nature of this segment of the market.

Proposal

Administrative costs could be cut by as much as 25 percent under five major reform initiatives. Four of the initiatives would streamline paperwork. The first four of these

Table 5–8. **Administrative Costs for Public and Private Insurance in the U.S., 1991**

(Source: HCFA, HIAA, BCBS, OMB staff estimates; excludes billing costs for providers)

	Cost in Billions of Dollars	As Percent of Total Administration	As Percent of Total Personal Health Spending
Total Public and Private Insurance Administrative Cost	43.6	100.0%	6.7%
Claims Processing, Quality Assurance and General Administration (private and public)	33.8	77.5%	5.2%
Taxes Paid by Private Insurers	3.8	8.6%	0.6%
Marketing and Commissions	3.8	8.8%	0.6%
Profit	2.2	5.1%	0.3%

Table 5–9. **Health Insurance Overhead Cost as Percent of Benefit Payments**

(Source: CRS, 1989)

Firm Size	Claims Administration	General Administration	Interest Credit	Risk and Profit	Commissions	Premium Taxes	Total
1 to 4	9.3	12.5	-1.5	8.5	8.4	2.8	40
5 to 9	8.6	11.2	-1.5	8.0	6.0	2.7	35
10 to 19	7.2	9.2	-1.5	7.5	5.0	2.6	30
20 to 49	6.3	7.6	-1.5	6.8	3.3	2.5	25
50 to 99	4.3	4.8	-1.5	6.0	2.0	2.4	18
100 to 499	4.1	4.0	-1.5	5.5	1.6	2.3	16
500 to 2,499	3.9	3.2	-1.5	3.5	0.7	2.2	12
2,500 to 9,999	3.8	1.4	-1.5	1.8	0.3	2.2	8
10,000 or more	3.0	0.7	-1.5	1.1	0.1	2.1	5.5

initiatives are already underway under the leadership of Secretary Louis Sullivan of the Department of Health and Human Services. These four paperwork reduction initiatives could reduce administrative costs by as much as 8 percent, saving up to $4 billion a year. These initiatives would be complemented by reform of the small group market. As described more fully in Chapter 3, health insurance market reform could reduce administrative costs for small group coverage by as much as 40 percent, saving up to $9 billion a year.

Reducing Claims Processing and Billing Costs Through Standardization and Automation.—Paper claims are expensive. Estimates suggest that providers and insurers save up to $2 per claim through electronic billing, and more is saved when claims are reviewed electronically. Since over three billion claims are submitted on paper every year, substantial savings are possible just by increasing electronic submission rates.

Standardization of claims forms can reduce billing costs and reduce provider billing costs to levels comparable to those that might be achieved under single payer systems. In December, 1990, the Health Care Financing Administration's HCFA–1500 claims form was finalized. This form—which is used for physician and outpatient services—was developed by the Uniform Claim Form Task Force, co-chaired by the American Medical Association and HCFA. Task Force participants included representatives of every major third-party payer. While use of the HCFA–1500 is voluntary, wide acceptance is expected. Similar efforts have led to near universal acceptance of the UB–82, as the standard form for inpatient hospital bills.

At Secretary Sullivan's recent Forum on Administrative Costs, Blue Cross/Blue Shield of America and the Travelers Insurance Company agreed to head up a public/private group to increase electronic claims and to standardize data elements and electronic transmission rules. The group is meeting already. Its recommendations are expected soon.

HCFA is actively working with the private sector to develop technical standards to promote greater use of electronic billing. Currently, 75 percent of Medicare Part A and 42 percent of Part B claims are submitted electronically. Electronic billing also reduces costs for providers and helps reduce clerical errors. Comparable savings can be achieved for private sector claims. HCFA has set 100 percent electronic submission for hospitals and 75 percent for others within three years—the private sector must drive toward similar efficiencies.

The combination of electronic claims submission and standardization of the data elements required for claims will reduce provider cost and frustration. Providers submitting claims

electronically benefit from faster and clearer resolution of claims. Moreover, electronic systems will help avoid technical mistakes, such as missing one line on a form, that often delay payment.

Streamlining Medical Review.—A third area—improving medical review—can reduce the "hassle factor" for physicians while reducing costs for unnecessary care. The goal would be to shift away from claim-by-claim denials toward monitoring and encouragement of cost-effective practice patterns. Claim-by-claim review is burdensome and costly—sometimes the cost of the review can exceed the potential savings.

HCFA has developed and is now testing the Uniform Clinical Data Set (UCDS) a new system that would permit a shift to pattern review for inpatient hospital care. The UCDS is a state-of-the-art system for abstracting critical medical information for hospital records. Once this information is abstracted and entered into a computerized system, "expert" system programs can identify patterns of care that suggest a systematic problem that might warrant further targeted review and corrective action.

If the UCDS system proves to be successful in practice, it would serve as a model for use by private insurers. In a complementary effort, the Public Health Service is devoting $130 million in 1991–1992 to outcomes research to increase information about what patterns of care are most effective in improving health outcomes and at what cost.

Developing Electronic Cards.—Secretary Sullivan has launched an initiative to accelerate development of electronic cards for use by consumers.

Electronic cards would be used by patients at the point of service to provide comprehensive insurance information to providers. This would eliminate the need for patients to repeatedly fill out confusing forms. Such cards also would streamline billing procedures for doctors and hospitals by providing immediate information regarding eligibility, coverage, benefits, copayments and deductibles.

Dollar savings will accrue directly to insurers and providers through more efficient administrative procedures, and be passed on to consumers through lower premiums and out of pocket costs. Eventually, electronic cards could be used for storage of the card holder's medical records. This would help prevent duplication of tests, medication errors, and other quality of care problems.

Developing Computerized Medical Record Systems.—Secretary Sullivan also has initiated a task force to accelerate development of computerized medical record systems.

Computerization will facilitate rapid access to critical information regarding an individual's past medical record. Once computerized patient records and related information networks are in widespread use, providers will have access to state-of-the-art information on the effectiveness of various care paths as well as more complete, accurate patient medical records.

"Expert" systems can be built-in as part of these systems to alert physicians to potential problems, such as the need to follow-up on an abnormal test result. Computerized records will also strengthen quality assurance by providing hospitals and health plans with reliable statistical information regarding outcomes and complication rates.

Health costs could be reduced as well. Up to 20 percent of all medical care performed in the United States may be unnecessary or harmful. Computerized patient records will capture clinical data for effectiveness research. This research will help physicians better understand when certain costly therapies should be used.

Early reports are encouraging. The General Accounting Office has reported that an automated medical record system reduced hospital costs by $600 per patient in a Veterans Affairs hospital. Other studies have demonstrated reduced lengths of stay associated with computerized patient records. If broadly implemented, computerized patient records could reduce unnecessary care by about 5 to 10 percent, saving $20 billion a year by the end of the decade. More significant savings are likely in later years.

Reducing Overhead Costs Through Health Insurance Market Reform.—Finally, health insurance market reform will reduce administrative costs for small group coverage

by an average of 40 percent. Savings will be even higher for groups with 10 or fewer workers. The bulk of this savings will be achieved through health insurance networks (HINs)—group purchasing associations for small business and individual coverage. It is projected that 67 percent of coverage sold to firms with fewer than 100 workers will be provided through HINs.

Even outside of HINs, substantial savings will be achieved through elimination of costs associated with medical underwriting. Moreover, by refocusing competition on costs, the reforms will also help to reduce marketing costs.

G. Making Public Programs More Efficient

Government health care programs at all levels account for 44 percent of national spending on personal health services. Costs for these programs have been increasing even more rapidly than for the population as a whole. Accordingly, no comprehensive health system reform proposal can be complete without measures to help make these programs more efficient. Indeed, thoughtful reform now is needed to prevent future problems that could threaten these programs.

1. Reforming the Medicaid Program By Enhancing State Flexibility

Overview

The President's reform proposal would dramatically modernize the twenty-six year old Medicaid program and provide States with significant new flexibility for reform.

- *Medicaid recipients will benefit from enhanced access and improved quality through coordinated care plans.*
- *States will have new flexibility to take advantage of innovation, program efficiencies, and better methods for cost control.* As Medicaid costs have risen by over 23 percent a year since 1989 (from $61.2 billion to $92.1 billion in 1991), States have strained to keep up. Thus, the federal and State governments must be partners in cost containment and reform.
- *Enhanced State flexibility and greater use of coordinated care can reduce Medicaid cost growth from a projected 16 percent a year and result in significant savings that can help fund expanded insurance coverage for an additional 24 million low and modest income Americans through the new transferable health insurance credit system (see Chapter 4).*
- *Coverage of all non-Medicaid poor for basic services will be fully financed by the Federal Government.* States would be able to retain their share of savings from Medicaid program reform. Federal savings would revert to State residents to provide health insurance for the non-Medicaid poor, without any State match.

Medicaid currently provides health insurance benefits for 26 million low-income Americans. Recently, Medicaid also has become the primary vehicle for funding "uncompensated care" provided by disproportionate share hospitals (DSH)—hospitals that have high charity care case loads ($12 billion in federal payments matched by the States—in 1993). These DSH payments would not be affected by this proposal.

Medicaid has been widely criticized as providing fragmented, episodic, and often substandard care. Moreover the program is viewed as wasteful and inefficient. These problems stem primarily from continued reliance on an outdated fee-for-service delivery system. In addition, the program is overly rigid and bureaucratic.

Under the proposal, Medicaid would be restructured to rely primarily on delivery of health care through coordinated care systems. Moreover, States would have new flexibility to respond to local needs and concerns. States would have the option of choosing between two broad approaches.

- A State could maintain existing Medicaid eligibility and benefit levels while shifting enrollment into coordinated care pro-

grams. Under this approach, the new transferable tax credit (certificate) system would operate separately from the existing Medicaid program, though States would play an important role in qualifying individuals for the tax credit.

- Alternatively, a State could combine its existing Medicaid programs with the new health insurance credit system to develop a new universal access program covering all State residents with incomes below poverty. Under this approach, a State could operate a single public insurance program or could provide credits for purchase of private coverage.

Coincident with these reforms, federal funding for acute care for the non-elderly (excluding DSH payments) would shift to a new per capita payment to the States. This would provide States with new incentives to maximize program efficiencies through coordinated care and other measures. Overall, the reforms would improve quality and access for program recipients while greater efficiency would free up funds to expand access for other low income individuals and families through the new tax credit system.

Background

Medicaid currently is a joint federal/State program designed to meet the health insurance needs of certain low-income individuals. States set most program rules within broad federal guidelines, determine beneficiary eligibility, and pay provider claims.

In general, Medicaid eligibility is linked to other cash assistance programs such as Aid to Families with Dependent Children (AFDC) or Supplemental Security Income (SSI). In recent years, mandatory eligibility has been extended to certain groups with incomes above the cash welfare program standards (for example, poor and near poor pregnant women and children). Optional coverage extends to certain other groups, such as the "medically needy," whose illnesses force them to "spend-down" to meet Medicaid eligibility criteria.

Current Medicaid eligibility requirements leave many poor without coverage. Certain categories of persons cannot qualify for Medicaid under current rules, no matter how poor or how sick they are (non-disabled single adults and childless couples, for example). Only about 45 percent of the poor are covered by Medicaid. Another 26 percent have other insurance. Twenty-nine percent, therefore, are without insurance.

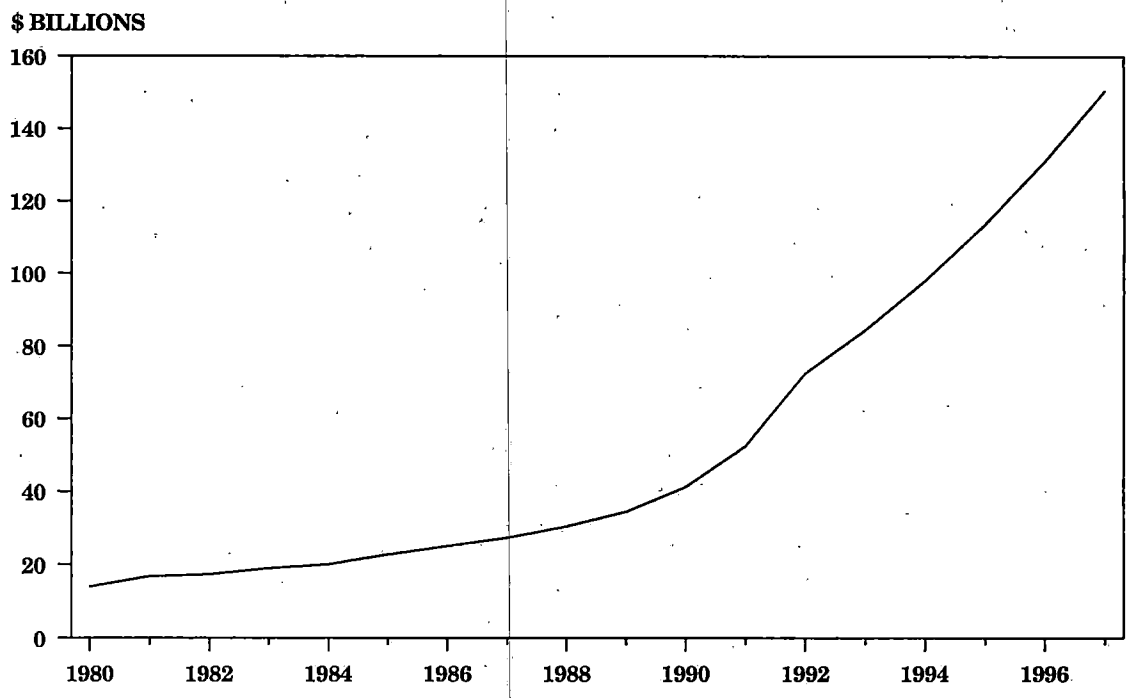
Problems With the Current Program.—Most Medicaid recipients receive health care through traditional and costly fee-for-service arrangements. Physicians, hospitals, and other providers are paid on the basis of itemized bills for the services they render. As a result, strong incentives exist to provide additional services regardless of benefit. Providers are not paid on the basis of outcomes: no one is paid to keep patients in good health. Nor is there anyone responsible for coordinating services to avoid duplication and to improve quality. As a result of this perverse mismatch of incentives and responsibilities:

- The care many Medicaid patients receive is often fragmented—too little, too much, inappropriate, or too late;
- Too many recipients use hospital emergency rooms as their primary entry point to the medical care system, often for non-emergency conditions; and
- Too many people are deterred from seeking treatment in the early stages of a medical condition. Receiving treatment in the later stages often leads to hospitalization and other care that could have been avoided.

The Medicaid program also has been strained due to frequently added service and eligibility mandates, increased caseloads, court mandated payment levels, and overall health care inflation. As a result of these forces, Medicaid is the fastest rising portion of both federal and State budgets.

Program Costs.—In 1993, combined federal/State spending on Medicaid will surpass $158 billion, up from $61.2 billion in 1989—a 250 percent increase. The federal contribution, based on State median income ranging from 50 to 83 percent of program expenses, will exceed $84.5 billion in 1993, or a 245 percent increase since 1989 ($34.5 billion).

Chart 19. GROWTH IN FEDERAL MEDICAID COSTS



SOURCE: HCFA Medical Bureau

As Table 5–10 shows, there are three main components to federal Medicaid program costs: (1) acute care for the non-elderly, (2) long-term care and services to "dual eligibles" (those eligible for both Medicare and Medicaid), and (3) program administration.

Coordinated Care.—While the current program is exploding, causing a crisis at the federal and State level, successful experience with coordinated care programs show that responsible reforms can improve the health care available to the disadvantaged while moderating cost growth. Three examples underscore this point:

- A Detroit-based health maintenance organization (HMO), Comprehensive Health Services, provides care for the 60,000 Medicaid recipients and has saved the Medicaid program at least $6.9 million in 1990. These savings are due to a reduction in unnecessary hospitalizations and in-

Table 5–10. **Projected Federal Medicaid Costs Under Current Law**
(Dollar amounts in billions, Federal Share)

	1992	1993	1994	1995	1996	1997	1993–1997
Total Medicaid	72.5	84.5	98.3	113.8	131.2	150.9	578.7
Percent Increase	—	16.6%	16.3%	15.8%	15.3%	15.0%	15.8%
Acute Care (including DSH)	31.0	36.5	42.9	50.2	58.5	67.9	255.9
Percent Increase	—	17.7%	17.5%	17.0%	16.5%	16.1%	17.0%
DSH Payments (non-add)	8.4	9.8	11.4	13.2	15.2	17.2	75.5
Long-Term Care and Dual-Eligibles	38.9	45.0	52.0	59.8	68.5	78.2	303.7
Administration	2.6	3.0	3.4	3.8	4.2	4.8	19.1

creased attention to preventive care, particularly for high risk pregnant women and infants.

- Under Kentucky's Primary Care Case Management (PCCM) program, each Medicaid recipient has a primary care physician responsible for providing or authorizing all non-emergency care. By emphasizing primary and preventive care through a single physician, cost and quality problems associated with overuse of emergency rooms and duplication of medications or tests have been avoided. As a result, the Kentucky program has reduced infant mortality rates and has achieved savings of $25 million a year, or approximately 10 percent of program costs.
- Until 1982, Arizona was the only State that did not participate in Medicaid. County governments provided acute and long-term care for the poor. In 1982, Arizona established a Medicaid program and obtained a waiver to operate this through the Arizona Health Care Cost Containment System (AHCCCS).

  AHCCCS is unique in that all care is provided through coordinated care arrangements. There is no fee-for-service option. Arizona contracts with participating health care organizations (HCOs) through a bidding/negotiation process. Modest savings have been achieved—estimated by HCFA at 5.7 percent in the fourth year of the program compared to fee-for-service alternatives.

While programs of this type hold promise, less than 3 million Medicaid recipients receive care through coordinated care programs: 1.4 million receive care through HMOs and other prepaid health plans, while an additional 1 million receive care through PCCM programs. The remaining 23 million (89 percent) continue to receive care through fee-for-service systems. In contrast, 27 percent of workers and dependents with employment-based private insurance are covered through coordinated care plans, and this percentage continues to grow rapidly (see Chart 15, Chapter 5, section B).

The comparatively small share of Medicaid recipients covered under coordinated care plans reflects a number of factors. Most importantly, under current law, States must go through a waiver process to secure federal approval to establish coordinated care programs. Complex statutory waiver requirements are overly rigid and have blocked a number of initiatives that long have been underway in the private sector. Moreover, State Medicaid programs are subject to political resistance from entrenched interests, a factor that is not significant in the private sector.

It is important to note that Medicaid also has become a vehicle for funding "uncompensated" or "charity" care provided by hospitals to individuals without Medicaid or other insurance coverage. Under recently enacted legislation, States will be able to provide higher Medicaid payments to "disproportionate share hospitals" (DSH) that provide care to a disproportionate number of uninsured patients. Over the next five years, the Federal Government will provide $75.5 billion in DSH payments.

While this is a reasonable stop-gap approach, it has two disadvantages when compared with a direct expansion of insurance coverage. First, there is no assurance that DSH payments are used exclusively for patient care. More importantly, DSH payments for inpatient hospital care fails to provide access to ambulatory care and primary and preventive services that could avert the need for a disabling illness and costly hospital care.

Proposal

The President's proposal focuses reform on the acute care portion of Medicaid for the non-elderly. Long-term care and acute care programs under Medicaid for seniors, including Medicare/Medicaid dual eligibles and qualified Medicare beneficiaries, would remain unchanged. Disproportionate share hospital (DSH) payments under Medicaid also would remain unchanged.

Federal financial participation for acute care (excluding DSH) would be shifted from open-ended cost-based reimbursement to a prospectively determined per capita payment. This change would provide important incentives for program efficiency. The resulting savings reflect the potential for significant improvements in efficiency through either

of the two major reform options that the States would have under the proposal.

The per capita payment would be State-specific, based on total per capita costs for the acute care portion of Medicaid in a State in 1992. Acute care costs related to Medicare recipients would be excluded from this calculation as would DSH payments. The State's 1992 per capita cost would then be indexed for general inflation, using the percent increase in the consumer price index for urban areas (CPI–U) plus an additional amount for medical cost inflation.

From 1960 to 1990, per capita health care costs for the entire United States population increased by about 4 percent a year faster than the CPI–U. Thus, an add-on of 2 to 4 percent in addition to the CPI–U for 1997 and future years seems reasonable. Savings of this magnitude should be possible through coordinated care and increased flexibility for State programs. A phase-in would provide time for States to take advantage of the new programmatic flexibility provided.

Actual federal payments to a State would equal the product of the total number of Medicaid recipients in the State times the inflation indexed State per capita acute care costs times the Federal Matching Assistance Percentage (FMAP). The FMAP formula would remain unchanged from current law and is intended to reflect a State's relative need for federal assistance. (The federal matching assistance percentage (FMAP) = 100 − .45 × [(State per capital income)/(U.S. per capita income)]^2.) Different per capita payment amounts could be used for different age-sex or other groupings to adjust for changes in the population covered by a State program over the years.

Although the proposal does not affect DSH payments, the need for DSH payments would decrease dramatically. With a projected increase in insurance coverage of 29 million Americans resulting from tax credits and other reforms, fewer uninsured patients would burden hospitals with "charity" care costs. Thus, additional funds could be available to further expand the credits. At State request, the payment formula could be revised to include DSH payments within the federal per capita payment while still yielding the same aggregate savings as those proposed.

State Option 1.—Separate Medicaid and Tax Credit Programs.—As noted above, States would have two broad options regarding reform of their Medicaid programs for acute care services provided to the non-elderly. Under the first option, States would shift all non-elderly Medicaid recipients into coordinated care programs, over a five year period. Otherwise, program rules would remain substantially unchanged.

Coordinated care programs would include health maintenance organizations (HMOs), preferred provider organizations (PPOs), primary care case manager (PCCM) programs and other cost effective alternative delivery systems. Current restrictions that impede access to coordinated care plans under Medicaid would be relaxed. Because enrollment would be shifted to coordinated care, State waivers to continue significant fee-for-service enrollment would be necessary.

Eligibility rules would remain the same as under the current Medicaid program. States would be required to continue to cover all current mandatory eligibility groups under Medicaid, as well as any optional groups they covered as of January 1, 1992.

States would continue to provide mandatory Medicaid benefits. States that currently provide optional Medicaid benefits would be able to adjust these benefits, but would be required to maintain the actuarial value of the total benefit package (e.g., an optional benefit could be dropped if another benefit of equivalent value is added). States also could modify the amount, duration, and scope of mandatory or optional benefits subject to a requirement that the actuarial value of the benefits be maintained. As under current law, providers would be required to accept Medicaid rates as payment-in-full with no significant cost sharing or balance billing.

Under this option, States would be responsible for coordinating certain aspects of the health insurance credit program. The tax credit would be used for the purchase of private insurance coverage. States would certify eligibility for and the amount of the

health insurance credit for those who wish to obtain their tax credit prospectively.

States also would be required to define a "basic" benefit package with an actuarial value equal to the tax credit amount. And, if a sufficient number of insurers do not offer the basic plan, States would be required to assure that at least two private health plans offer this basic plan to credit recipients within the State. Federal/State quality assurance programs would continue to assure proper program administration, e.g, proper eligibility determination for Medicaid and tax credit recipients and prevention of fraud and abuse.

State Option 2—Unified Program.— Under this option, States could establish a unified program that combines Medicaid with the new federal health insurance credit to provide health insurance coverage for all State residents with incomes below poverty. Coverage would be phased-in in tandem with the phase-in for the health insurance credit.

States would have broad flexibility in establishing these programs. They could operate a unified public insurance program or establish a State health credit program to supplement federal health insurance credit payments. Any eligible individual or family could opt-out of the State's public insurance program to purchase private insurance. Those who opt out would receive the full amount of the federal health insurance credit that they would otherwise be eligible to receive. The credit could be higher if the State supplemented the health credit.

States that provide insurance directly would cover all Medicaid mandatory benefits and as well as prescription drugs. States would have flexibility to modify the amount, scope, and duration of benefits and could add or drop optional benefits provided that the actuarial value of the benefit package is maintained when spread over all individuals who are eligible to participate in the program.

States that operate a unified health insurance credit program would be subject to a maintenance of effort requirement. The State's financial contribution would be set to equal the amount the State would have paid had it maintained a separate Medicaid program, as under option 1.

To help finance these programs, States would receive a lump sum payment from the Federal Government. This payment would equal the sum of federal per capita payments for those who meet Medicaid eligibility requirements and health insurance credit payments for those who are eligible for them. Payments would be based on estimates of the Medicaid and health insurance credit eligible populations within the State. Estimates would be base year eligibility rates updated to reflect changes in population and changes in unemployment and other factors likely to influence the size of the eligible population. Adjustments would be made to reflect actual participation.

To the extent practical, States would no longer apply complex Medicaid eligibility standards. Eligibility would be based simply on individual or family income in relation to poverty. States would help to administer the federal health insurance credit and would assure availability of "basic" benefit coverage from at least two private health plans, as under option 1.

2. Phasing-Out Duplicate Subsidies and Increasing Efficiency in Other Federal Health Programs

Medicare Program History

Since enactment in 1965, Medicare has successfully reduced the financial burden of health costs for the nation's elderly. However, the Medicare program also has experienced unsustainable increases in costs that have far outpaced both initial projections, and inflation (far exceeding the CPI), and even the medical component of the CPI.

Medicare outlays were $3.4 billion in 1967, and at the time, projected 1990 outlays were $15.7 billion. Actual 1990 Medicare outlays totalled $110 billion. The average annual rate of growth in Medicare expenditures between 1970 and 1990 was over 14.7 percent, well above the rate of inflation and beneficiary increases (about 8.2 percent). The following table compares actual Medicare

growth rates to inflation and beneficiary growth.

Medicare has outpaced the Medical-Consumer Price Index (MCPI) and the Consumer Price Index-Urban (CPI–U) by an average annual rate of 6.3 percent and 8.4 percent, respectively, over the 1970–1990 period. Over the next five years, if not reformed, it will continue to surpass general inflation rates, as indicated in the graph and chart below.

With almost 12 percent a year growth anticipated for each of the next five years, reasonable efficiencies must be found in Medicare growth to avoid draining American taxpayer resources—regardless of the beneficial private sector effects of the President's plan's private market reforms.

Reforms will not affect benefits for seniors.—Because important efficiencies are possible in the Medicare program, no senior will have any benefits reduced as part of health care reform. In fact, senior citizens could save money as a result of possible Medicare reforms—due to the lower coinsurance payments and lower Part B premiums that automatically

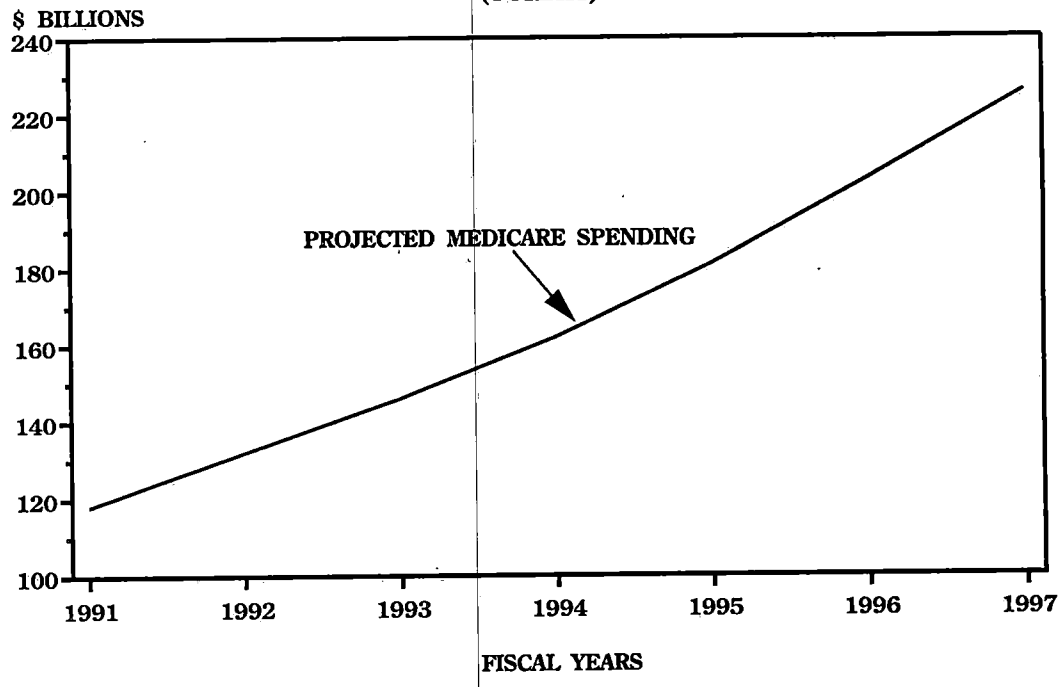
Table 5–11. **Average Annual Medicare Growth Compared to CPI–U and Beneficiary Growth, 1970 through 1990**

	Annual Growth Rate	Excess over CPI–U and Beneficiary Growth
CPI–U + Beneficiary Growth	8.2%	—
Medicare	14.7%	+80%

Chart 20. GROWTH IN FEDERAL MEDICARE COSTS

AVERAGE ANNUAL INCREASE -- 11.5%

(OUTLAYS)



result from many supplemental medical insurance (SMI) reforms.

Hospital Insurance (HI) Reforms

Under current law, the Medicare Hospital Insurance program will grow at 10.6 percent per year from 1993 to 1997. Numerous policy changes exist to reduce this high annual rate of growth—without affecting services.

Recapturing Unreimbursed/Uninsured Care Subsidies as Health Insurance Tax Credits Expand Access.—Many hospitals receive Medicare "disproportionate share payments" (DSH) to help cover the cost of the uncompensated care they provide to uninsured patients. Medicare DSH payments will total over $2.3 billion in 1992. A significant portion of the $3.2 billion provided to teaching hospitals in fiscal year 1992 through the "indirect medical education" (IME) adjustment also is intended to help defray uncompensated care costs.

As the new health insurance tax credits and tax deductions are phased-in—to ensure that nearly everyone coming into a hospital has insurance—these subsidies would, for the most part, be unnecessary. With insurance, low-income families will be able afford primary care on an ambulatory basis—to maintain good health and prevent serious illnesses that result in the need for costly hospital admissions. (Some indigent care subsidies could be retained as "gap fillers"—to provide for the small number of remaining cases where people still fall through the cracks.)

Adjustment of IME payments is justified on other grounds. Major studies by the General Accounting Office (1991) and the Congressionally-appointed Prospective Payment Assessment Commission (ProPAC, 1990) have consistently shown that these payments are excessive even under the existing system. Therefore, a phase-down in IME payments to rates already recommended by ProPAC (on the basis of excessive payment under current law) should be possible without any harm to teaching hospitals as the burden of uncompensated care decreases with the tax credit phase-in.

Reforming Graduate Medical Education Payments.—In addition to IME payments, Medicare also makes graduate medical education (GME) payments to help cover the cost of intern and resident salaries and the cost of teaching physicians. GME payments should be reshaped to help ensure that teaching hospitals meet the Nations needs for primary care physicians in the next century. Teaching hospitals should be encouraged through payment policy to shift the primary care/specialist training mix back towards more sensible ratios that will produce more primary care physicians.

Other Possible HI Reforms.—Other reforms could further reduce the excessive growth rate in HI costs. These reforms would: ensure that Medicare pays only once for certain hospital procedures; phase out unequal and special return on investment payments to for-profit skilled nursing facilities; create specific categories of payment to recognize more home health professions; and create additional incentives to Medicare beneficiaries to enroll in coordinated care organizations.

Preventing Program Abuse

Other policy changes should be considered to address areas where there have been documented abuses of the Medicare program.

Durable Medical Equipment.—A notable example is in the area of durable medical equipment (DME). Numerous reports of fraud and abuse have prompted calls for DME payment reform. Attempts to correct overcharges by instituting a fee schedule for DME have failed.

- A recent GAO (1991) study of six DME suppliers found that the suppliers' average profit margin in 1988 was 19 percent for Medicare business, significantly more than for non-Medicare business. The GAO projected that Medicare profits would be even higher in 1993—34 percent overall. The GAO study also found that Medicare payments in 1989 were 24 percent higher under the new fee schedules than they would have been under the previous system, which was based on reasonable charges.

To bring these excessive payments under control, the Secretary of the Department of Health and Human Services should be authorized to revise DME payment rates

to reflect market considerations, using such procedures as competitive bidding to establish payment rates for oxygen and oxygen products.

Growth of Physician Payments and Related Services (SMI)

Current projections of Supplementary Medical Insurance (SMI) program costs (primarily doctor's fees) show it growing at an average annual rate of 14.6 percent from 1993 to 1997. Over the past decade, Medicare Part B payments have grown at an average annual increase of 15 percent—twice as fast as the Consumer Price Index for urban areas (CPI–U), adjusted to take into account beneficiary growth.

With the ongoing five-year phase-in of physician payment reform, many physician payments are in the process of being adjusted significantly. While it is important to let this process proceed, the payment system should be examined to remove inappropriate incentives.

A recent study done by the State of Florida has focused attention on the abusive practice of physician "self-referrals." Physicians "self-refer" when they order health care services from a facility in which they have an investment or other financial interest. The Florida study showed that physicians who self-refer utilize services at a far higher rate than physicians who do not have these financial interests (Florida Cost Containment Board, 1991). The result is a significant increase in public and private sector health care costs.

In addition, self-referrals are viewed by many as involving an unethical conflict of interest. The American Medical Association (AMA) has recognized self-referrals as an area of abuse in need of reform and has taken the position that self-referrals should generally be discouraged except in situations where physician investment is needed to make services available (AMA, 1991).

Reform legislation should consider prohibiting Medicare payment in the case of "self-referrals" in areas such as radiology, radiation therapy, durable medical equipment, home health, physical therapy, and rehabilitation where abuses have been found. Current law already prohibits Medicare payment for self-referrals involving clinical lab tests.

A number of other policy options could be developed to help restrain growth of physician fees and other SMI expenses to a rate below 14.6 percent a year. Controlling the costs of physicians payments and related services (SMI) is critical. All seniors and general taxpayers are at risk when SMI costs grow at 14.6 percent a year, because 75 percent of SMI costs are borne by the general taxpayers and 25 percent from seniors' premiums.

Chapter 6

Problems with Alternative Approaches

Many of the proposals for health system reform are patterned after one of two basic models: a centralized Canadian-style national health insurance system or an employer "play-or-pay" mandate. Both of these alternative approaches deserve careful analysis because, if they were adopted, they would have enormous consequences not only for our health care system but for our way of life and the fabric of American society. This chapter analyzes these approaches.

A. The Canadian Model

Overview

While apparently successful in many respects and highly popular with the Canadian people, the Canadian system—like all other universal public insurance systems—suffers from two basic structural flaws that are bound to lead to serious long term problems with cost, access, and quality.

- First, there are no demand side incentives for efficiency. Because medical care is free to consumers, consumers do not play the same role they play in normal markets.

  Market forces that normally produce greater economic efficiency simply do not exist. Moreover, consumers are unable to express their preferences through market choices.

- Second, major resource allocations are made centrally through the political process. Health care is too complex and too sensitive to micro-level conditions, for centralized management to be effective.

  The Canadian system relies on blunt, macro-level, supply-side constraints such as an aggregate level of expenditures, limits on high-tech equipment, and limits on physician supply.

  But, efficiency—high quality care at the lowest possible cost—requires making optimal decisions at the hospital bedside and in the physician's office.

  Central planning inevitably wastes resources and places quality at risk.

These flaws are now increasingly apparent in the experience of the Canadian system:

- Costs have not been controlled effectively despite the enormous power that a single payer has under a universal public insurance program. Indeed, Canadian health care costs have risen slightly faster than health care cost in the U.S.

  Non-market means can moderate the growth of costs, but with significant inefficiency. Resources are often wasted on low-priority care while blunt cost containment measures limit spending where added resources could make a real difference in outcomes.

- Supply-side constraints have led to artificial shortages of critical personnel and equipment.

  Canadians have significantly less access to state-of-the-art technologies and often must wait weeks or months for treatments that are readily available to Americans. And, certain procedures, such as coronary bypass surgery, appear to be rationed, especially for senior citizens.

  Lost productivity and other costs associated with delays in surgery are estimated at 0.6 percent of Canadian GDP. These losses could be even higher if delays for

other medical services are taken into account.

- Incentives for Canadian physicians and hospitals often reward additional care regardless of its appropriateness. As a result, utilization rates have increased rapidly wasting resources.
- Reliance on crude global budgets as a means of controlling costs has forced Canadian hospitals to cut back on staffing in critical areas. As a result, post-operative death rates in Canada are 40 percent higher than in U.S. hospitals for certain high-tech, life-saving surgical operations.

Even if the Canadian system were an unqualified success, its successful adoption in the United States could not be assured. Each Nation has its own unique political, cultural, and economic environment. Experience with the Medicare and Medicaid programs in the United States suggests several difficulties in adopting a Canadian-style universal public insurance system.

- Over the past decade and a half, effective management of Medicare and Medicaid has been stymied by increasing politicization. Virtually all payment rates are fixed by law. Thus, an Act of Congress is needed to change the amount that Medicare pays for a routine lab test or X-ray.
- As a result of this inflexibility, Medicare and Medicaid per capita costs continue to grow more rapidly than per capita costs for the remainder of the population.

  If the U. S. political process has been unable to control 30 percent of health spending, there is little reason for optimism that it could be more successful in controlling costs for the entire health system.

Indeed, the thought that as much as 16 percent of the GDP by the year 2000 (32.7 percent if non health-related federal spending is included) could be subject to direct political control should give most Americans pause for serious concern.

Basic Features of the Canadian Model

For the past two decades, the ten Canadian provinces have operated government-based health insurance plans that cover hospital and physician care. The Canadian system itself, and American proposals to implement a Canadian-style approach, share a number of basic structural features:

- Health insurance is provided to all citizens through a centralized, publicly administered program. Health care services are provided by private-sector hospitals, physicians, and other providers. Private insurance is prohibited, except for services not covered by the public program.
- Covered benefits include hospital, physician, mental health, and preventive care. (Some Canadian provinces also cover prescription drugs and long-term care.) Care is free with no cost-sharing at the point of service.
- Hospitals and other institutional providers are paid on the basis of global budgets that cover all patient care costs during a year. Global budgets are set annually by government authorities, through a process that involves some element of negotiation.
- Physicians and other non-institutional practitioners and providers are paid on a fee-for-service basis according to a government-established fee schedule. Overall payments for physician services are limited by a global budget or "expenditure target."
- To control costs, the supply of facilities, equipment, and providers is strictly regulated. Hospitals are limited to government-set budgets for capital expenses. Construction projects and high-cost equipment purchases require special approval. Physician supply is limited and the specialty distribution is regulated to encourage general practice.
- Financing is primarily through broad based taxes (including a payroll tax). Some Canadian provinces also require small premium payments. Others place a special tax on employers.
- The Canadian system is administered through the provinces with supplemental Federal financing. A Canadian-style system in the U. S. could be jointly administered by federal and State governments (as proposed by Senator Kerrey) or pri-

marily by the national government (as proposed by Congressman Russo).

Basic Structural Flaws in the Canadian Model

Lack of Demand-Side Incentives.—The Canadian system lacks effective incentives for efficiency. Because medical care is free to consumers, market forces that normally drive economic systems to greater efficiency simply do not exist. This flaw could be partly remedied by requiring some cost-sharing at the point of service. The RAND health insurance experiment has conclusively shown that modest levels of cost-sharing reduce demand with little or no measurable impact on health status (Brook et al., 1983). But, the flaw in the Canadian system is much deeper than a simple lack of cost-sharing.

Because consumers do not have a choice of alternative health plans and do not pay any portion of the premium cost, there is no dynamic that could lead to the development of more efficient systems for delivering high quality care at low cost. It is no accident that innovative health care delivery systems, such as Kaiser Permanente or Group Health of Puget Sound, have emerged in the United States, but not in Canada.

In the U.S., employers and individuals, concerned about getting good value for their health care dollars, have incentives to demand better forms of health care delivery. This, in turn, creates a market for such systems, and organized health plans then compete with one another for market share, leading to progressive improvements in cost-effectiveness and quality. This consumer-driven process of progressive improvement simply cannot occur in a Canadian-style system. All significant change in Canada requires legislation.

As a result, the Canadian health care system is less dynamic, resembling the U.S. health care system as it existed in the mid-1960s. Medical care continues to be an unorganized cottage industry. Physicians are subject to little oversight to assure efficiency and quality of care. And physicians continue to be paid exclusively on a fee-for-service basis despite clear evidence that this approach is inflationary. None of the improvements in health systems delivery or innovative payment arrangements that have been developed in the United States over the past decades have taken root in Canada.

Overall, Canadian citizens as individuals are relegated to a diminished role in decision making in the health care system. Because they cannot make their own choices in the market, they are forced to rely on the vagaries of the political process.

Supply-Side Controls.—Because incentives for needed, appropriate care only are poorly structured, the government is left with controlling costs through overall supply side controls. There are at least three main problems with this approach.

- Macro-level supply side controls cannot achieve micro-level efficiency. Resources are invariably wasted. Needed services are often caught in the squeeze compromising quality and good medical care.

  Every day, medical personnel make hundreds of decisions that affect resource allocation. Should a particular test be provided? What level of staffing should be provided in a busy emergency room? Consumers also must make important decisions regarding their care.

  For efficient decisions to result, all of the participants must have appropriate incentives and must have critical information. Macro-level budget constraints do nothing to assure that proper incentives and accurate information are brought to bear.

- Supply side measures are often arbitrary and inflexible. Regulators must make thousands of decisions each year—decisions that involve billions of dollars to implement global budgets, limits on high-tech equipment, and similar measures. Regulators must decide whether to increase a hospital's budget or to approve the construction of a new cardiac surgery facility. A centralized allocation process can be cumbersome, expensive and politicized, without resulting in an efficient allocation of resources. (Deber and Leatt, 1987; Feeny et al., 1986).

- Third, a centralized allocation process may be too removed or too politicized to effectively contain costs. Broad-based political

support for cost-containment is unlikely. Lobbying by providers and special interest groups, partisan disputes, and a host of other complications make success in containing costs problematic, at best.

Canada: The Evidence to Date

The preceding discussion suggests that the design inherent in any centralized, government-controlled health insurance scheme will have adverse impacts on costs, access, appropriate use of resources, and quality. In fact, a growing body of evidence strongly suggests these are characteristics of the current Canadian system.

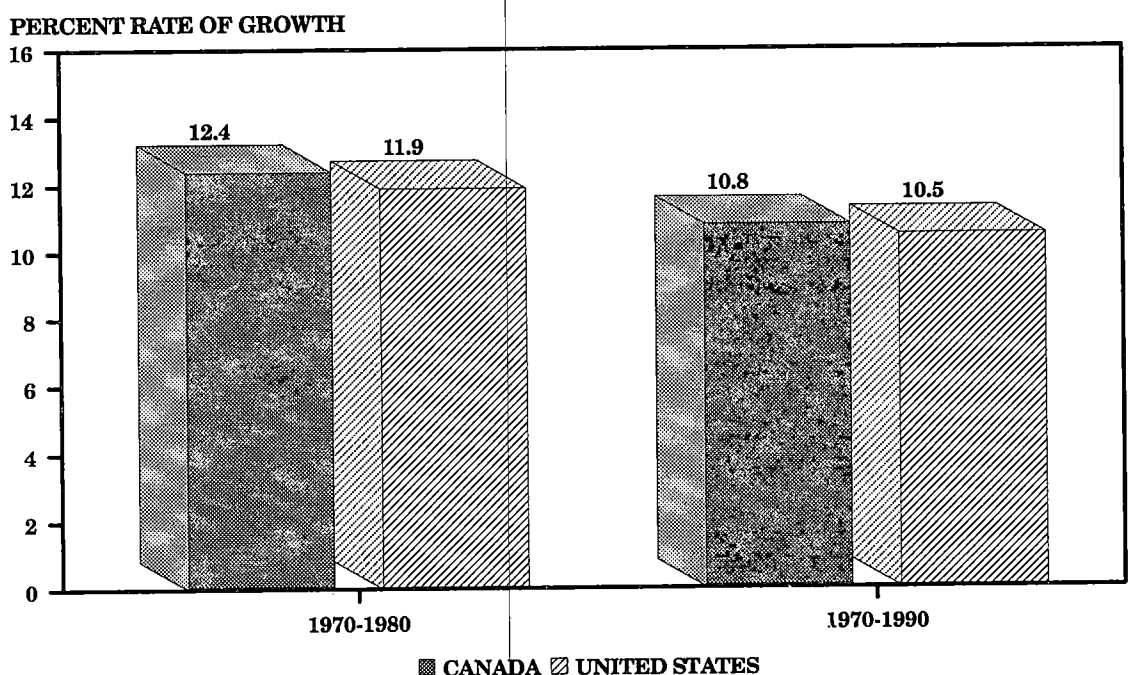
Failure to Control Cost Growth.—Even with strict global budgeting and some rationing of care, Canadian health costs continue to grow faster than U.S. costs. Between 1970 and 1980, Canada's annual compound rate of growth for per capita health expenditures was 12.4 percent, compared with 11.9 percent in the U.S. Between 1970 and 1990, Canada's expenditures grew annually 10.8 percent, compared with 10.5 percent in the U.S. (OECD, 1990; Schieber et al., 1991).

Cost-containment also has become more difficult in Canada in recent years. Rising demands on the system resulting from free universal access have placed increased financial burdens on the government.

Declining national contributions and cost-containment measures have initiated a recent round of hospital staff layoffs and bed closings. Ontario, for example, the richest and most populous province, where more than a third of the Canadians live, has lost nearly 5,000 hospital jobs and 3,500 beds over the last two years. In Toronto, the provincial capital, 2,900 of 15,000 acute-care beds have been taken out of service (Media Digest, November 25, 1991).

To contain costs, Canada has cut payments to providers, making the yearly price negotiations more and more difficult. The rising Canadian costs, kept artificially under control by government price and spending caps, have been described as "a pressure cooker that

Chart 21. COMPOUND ANNUAL PERCENTAGE RATES OF PER CAPITA NOMINAL GROWTH



SOURCE: OECD, "OECD Health Systems: Facts and Trends" (Paris: OECD forthcoming)

is building steam on a hot stove" (Iglehart, 1986).

Treatment Delays.—Reliance on supply constraints to control costs inevitably leads to shortages and delays in treatment. Canadians must often wait to receive treatment. For example, Canadians wait on average 4.9 months for open heart surgery, and 5.5 months for bypass surgery (Globerman, 1990).

These waiting times for medical treatment can have potentially adverse effects on a patients' health. Patients not receiving timely access to diagnostic procedures—such as MRIs, CT scans and mammograms—can suffer setbacks due to delayed treatment. Those waiting for acute procedures—such as open heart surgery—can risk death waiting for care.

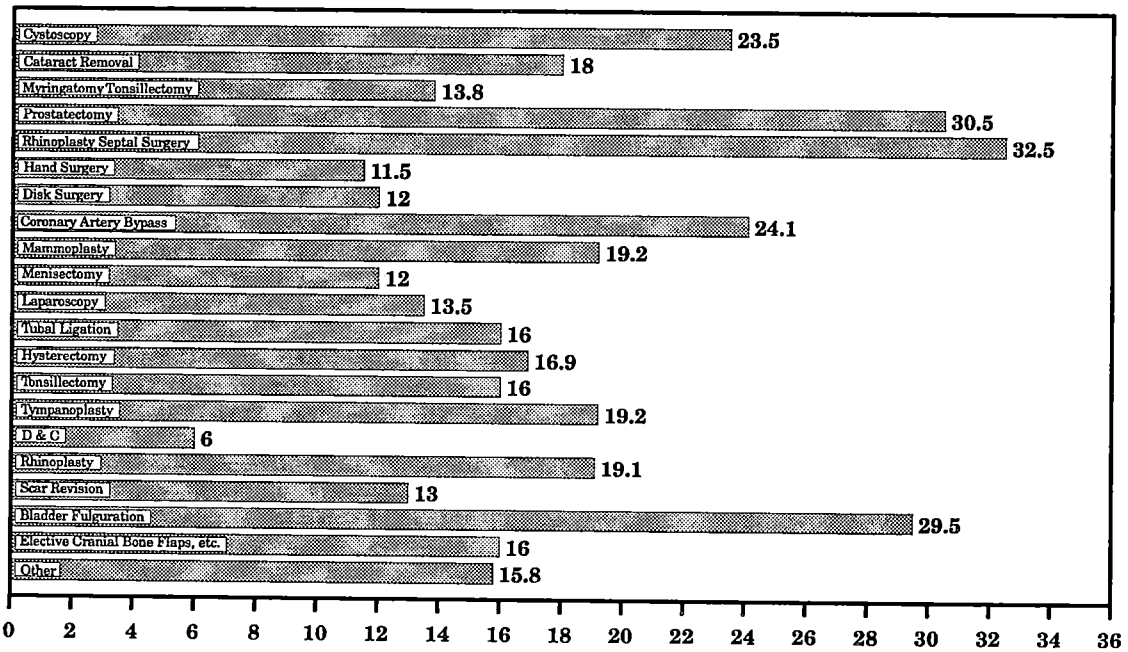
Waiting for treatment also results in a direct economic loss. If unable to work while waiting for care, individuals may face financial setbacks. Some may even lose their jobs. There is the additional social loss of productivity. The overall cost of delays in surgery has been estimated at 0.6 percent of Canadian GDP (Danzon, 1991).

Limited Access to Advanced Technology.—Government control of hospital capital and operating budgets limits the adoption of medical technology in Canada. For example, U.S. citizens have access to more open heart surgery, cardiac catheterization, organ transplants, radiation therapy, extracorporeal shock and lithotripsy, and magnetic resonance imaging.

Data from Anderson et al. (1989) also suggest rationing of selected expensive procedures for older age groups. Heart valve surgery and bypass surgery for patients ages 65–74 and 75+ were consistently performed less often in Canada. For patients age 75 and above, a full 4 times as many bypass procedures were performed in the U.S. as in Canada for the same age group of patients.

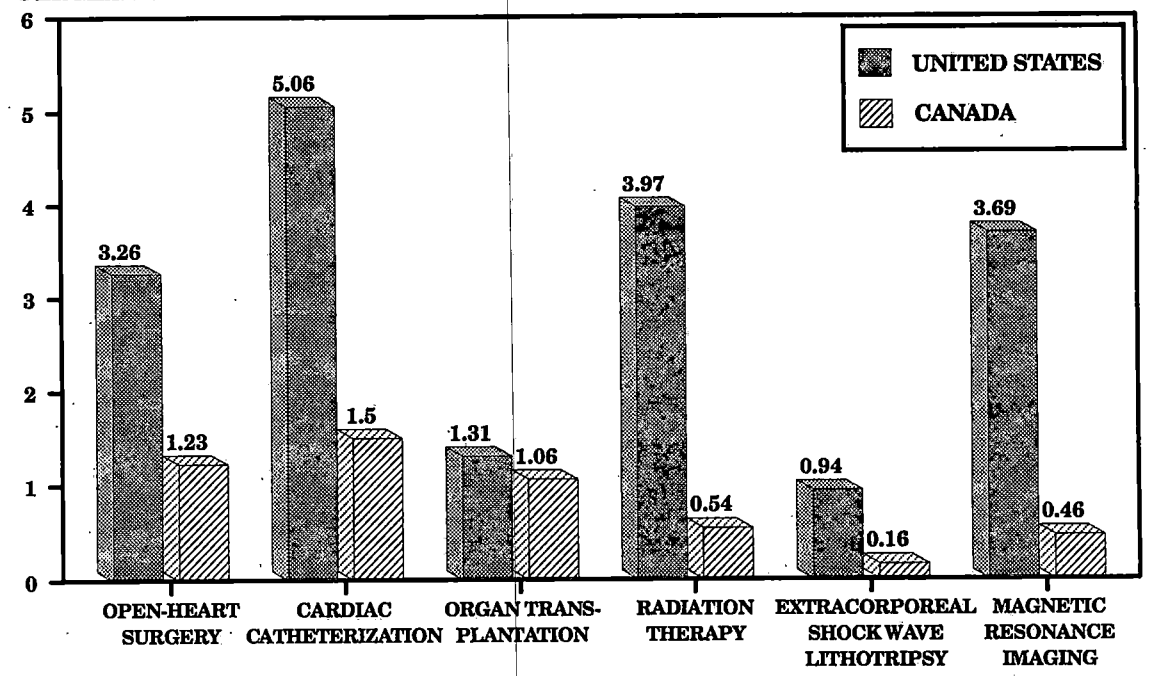
Limited availability of medical technology has prompted the Canadian government to send some patients to the U.S. to seek advanced medical care. For example, the

Chart 22. AVERAGE WAITING TIMES IN BRITISH COLUMBIA



SOURCE: Steve Globerman, Waiting Your Turn: Hospital Waiting Lists in Canada (Vancouver: Fraser Institute, 1990)

Chart 23. ACCESS TO MODERN MEDICAL TECHNOLOGY UNITED STATES (1987) VS. CANADA (1989)



SOURCE: Dale A. Rublee, "Medical Technology in Canada, Germany and the United States," Health Affairs, Fall 1989, Table 1, p. 180

British Columbia Health Association has contracted with Seattle hospitals for coronary bypass surgeries (Washington State Hospital Association, 1990), and Ontario and Alberta have similarly contracted with U.S. hospitals for high technology care (Goodwin, 1990; Sherlock, 1990).

While these instances may be rationalized as temporary problems, the Canadian system is able to use access to U.S. technology as a "safety valve." Since the U.S. provides an available supply of medical technology just across the boarder, Canada may have an incentive not to invest in sufficient supply. If the U.S. were to adopt a Canadian system, this safety valve would no longer exist for Canada, nor would one exist for Americans (HIAA, 1990).

Limited hospital budgets for capital improvements also have meant that the physical plant and equipment in many hospitals is nearing obsolescence (Iglehart, 1986). This lessens some Canadian hospitals' ability to provide the highest quality care.

Ineffective Use of Resources Resulting from Inappropriate Incentives.—Because Canada continues to rely primarily on fee for service payment, physicians are rewarded for additional care regardless of need or quality. As a result, utilization per physician increased by 25.1 percent in Canada between 1971 and 1985, compared with only 7.0 percent in the United States (Barer et al., 1988). Overall, Canadian physicians provide a much higher volume of services than U.S. physicians. While data is not available on rates of appropriateness, these substantially higher levels of medical utilization raise concerns about the amount of inappropriate and unnecessary care being delivered and paid for by the Canadian taxpayer.

Hospitals also face perverse incentives. Because hospitals are paid a fixed aggregate budget, they have a financial incentive to use available beds for patients with the lowest cost. As a result, Canadian hospitals are filled with chronically ill, but low cost, patients, termed "bed blockers."

Table 6–1. **Relative Use of Physician Services in Canada and the United States**
(Services per capita)

Service Type	Canadian Rate as Percent of U.S. Rate
Diagnostic and Therapeutic Procedures	120
Office Visit and Consultations	156
All Physician Services	139

Source: Fuchs, 1990.

These incentives affect quality and hospital staffing decisions. Canadian hospitals have lower average staff-to-patient ratios than do U.S. hospitals, (1.87) versus (3.47) (Newhouse et al., 1988). Quality for high-risk patients, however, can suffer as a result of these staffing patterns (see below).

Pressures on Quality.—Roos et al. (1989) recently compared Canadian and U.S. post-operative mortality rates. Interestingly, Canadian hospitals did as well as U.S. hospitals on low risk surgical procedures. Post-operative mortality, however, is 44 percent higher in Canada than in the U.S. for high risk procedures including heart surgery. This outcome may result from hospital budgeting practices which encourage lower staff-to-bed ratios. This means that patient care resources might not be available when critically needed.

Quality assurance activities such as peer review, second opinion, utilization management and outcomes information also are relatively undeveloped in Canada compared with the United States. Similarly, Canadian hospitals have few incentives to compete on increased quality of care. Because of tight budgets, hospitals in Canada do not invest to any significant level in data collection and quality review.

Could a Canadian-Style System Be Successfully Implemented in the United States?

Critical Differences Between the United States and Canada.—The notion of simply adopting the Canadian system is simplistic. Each nation has its own unique political, cultural, and economic environment and history.

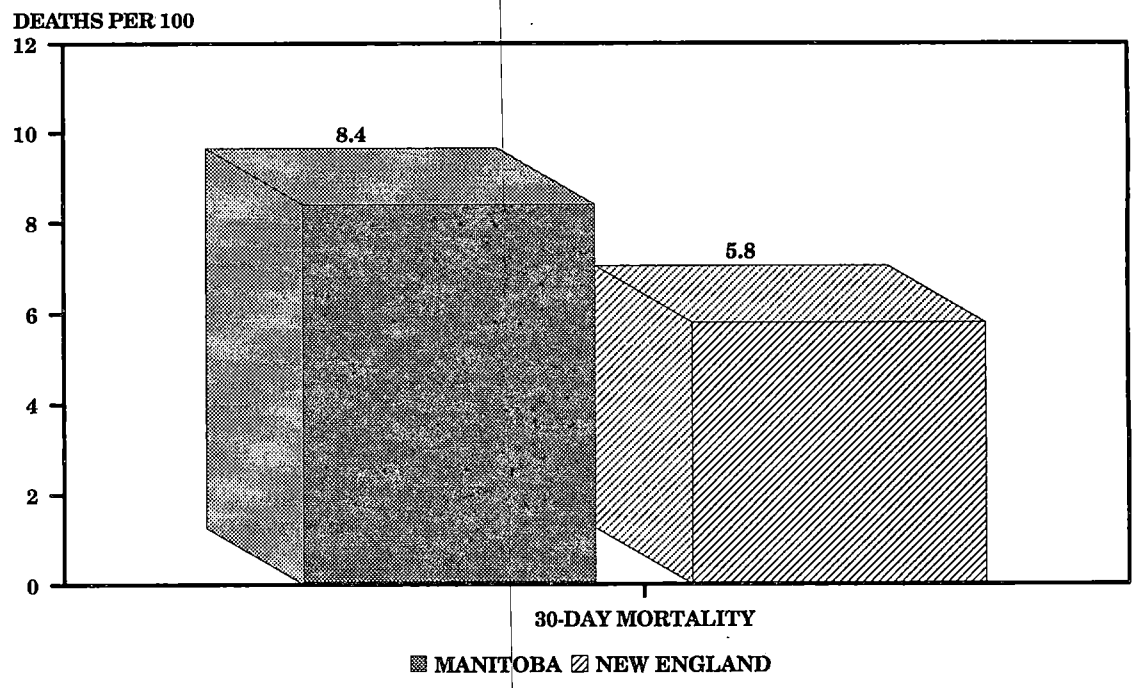
One major difference between the United States and Canada is our form of government. We rely on a system of checks and balances, with independent executive, legislative, and judicial branches. Canadians, in contrast, have a parliamentary form of government, which

Table 6–2. **Comparison of Hospital Care in Canada and the United States**
(Use rates for people aged 65 and older)

	Unites States	Canada	Canadian Rate as Percent of U.S. Rate
Admissions Per Capita	0.33	0.35	106
Length of Hospital Stay (in days)	7.96	13.32	167
Hospital Days Per Capita	2.63	4.66	177
Hospital Staff Per Occupied Bed	3.47	1.87	54

Source: Newhouse, 1988.

Chart 24. POST-OPERATIVE MORTALITY FOR HIGH RISK SURGICAL PROCEDURES FOR PATIENTS 65 AND OLDER



SOURCE: Roos, et al., JAMA, Vol. 263, No. 18, May 9, 1990

effectively combines legislative and executive functions. There is less potential in Canada for the political deadlock that has characterized health policy in the United States over the past decade.

Experience with the Medicare and Medicaid Programs.—Experience with the Medicare and Medicaid programs suggests that a Canadian-style universal public insurance program could not be translated successfully into the United States. While these programs have succeeded in expanding access to the elderly, the disabled and many low income Americans, these programs have become increasingly politicized over the past 10 years thwarting effective program management.

When enacted in 1965, Congress delegated broad responsibility for management of Medicare and Medicaid to the executive branch and to the States. Congress legislated only the broad outlines of the programs and limited its role to oversight. Today, virtually every detail of operation of Medicare and Medicaid is dictated in hundred of pages of dense legislative language that are comprehensible only to a handful of Congressional staff and executive branch experts.

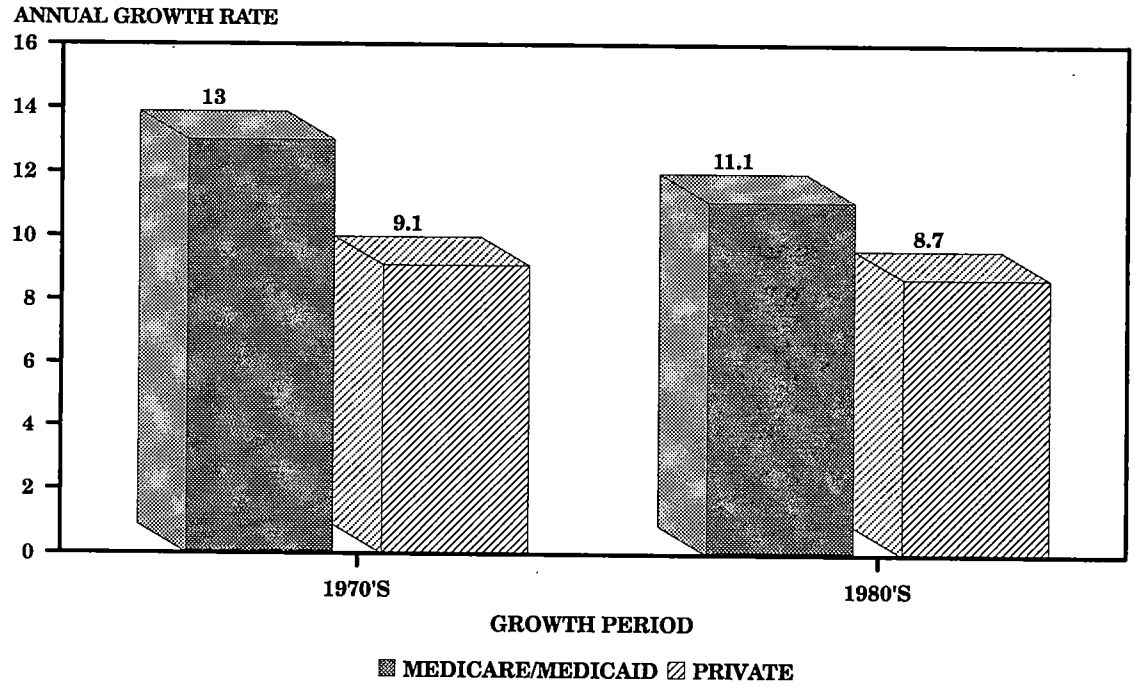
With the increasing complexity of the legislation, few Members of Congress even have an opportunity to vote on the issues involved. Over the past decade, the full House and Senate have only had a handful of opportunities to debate and vote on critical programmatic issues.

Micromanagement of program details by legislators may be inevitable because it extends the political power and influence of key committee members. The technical details of payment policy often are highly arcane but of great monetary significance. Many payment policies are somewhat arbitrary.

Per capita health care costs for Medicare and Medicaid recipients have grown consistently faster than per capita health care costs for the remaining population.

If the political process has been unable to control 30 percent of health spending, there is little reason for optimism that it

Chart 25. ANNUAL GROWTH IN PER CAPITA HEALTH CARE EXPENDITURES



SOURCE: HCFA, Office of the Actuary, Office of National Health Statistics

could be more successful in controlling costs for the entire health system.

Potential for Massive Transition Costs and Disruptions.—Establishing a universal public insurance program in the United States would involve massive transition costs and disruptions. Either taxes and government spending (federal and/or State) would have to increase by $250 to $500 billion per year, and either taxes or government borrowing would rise by the same amount. Using 1992 dollars or cost controls would have to cut enlisting problems and expenditures by an equivalent amount. Either tax increases or program costs of this magnitude would have devastating effects. If coverage is financed through a payroll tax that would increase the cost of employment, job losses could exceed two million workers. Millions of people currently satisfied with their current insurance arrangements would be forced to switch their coverage.

B. Problems with "Play-or-Pay"

Overview

"Play-or-pay" is a widely discussed approach for expanding health insurance access. Employers would be required to "play", e.g., provide private insurance for workers and dependents, or "pay" a payroll tax to fund public insurance for their workers and dependents. Variants of this approach have been proposed by Senators Mitchell and Kennedy and by Representative Rostenkowski, among others.

While "play-or-pay" would expand insurance coverage, it suffers from four serious drawbacks. "Play-or-pay" would:

- Hurt workers by reducing jobs and by forcing employers to cuts wages to offset mandate costs. While "play-or-pay" seems to put the burden on employers, this is large-

ly an illusion. Employers will inevitably shift the burden to employees. Between 350,000 and 750,000 jobs could be lost in the short-run, with a long-term potential as high as two million. These job losses are about 50 percent to 100 percent of those endured during the recession. Moreover, cash wages for many of the "beneficiaries" of the mandate would decrease by 7 to 9 percent depending on the payroll tax rate, and would fall by about another 1 percent as newly unemployed workers compete for increasing scarce jobs.

- Cascade into a form of national health insurance. "Play-or-pay" is inherently unstable. According to the Urban Institute, 60 million workers and dependents who now have private coverage would be shifted into the public plan. Overall, 58 percent of Americans would be insured publicly. At this point, the public could use its near-monopsony position to gain deep discounts from providers resulting in a massive cost-shift that would rapidly price the remaining private coverage out of the market.
- Hurt small business. While the $30 billion cost of the mandate will be shifted to workers, in the near-term, employers will bear the burden. Some employers may try to pass this added cost on to consumers in the form of higher prices. But many businesses that do not currently provide coverage have low profitability, are engaged in competitive markets and may fail as a result of the higher costs. Small business will suffer disproportionately.
- Increase costs for government over and above the new payroll tax receipts. "Play-or-pay" is not self-financing. A federal subsidy would be needed to fund the gap between payroll tax receipts and actual costs, and this gap is likely to grow rapidly. Although premium costs average 7 percent of payroll, actual costs vary widely. Low-wage firms incur costs well in excess of 7 percent. These firms will disproportionately opt to "pay," but the tax will be inadequate for health coverage for these firms. This problem will be compounded by the fact that premium costs also vary widely. Firms with higher premiums due to an older or sicker work force would have a strong incentive to opt into the public plan, further undermining the solvency of the plan.

How Play-or-Pay Plans Operate

"Play-or-pay" employer mandates are designed to provide coverage for workers and their dependents with little direct cost to government. Employers are required to provide coverage directly or pay a payroll tax. Mandates typically apply for all workers employed more than 17.5 hours a week.

- To "play," employers would be required to provide "basic" health coverage. Typical employers could require workers to pay up to 20 percent of premium costs as well as make modest copayments upon the receipt of health care.
- Employers not providing health benefits directly would be required to pay a payroll tax to cover a portion of the cost of benefits provided through a public insurance program. Estimated payroll tax rates are in the range of 7 to 9 percent. Generally, there is no cap on the taxable wage base.

"Play-or-pay" mandates usually are accompanied by an expanded public insurance program to replace Medicaid and provide subsidized coverage on a sliding-scale basis for those without employer-paid coverage or Medicare. Some form of price regulation also generally accompanies "play-or-pay" proposals as a means of restraining costs. The regulation may involve some form of payer/provider negotiations or may be administered directly by a regulatory agency.

Characteristics of the Working Uninsured

The working uninsured are the intended beneficiaries of "play-or-pay" mandates. In 1987, almost half (47.4 percent) of uninsured workers earned $5 or less an hour. Sixty percent were employed in small establishments with 25 or fewer workers. Most worked in low-skilled occupations and in industries that are characterized by intense competition and comparatively low profitability. Many of these low-wage workers will be those who would lose their jobs under play-or-pay.

Consequences of "Play-or-Pay"

Effects on Insurance Coverage.—From the standpoint of expanding insurance coverage "play-or-pay" appears to be a success. According to a simulation conducted by analysts at the Urban Institute, an estimated 33 million uninsured Americans and their dependents would receive insurance coverage as a result of the mandate—22 percent through their employer and 78 percent through the new public plan.

Assuming a 7 percent "play-or-pay" tax, insurance costs would increase by $30 billion for employers, in 1989 dollars, and by $37 billion for employers with a 9 percent tax. Premiums paid by individuals would increase by less than $1 billion, while uncompensated hospital care would decrease by $15 billion.

The Effects on Wages and Employment.—"Play-or-pay" mandates appear to put the burden on employers, but in the long-run, the burden falls primarily on workers. The effects are two-fold: lower real take-home pay and fewer jobs.

The reason is straightforward. At the margin, the total compensation an employer is able to pay (including wages and fringe benefits) must equal the marginal value to

Table 6–3. **Shifts In Insurance Coverage for the Under 65 Population**

	Employer Sponsored Insurance	Private Nongroup	Government (Excluding Medicare)	Uninsured
Number of People Covered in Millions:.				
Current System	142	18	23	33
Under Pay-or-Play:				
With a 7 percent tax	105	0	112	0
With a 9 percent tax	132	0	85	0
Percentage of Population Covered:.				
Current System	66	8	11	15
Under Pay-or-Play:				
With a 7 percent tax	48	0	52	0
With a 9 percent tax	61	0	39	0

Table 6–4 **Insurance Costs**
(Billions of 1989 dollars)

	Total	Employers	Individuals	Government
Total Insurance Costs:				
Current System	202	129	46	28
Under Pay-or-Play:				
With a 7 percent tax	269	159	46	64
With a 9 percent tax	272	173	46	53
Added Insurance Costs:				
With a 7 percent tax	67	30	0	36
With a 9 percent tax	70	44	0	26
Less Savings from Reductions in Uncompensated Care:				
With a 7 percent tax	15	—	—	—
With a 9 percent tax	15	—	—	—
Net Added Insurance Costs:				
With a 7 percent tax	52	—	—	—
With a 9 percent tax	55	—	—	—

the employer of the labor that is provided. If an employer is forced by a government mandate to increase benefits, the employer will reduce employment or reduce cash wages. A mandate simply cannot force an employer to pay more in compensation than the value of the labor to the employer. This conclusion is supported by a number of empirical studies analyzing other mandates (see, e.g., Gruber and Krueger, 1990).

For uninsured workers, the cost of keeping their jobs with a 7 percent "play-or-pay" payroll tax would be a 7 percent reduction in gross wages, and a larger proportionate drop in after-tax income. In addition, wages, corrected for inflation, would fall by about another 1 percent as newly unemployed workers compete for fewer jobs. The burden would be particularly great because most of the working uninsured are low-wage workers already struggling to make ends meet. For example, the mandate would result in—

- A pay cut of $1,680 a year for the average 30 year old male high-school graduate, currently earning $24,000 a year in wages; and
- A pay cut of $1,260 a year for the average 30 year old male high-school dropout, currently earning $18,000 a year in wages.

For other workers, 350,000 to 700,000 jobs would be lost. Moreover, if the "play-or-pay" mandate evolves into a universal public insurance program, available to all regardless of employment, job losses could reach two million.

A review of the characteristics of the uninsured workers makes these predictions seem even more realistic. Most of uninsured workers are low-wage, low-skilled workers. These workers have little ability to command costly fringe benefits.

A better approach is to provide direct assistance for low-income workers through tax credits, as the President has proposed. This approach is more "progressive" in terms of income distribution. Income is transferred directly to assist low-income workers, without the risk of job loss or a reduction in wages that a mandate inevitably involves.

"Play-or-pay" has other disadvantages for workers as well.

- With a 7 percent payroll tax, 52 million currently insured workers and dependents with employer-based plans would be forced to change coverage. Another 14 million Americans would be forced to give up their private insurance and would be forced into a "one size fits all" public insurance plan. These shifts in coverage are illustrated in Table 6–5.
- Families that depend on supplemental income from part-time employment of a spouse could be hurt. If the mandate applies to part-time work. Employers will cut back on part-time jobs because of the added cost. On the other hand, if the mandate does not apply, it would fail to close an important gap in coverage and government would be forced to pick up the costs through the back-up public plan.

Table 6–5. **66 Million Lose Choice of Plan Under Play-or-Pay**
(Coverage under new public plan in millions)

	Workers	Dependents	Nonworkers	Total
With a Pay-roll Tax of 7 Percent				
Former Source of Coverage:				
Employer	37	15	0	52
Private Insurance	6	2	6	14
Government	2	4	13	19
Uninsured	12	6	8	26
Total	57	27	28	112

A Backdoor to National Health Insurance

Advocates present "play-or-pay" as means of providing universal coverage while avoiding national health insurance with all of its shortcomings. (See Chapter 6.A.) But, this argument is flawed. "Play-or-pay" is inherently unstable and will likely collapse into a full blown national health insurance system.

Many employers who now provide private health insurance to their workers will have strong incentives to shift coverage to the public plan "pay" option because a 7 or even 9 percent payroll tax will be significantly less costly than private coverage. The incentives are particularly great for small firms with comparatively low average wages. A recent study conducted for the Labor Department by policy analysts at the Urban Institute reaches some startling conclusions on the potential size of such a shift.

With a 7 percent payroll tax, total enrollment in public insurance (including Medicare) would be 144 million or 58 percent of the population. Sixty-six million Americans with private coverage would be shifted to the new public plan. Twenty-six million of the 33 million who are currently uninsured would end up in the public plan. Only 7 million would actually receive health insurance through their employers.

For workers in small firms, private health insurance would quickly become a thing of the past under "play-or-pay". At a 7 percent tax, 81 percent of the workers in firms with 25 workers or less would be enrolled in the public plan. Even with a 9 percent payroll tax 117 million, or 47 percent of the total population would be covered by public insurance. Thirty-two million Americans who currently have private employer-paid coverage would shift into the new public plan as would 22 million of the currently uninsured.

It is important to note that the Urban Institute study focused only on the "static" effects of a "play-or-pay" mandate. Once a "play-or-pay" system is in effect, however, dynamic forces will be set in motion that drive the system further toward universal public coverage.

In the absence of other reforms, health care costs are likely to increase much more rapidly than wages. As a result, the public plan will become increasingly underfunded unless the payroll tax is increased to keep up with health care inflation. But, due to political pressures, the Congress is unlikely to let this happen. So, the Congress is likely to turn increasingly to general revenues to subsidize the public plan. Or the Congress may try to use some form of blunt price regulation to hold down public plan costs. Either way, the public plan would gain an increasing competitive advantage over private health plans, and private health plans would rapidly lose market share.

Effects on Employers

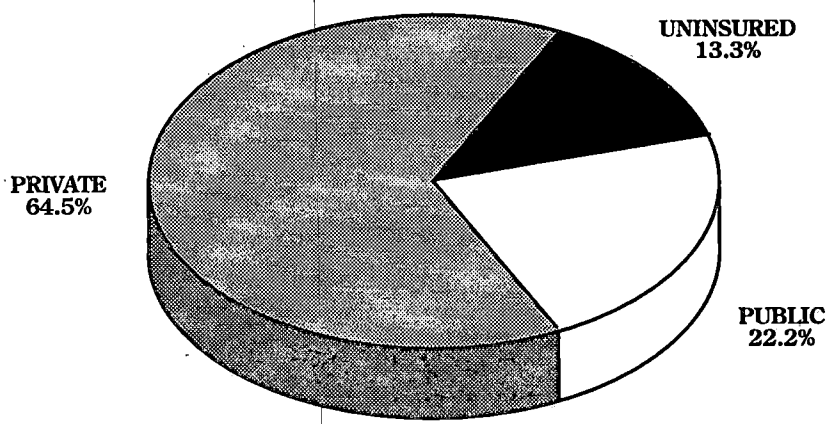
In the short-run, employers will not be able to react fully to the mandate by reducing wages or employment. As a result, the initial harmful effects of the mandate will fall mainly on employers. Small firms would be especially hard hit.

- Health insurance costs for employers would increase by $30 billion under a mandate with a 7 percent payroll tax—a 23 percent increase in current health insurance costs. With a 9 percent tax, the added cost for employers would be $44 billion—a 34 percent increase in insurance costs.
- The largest proportional increases would be for small employers. For firms employing fewer than 25 workers, costs would rise by 71 percent with a 7 percent payroll tax rate, and by 101 percent with a 9 percent tax. As noted, 60 percent of currently uninsured workers are employed in establishments with 25 or fewer workers.

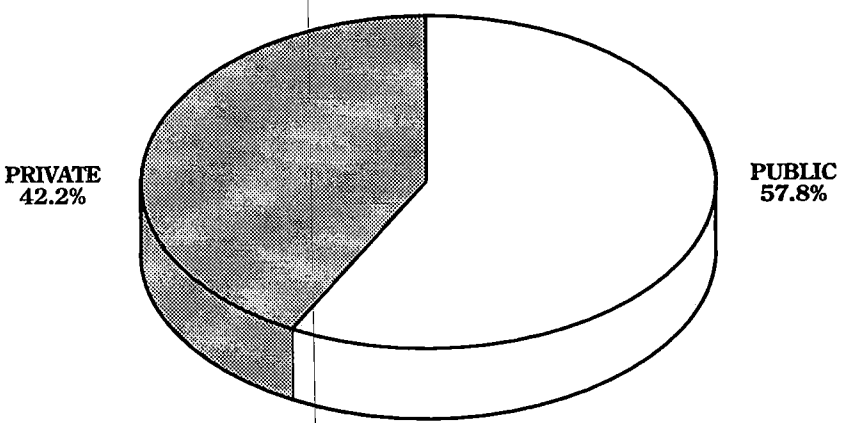
In the short run, a "play-or-pay" mandate will lead to somewhat higher prices and an increase in the inflation rate. For firms, that cannot pass on increases in costs through higher prices, there would be a fall in profits. Assuming the monetary authorities maintain their existing targets for inflation, the effect of the mandate would be to lower employment and lower real GDP.

Chart 26. SOURCE OF HEALTH INSURANCE COVERAGE FOR U.S. POPULATION

CURRENT SYSTEM



PAY-OR-PLAY WITH A 7% TAX



SOURCE: The Urban Institute, "Pay or Play Employer Mandates: Effects on Insurance Coverage and Costs," January 8, 1992

The Cost to the Government of "Play-or-Pay"

A "play-or-pay" mandate would give rise to a vast new federal health insurance program, four times as large as Medicaid and inadequately funded.

The Urban Institute estimates that a pay-or-play mandate with a 7 percent payroll tax would not be adequately funded. The new payroll tax would not cover the full cost of the new public plan. A subsidy of $37 billion would be needed from general revenue. A 9 percent payroll tax would lower the subsidy to $25 billion. The subsidy is likely to grow over time for reasons noted previously.

"Play-or-Pay" Fails to Address Cost-Control Effectively

Play-or-pay proposals are often coupled with "all-payer" price regulation schemes that attempt to limit aggregate payments by all public and private insurers to hospitals, physicians, and other providers to pre-set global budget targets. These schemes are closely related to Canadian-style national health insurance plans and share the same drawbacks.

All-payer rate setting preserves a role for private insurers, but is otherwise identical to a Canadian-style system in relying on supply-side constraints to control costs. Neither approach addresses the dynamic factors that are driving up health care costs.

In the absence of meaningful reforms, imposing price controls is like putting lid on a pressure cooker. If the heat remains, the lid eventually blows off and the pot boils over. The disadvantages of the Canadian system are discussed in detail elsewhere. Problems with all-payer rate setting are briefly summarized here (see Table 6–6).

Although advocates often argue that all-payer rate setting would encourage coordinated care plans, the opposite seems more likely to be the case. All payer rate setting robs coordinated care plans of their cost-savings advantage relative to traditional fee-for-service arrangements by artificially holding prices down.

The more rate setting succeeds in controlling costs, the less incentive that consumers (and therefore providers) will have to switch to coordinated care. So, all-payer rate setting, like Canadian-style national health insurance, seems likely to preserve inefficient forms of service delivery.

Table 6–6. **Potential Problems with All-Payer Rate Setting**

1. Supply constraints will lead to shortages and waiting lines. Tight global budgets will force hospitals to cut back on personnel in critical areas—jeopardizing the quality of patient care.
2. Rate setting fails to reward efficient physicians while creating incentives for overutilization.
3. Rate setting fails to reform incentives/structure/organization at the micro-level and so will lose effectiveness with time.
4. Rate setting will reduce the competitive edge of coordinated care—thereby retarding critically needed change in the delivery system.
5. Primary reliance on all-payer regulation to control costs opens up a broad range of issues to political interference and manipulation.

Chapter 7

Examples of Impacts on Individuals and Families

The President's plan will allow all Americans to have access to affordable health insurance. The following are illustrative examples of how the President's plan would work.[1]

Case #1

A family of two parents and a child with one working parent without employer coverage, and a total family income of $10,000 (just below the poverty level):

[Full Credit of $3,750]

- Under the current system, this family is not eligible for Medicaid and cannot afford private health insurance.
- Under the President's plan, this family would qualify for a $3,750 transferable credit to buy basic health insurance through the State designed group health plan (or another of their choice).

Case #2

A mother with two children who was on welfare (AFDC) in the past, and has returned to a job earning $8,500 per year. No employer health insurance is provided:

[Full Credit of $3,750]

- Under the current system, a mother receiving AFDC who returns to work continues to receive Medicaid for six months; after the six-month period, the family may be charged three percent of the family income as a Medicaid premium in this case, $255 for six months of coverage. After one year, the family is no longer eligible for Medicaid.
- Under the President's plan, the family would qualify for a $3,750 transferable credit to buy basic health insurance through the State group health plan (or another private plan) when they no longer qualify for Medicaid.
- The President's plan removes the current incentive for AFDC families to remain on welfare because they fear losing Medicaid coverage—the President's plan will ensure continued coverage for welfare recipients who return to work.

Case #3

A family of four with a modified adjusted gross income of $60,000 (in which the filer is married and filing jointly), and no employer sponsored health insurance:

[Full Health Care Deduction of $3,750 and Access to Group Coverage]

- Under the current system, they often cannot find affordable coverage.
- Under the President's plan they would receive a $3,750 tax deduction (a benefit of approximately $1,050) to help with the purchase of insurance.
- In addition, their employer(s) would provide information and arrange access (but not be required to contribute) to group coverage. For example, the employer could arrange coverage through a Health Insurance Network (HIN), so that the family could buy more affordable coverage through a large group—with larger risk pools rather than costly individual coverage.

Case #4

A single individual with intermitent income at the minimum wage and not eligible for Medicaid (e.g. most males or a woman who is not a mother):

[Individual Credit of $1,250]

- Under the current system, this individual has no access to health insurance, and

[1] The examples presented assume the fully-phased in program, and use 1993 income thresholds.

usually receives "unreimbursed care" through hospital emergency rooms.

- Under the President's plan, this person would receive a $1,250 transferable credit for the purchase of group health insurance through the basic State health plan, or some other private plan.

Case #5

A family of four with a modified adjusted gross income of $50,000, and a $1,000 employer contribution to health insurance:

[Health Care Deduction]

- Under the President's plan, this family would receive a health care tax deduction of $2,750 ($3,750 minus employer contribution of $1,000), making their health insurance much more affordable.

Case #6

An individual with a serious health problem is considering changing jobs, but is afraid of giving up current employer coverage:

[Portability and Security of Health Care]

- Under the current system, a person changing jobs may not be covered under a new employer's policy because of health status. A pre-existing condition exclusion may also apply, interrupting coverage.
- Under the President's plan, regardless of the employee's health status, the new insurer would be required to offer unrestricted access to the new employer's group coverage.
- In addition, insurers would not be permitted to deny coverage due to health status, and persons with previous health benefits could not be denied coverage of pre-existing conditions. (So long as no insurer can avoid pre-existing conditions, and all must accept new risks, no insurer will be disadvantaged.)

Case #7

An employer of a small firm of 20 workers would like to offer employees health insurance, but cannot find affordable coverage:

[Small Market Reforms]

- Under the current system, small employers have difficulty finding affordable coverage. The problem becomes worse when one member of a small group has a poor medical history or current high medical costs.
- Under the President's plan, small employers would have access to larger group coverage through Health Insurance Networks (HINs) spurred by major insurance and ERISA reform. Large group coverage is less expensive and more efficient, since insurance administrative costs are much lower and risk is more effectively distributed.
- In addition, the plan would set limits on the variation of premiums insurers could charge to different groups. Insurers would not be able to deny coverage to any individual, or drastically increase premiums when one member of a group becomes ill.

Case #8

A small employer with an employee just diagnosed with a serious health problem applies for health insurance for the first time:

[Guaranteed Coverage Issue]

- Under the current system, uninsured persons with serious health problems are often denied health insurance—at any price.
- Under the President's plan, insurers would be required to offer coverage to any group, regardless of health status. Premium levels would be limited so that costs would not be prohibitive.

Case #9

A family of four with a modified adjusted gross income of $17,000 has no employer coverage and currently cannot afford health insurance:

[Partial Health Credit]

- Under the President's plan, this family would receive a partial health tax credit towards the purchase of health insurance (or a $3,750 deduction—whichever provides the greater benefit) because their in-

come faces between 100 percent and 150 percent of the tax threshold.

- Affordable group coverage would be made available through a State coordinated "basic plan" pool that would guarantee access to basic health insurance coverage.

Case #10

An individual is planning on choosing a health plan and wants to get the best quality plan for the best price. But he is unsure of which plan to choose:

[Consumer Information]

- Under the current system, consumers have limited knowledge of the relative prices of insurance an health care services. Nor are they aware of the hospitals and doctors included in the plan—or of the relative quality of local hospitals and doctors.
- Under the President's plan, comparative information on quality and price of health care will be available to consumers and large purchasers of care. State insurance commissioners will collect information on area providers, and also on individual providers such as physician, hospitals, labs and other facilities—both on price and quality. This information will be made available by employers. A type of local health care market "blue book" will allow consumers to identify the best health plans, and providers. As a result, consumers will be better equipped to choose the health plan or provider best suited to their needs and the best value for their health care dollar.

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MAGIC JOHNSON, AIDS, AND BLACK AMERICA

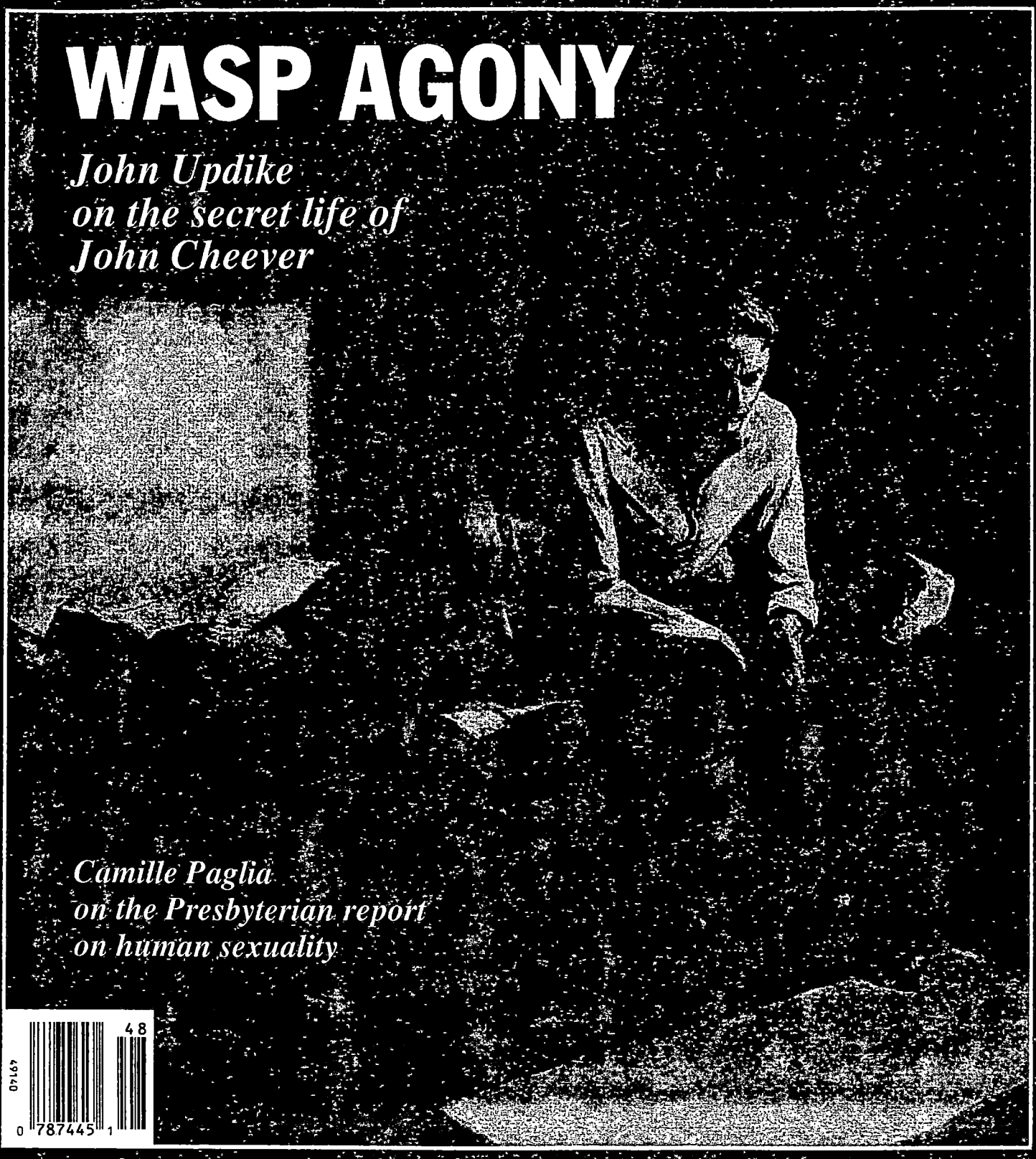
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ica's ability to exert pressure on them—whether to secure trade concessions or acquiescence to U.S. leadership—will be sharply reduced. No one wants to kick the United States out, as the administration complains. After all, it's always good to have an insurance policy. But most of them know that the Americans won't stay on indefinitely anyway. And they feel that an economically powerful European Community ought to have a greater say in its defense than a U.S.-dominated NATO allows. The Europeans do not all, of course, view the issue through the same lens. The French see a European army, based on a Franco-German core, as a way of dissuading the Germans from any temptations to act on their own. The Germans want to show that they are good Europeans who are willing to join forces with their neighbors. And the British, ever reluctant to merge their sovereignty into Europe, prefer a U.S.-dominated NATO to a European force run by France and Germany.

With the Soviets flat on the mat, the unavoidable question for Americans is: What do we get out of NATO? In the past the answer was easy: advance bases, leverage against Moscow, deference from dependent Europeans. Now the answer is different: the bases are unnecessary, the leverage irrelevant, and the deference gone with the wind. The NATO bureaucracy is still firmly in place, providing employment and pleasant European assignments for an army of military and civilian administrators. But they're now tending a monument rather than manning a battlefront.

NATO was set up to keep the Russians out of Western Europe and, as a real but unexpressed subtext, to keep the Germans in check. Now the Europeans are trying to figure out a way of bringing the Russians into a wider Europe, without bankrupting Brussels in the process, and of building a Community both tight and large enough that even the new united Germany won't dominate it.

Unfortunate though it may be, there isn't much place for NATO in all this. The Europeans know that the United States, because of budget constraints and the disappearance of the Soviet threat, is going to pull most of the GIs out of Europe. They're acting accordingly to build, through a Franco-German nucleus, a European defense force. They don't need a briefing to see that NATO hasn't been of much help in dealing with their new security problem: regional wars in the detritus of the Soviet internal and external empire. Nor is this an area in which Americans are going to expend their lives, honor, and sacred fortune. George Bush may have gotten the folks cheering for a war to liberate Kuwaiti oil, but the "freedom fighters" from Chechen-Ingush in the deepest Caucasus will be on their own. Let Moscow, or Brussels, worry about that one.

Deprived of a foe, of a mission, of a strategy, NATO, now demoted in its ambitions to such mundane and easily evaded tasks as "crisis management," will nonetheless linger on for a few more such extraneous summits, demonstrating once again that the first law of every bureaucracy is survival. •

The failings of 'managed' care.

SICK JOKE

By Robert Kuttner

On April 11, 1990, Lawrence Megge, a 34-year-old machine-part designer, rammed his car into a highway stanchion near Detroit, killing himself and his wife. Megge had repeatedly sought treatment for extreme depression, suicidal tendencies, delusion, and sexual abnormalities. He believed his boss was the archangel Michael, and that his colleagues were out to kill him. Megge's health plan, SelectCare, provided generous mental health benefits. However, in an effort to cut its costs, SelectCare had recently contracted with a company called American Biodyne, which specializes in an aggressive brand of "managed care."

Biodyne assumed SelectCare's entire financial risk for mental health claims, in exchange for a flat per-patient, per-month payment. Biodyne thus capped SelectCare's costs—and made Biodyne's own earnings dependent on its ability to keep patients out of the hospital and otherwise minimize their treatment costs. According to medical records, on two occasions Biodyne psychologists had overruled emergency room doctors who suggested that Megge be hospitalized, recommending instead that he use a drop-in therapy group, or stay in touch by phone. Megge's family says that in the two days before his death, calls to his Biodyne therapist went unreturned. They are suing Biodyne, SelectCare, three psychologists, and a psychiatrist for $21 million, for breach of contract and gross negligence. All of the defendants deny any wrongdoing.

Managed care—the free enterprise solution to medical inflation touted by the private insurance industry, the Bush administration, *The New York Times*, and conservative health experts—has more than a few glitches. In some cases, as illustrated by the Megge affair, it can pinch far too tightly and tragically deny needed treatment for which people are presumably covered. At the same time, managed care as currently practiced fails to do what its proponents claim: significantly reduce medical inflation.

Employer medical costs are rising at about 18 percent annually. At this rate health care would consume 100 percent of the gross national product by the year 2050. In response to this chronic inflation, insurance carriers, large employers, and specialty companies like Biodyne have pursued a number of cost containment strategies, all under the general heading "managed care." These include restricting what will be reimbursed; increasing subscriber out-of-pocket payments; giving subscribers

incentives to choose health maintenance organizations (HMOs), which limit doctors and treatments, rather than "indemnity plans" (traditional forms of insurance that reimburse bills); organizing networks of "preferred providers" who agree to serve subscribers at cut rates; shifting to company on-site clinics; or hiring outside "utilization reviewers" such as Biodyne who often overrule doctors in an effort to keep patients out of the hospital or limit hospital stays or promote less costly forms of treatment. Many large employers, in an effort to save money, have become self-insured, using large insurance companies such as Prudential or John Hancock simply to organize and manage their health plans but not to bear the actuarial risk. And many insurance companies now view utilization review and managed care as their most promising product line.

Some of this works well for insurer and patient alike. For example, Harvard Community Health Plan, an HMO, gently bribes healthy maternity patients to accept sixteen hours' worth of home health care visits in exchange for one night less in the hospital—cutting the health plan's costs in half and offering a sensible service to new mothers. A number of insurance companies and large corporations also provide a relatively benign version of managed care, though this is a very costly proposition. Prudential, for example, manages cases individually in its blue-chip policies; if a patient is entitled to sixty days of hospitalization, Prudential is flexible about converting that into more days of outpatient treatment while preserving the cash value of the benefit. The newer, more entrepreneurial managed-care companies promise the same flexibility at lower cost.

Unfortunately, the general trend seems to be in the direction of the more aggressively entrepreneurial brand of cost containment, which saves money not by finding the most medically appropriate means of treatment, but simply by limiting patient care. And if America ever does rise up to demand universal health insurance, it will be not because of an outbreak of solicitude for the uninsured, but because it dawns on the insured middle class that managed care is eroding the coverage they think they have.

The managed-care industry includes some 300 companies. Biodyne is typical of the new-wave firm. It specializes in cost control of mental health and substance abuse, two of the most inflation-prone areas of health care. Biodyne was founded in 1985 by Dr. Nicholas Cummings, a psychologist who spent most of his career at Kaiser-Permanente, one of the nation's oldest HMOs. The current CEO, Dr. Albert Waxman, whose doctorate is in electrical engineering, initially put up the capital to launch Biodyne and then took over as chief executive in 1989, citing concerns about marketing and quality control.

Biodyne markets a variety of managed-care products. One basic strategy is the approach offered to SelectCare—Biodyne in effect becomes the provider of mental health care with a financial incentive to economize on costs. Under this plan, Biodyne hires a small force of staff clinicians and a much larger network of contract therapists, often part time, who agree to follow the "Biodyne model," which stresses limited forms of treatment. According to Waxman, "We typically cut the hospital admits in half, and cut the average length of stay from fifteen or twenty days to six or seven." Biodyne's other basic approach is to contract with employers, insurers, or HMOs to function as a gatekeeper to insured medical treatment, reviewing doctors' decisions, discouraging hospitalizations, and limiting their duration. Biodyne's clients include Blue Cross/Blue Shield plans in Arizona, Ohio, Indiana, and Massachusetts, several Humana HMO plans in Texas and Florida, and other individual insurance companies. As the fastest-growing company in its field, Biodyne's revenues nearly tripled, from $10.7 million in 1989 to $27.7 million in 1990, and are expected to double again this year to upward of $50 million. Biodyne went public last July.

Biodyne's approach has produced an outcry from the mental health profession—some of it deserved, some of it purely self-serving. In general, Biodyne reviewers insist on visiting patients in the hospital, and a number of psychiatrists have filed complaints alleging that unqualified Biodyne personnel undermined treatment. Dr. Rigoberto Rodriquez, a child psychiatrist, was treating a depressed 12-year-old boy in the psychiatric unit of Charter Hospital in Miami. He was startled when a Biodyne case reviewer talked her way into the unit, ostensibly to review records, and attempted to persuade the patient and his parents that he would be better off out of the hospital. In San Antonio, Texas, a teenage girl was hospitalized for an addiction to heroin. According to the attending psychiatrist, Dr. John Peake, the Biodyne reviewer managed to get into the unit and suggested that the girl would be happier if she left the hospital. "She became so agitated that she had to be sedated," said Peake. "We barred the Biodyne reviewer from the unit."

According to Waxman at Biodyne, the managed-care industry is still maturing, and any such misunderstandings are to be expected in its early stage. "Our current philosophy is to provide a continuum of care," he says. "The basic idea is to keep moving patients to the most appropriate and most cost-effective level of care." Waxman adds that "we don't make decisions about hospitalization without consulting a psychiatrist. It's not our job to talk the patient out of going into the hospital. If that's what we said, that's wrong." Waxman says Biodyne is now organizing comprehensive mental health networks in several states—everything from crisis intervention to hospitalization to day treatment to outpatient therapy and "wellness" programs. However, for the most part this ideal is still more a vision than a reality, and because of the intense pressure to cut costs, managed firms that take this high road risk losing business to competitors that market mainly reduced costs.

Ironically, this round of medical entrepreneurship, which is selling cost containment, stems partly from the

trend of for-profit psychiatry that flourished in the 1980s. Because insurance policies were typically generous with hospital benefits and stingy with other forms of treatment, private psychiatric hospitals proliferated in the 1980s, and the less scrupulous ones aimed to maximize hospital stays. "It's a bit like the S&L scandal," says one psychiatrist. "The sharks spoiled it for everybody. Now the crackdown is hitting even the people who need treatment—the deserving cases—just like the credit crunch is hurting legitimate businesses."

The law is very murky on who is ultimately responsible when a bad decision by a reviewer harms a patient. Insurance policies provide coverage of treatment that is deemed "medically necessary." Before the cost containment era, that judgment was left to the doctor. But now the insurance industry and its managed-care allies argue that if an insurance reviewer makes a misjudgment, it is up to the doctor and the hospital to appeal it, and even to hospitalize the patient at their own expense if they think it medically essential. "If the physician thinks the patient should be put in the hospital, he has the ultimate call," says Waxman.

Although insurance companies are heavily regulated, due to quirks in the law, managed-care companies such as Biodyne are largely unregulated. In response, several states have enacted such minimal consumer safeguards as requiring the use of qualified medical personnel and a clear procedure for appeals. And the managed-care industry, meanwhile, is attempting to pre-empt government regulation by policing itself. Last spring the American Managed Care and Review Association set up a group called the Utilization Review Accreditation Commission (URAC), to set minimal standards and drive out sleazy operators. To date, about 170 managed-care companies have applied for URAC accreditation.

But even if the managed-care industry does clean up its act, it is doubtful whether this approach, grafted onto a patchwork system, can cure medical inflation other than by reducing care. Dr. Roger Taylor, the physician and health policy consultant who organized URAC, admits that managed care by itself can reduce medical inflation by only a few percentage points—in part because of the pressure to replace hospital benefits with other benefits. The underlying forces driving inflation in health care, according to Taylor and other experts, are the shifting of costs from the uninsured parts of the system to its insured parts; the largely unregulated use of ever more expensive technology; the demographics of an older and sicker population; the fact that the present system largely rewards medical providers in proportion to how much they can bill; and the fact that the overall system has numerous missing links. Managed care, by itself, can't make up for those gaps until the overall system insures everybody. As a result, the system often treats patients in the most expensive venues—emergency rooms and psychiatric hospitals—because nobody is willing to pay for less expensive settings. As Taylor observes, "HMOs tend to attract younger, healthier patients, leaving traditional indemnity policies and Medicare with older, sicker patients. High-quality emergency rooms and trauma centers are being overwhelmed by the high percentage of indigent care they provide. You need a universal payment policy to avoid cost-shifting, and a national approach to reviewing new technology to make sure it adds value."

Obviously a universal system would also have to manage care. Every universal system does precisely that. But only in a system comprehensive enough to ensure the most appropriate treatment option at the least possible cost is genuine managed care—rather than cost shifting and case dumping—realizable.

Unfortunately, benign, paternalistic companies with long-term commitments to their employees are a vanishing breed. Although it is possible to construct what amounts to social medicine in one company, few companies seem willing to bear the expense; most are more interested in shedding costs. And, as Taylor observes, "While some individual companies have excellent, comprehensive managed health care systems that get the rate of inflation down to about 10 percent, one employer just can't control all the underlying factors as an individual employer."

Any system of medical care necessarily entails some form of rationing; our system also cries out for some rationalizing. The best alternative is one that internalizes the hard choices to clinic and hospital, rather than using an external, for-profit reviewer. That describes a well-run HMO; it also describes most universal health systems, in which hospitals are given overall annual ("global") budgets, populations to serve, and then are told to go out and deliver the best possible medicine within those constraints. These systems reap cost savings by driving out the inefficiency, not by driving out the care. Yet as generous companies keep being squeezed by competitive pressures, the trend is for the bad brand of managed care to drive out the good.

The New York Times thinks "managed competition" is the answer to America's health problems. In a series of editorials, most recently on October 29, the *Times* hails corporations and insurers with the market power to ratchet down costs, and paints a rosy picture of managed competition leading to greater consumer choice. But the *Times* fails to acknowledge that the competition occurs at the level of companies like Biodyne competing with one another by promising to save insurance carriers and corporations money—not at the level of the individual shopping around for the best policy. Too often the consumer is locked in to his present plan by worries about a pre-existing medical condition, or by the fact that blue-chip policies are beyond his pocketbook, or because he's stuck with whatever deal his employer made. Lawrence Megge, for one, did not reap any benefits from managed competition. All health systems will involve some form of case management. It remains to be seen whether our approach will squeeze out costs, or just squeeze out care. •

Health & Welfare Practice
Legal & Research
Ed Davey & Henry Saveth

July 15, 1991

EMPLOYER-SPONSORED HEALTH COVERAGE FOR THE 1990s: PLAY OR PAY?

1. Summary

A key group of Senate Democrats has introduced a bill that would impose a "play or pay" health benefit program on employers. Employers would have to either "play," by giving employees a minimum level of health benefits, or "pay," by contributing to a government-sponsored insurance plan. People not covered by an employer plan, including the unemployed, would participate in a public plan called AmeriCare. The legislation also includes a comprehensive program intended to control health care costs.

Since most larger companies already provide benefits equal to the proposal's mandated minimum (except, possibly, preventive benefits), the required benefits may not be a problem for them. Of greater concern is whether the public plan would create a larger than anticipated deficit and whether new health benefit taxes would be used to finance such a shortfall. Finally, whether the initiative's ambitious cost containment provisions would work is questionable.

2. Political Outlook

The proposal certainly puts universal health coverage into play. However, many think the old adage, "When all is said and done in Washington, much is said, but little is done," applies to this proposal. Indeed, although the measure's sponsors deny it, some cynics feel that the initiative is designed not to pass this year, but to inject the health care issue into the 1992 presidential campaign.

A key difficulty with the measure is that first-year operation would cause an estimated $6 billion revenue loss. And under last year's pay-as-you-go budget agreement, passage couldn't occur without accompanying revenue gains or spending cuts. A logical revenue target would be a limit on tax-free employer-paid medical premium, but both labor and management would strongly object to this approach.

Republicans point out that the bill resembles the Pepper Commission Report, which not even all Democrats endorsed. Some also say the bill is a mere political ploy designed to provoke the President's veto, which would be used to claim he is against health. The White House has responded to the initiative with what has been called a blank stare. For their part, the various constituencies of the health care community have greeted the proposal with polite but unenthusiastic applause.

Congress, having only recently suffered a case of political indigestion as a result of Medicare Catastrophic and Section 89, may prefer to nibble around the edges of this Big Mac of an issue, rather than try to swallow it whole.

3. Playing

The legislation covers employers subject to the minimum wage provisions of the Fair Labor Standards Act of 1938. State and local governments are specifically included.

For employers who "play," rather than pay the "tax" described below, the bill sets out a fairly standard medical benefit structure that would have to be provided for employees.

A variety of special rules (not included in this release) would apply to employers with fewer than 100 employees.

- o Eligibility

  Employees who work at least one hour a week (and their families) must be eligible after a waiting period of no more than 30 days. During the waiting period the employee can purchase coverage by paying the combined employer and employee premium.

- o Benefits: Mandatory "basic plan" provisions

  These expenses for "basic benefits" would have to be covered:

  Inpatient/outpatient hospital care and physician charges, diagnostic tests, prenatal and well baby care (under 12 months old), certain preventive services (well child care, Pap smears, and mammograms), and mental illness benefits. Inpatient care for mental illness could be limited to 45 days annually, outpatient care to 20 visits annually; the employee copayment share for outpatient care could be as high as 50 percent.

- o Cost Sharing

The following "standard" cost sharing items are suggested, but they could be varied under an actuarial equivalence rule described on page 3.

- Deductible

  In general, annual deductibles would be capped at $250 for individuals and $500 for families. Both amounts would be indexed yearly for consumer price increases. As an alternative, other deductible structures that don't exceed 1 percent of wages (2 percent for family coverage) could be used.

- Copayments and Out-of-Pocket Limit

  For the basic benefits, the employee's copayment share couldn't exceed 20 percent. The copayment and deductibles would be subject to an out-of-pocket limit of $3,000. As an alternative, an annual 10 percent of pay out-of-pocket limit would be permitted. While the $3,000 limit would be indexed for inflation, it would be the same amount for individual or family coverage.

  Special rules would apply to mental illness (previously specified), out-of-plan services under plans with preferred providers, and for utilization review penalties.

- Employee Contributions

  Employee contributions couldn't exceed 20 percent of total premium. (Employers would pay at least 80 percent.) A special discounted premium rate would have to be figured when dependent spouses have other primary coverage.

  An employer could withhold employee contributions from wages. Any state laws that might prevent this without employee consent would be preempted. Special prorated contribution rates would apply to employees who work fewer than 25 hours a week.

- Managed Care

  Managed care programs and fee schedules that provide reasonable access to benefits generally wouldn't be considered as violating the minimum benefit requirements of the basic plan.

- Alternative Plan Designs: Actuarial Equivalence

  Employers would have to offer all of the basic benefits. Some flexibility could be available, however, in setting employee

contributions, deductibles, coinsurance, and out-of-pocket limits. If the actuarial value of a particular plan's benefits were greater than that of a plan with the standard cost-sharing provisions, the cost-sharing provisions could be varied. Thus, a plan with a lower deductible could have a higher out-of-pocket limit. Also, a plan providing extra, non-mandated benefits could ask employees to pay a larger share of the premium or a higher deductible. But the plan would have to retain some out-of-pocket limit, couldn't lengthen the prescribed eligibility waiting period and, as indicated, would have to include the prescribed basic covered services. For mental illness a "reasonable combination" of both inpatient and outpatient charges would have to be covered in an amount actuarially equivalent to the "standard" mental health benefit.

Employers who don't like the standard cost-sharing design could use the actuarial equivalence provision instead. These employers could use their current plan's additional optional benefits (presumably including dental and prescription drugs) as justification for designing their own, nonstandard cost-sharing features. The legislation would establish an actuarial equivalence advisory board (no pay but they would get bus fare) to develop guidelines.

o Exclusions

The legislation would permit plans to exclude: items and services that aren't medically necessary, routine physical examinations and preventive care not specifically required as basic benefits, and experimental treatments.

Basic benefits couldn't otherwise be limited in amount, scope, or duration (that is, no "inside" or "outside" limits). However, regulations would allow some limits on preventive services on the basic benefits list.

Preexisting condition limitations wouldn't be allowed.

- Benefits Mandated by State Law

The bill would amend ERISA to preempt state laws mandating benefits for insured plans that meet the proposal's requirements. Self-insured plans would continue with existing ERISA preemption rules.

o Subsidies for Lower-Income People

The public plan, described below, would subsidize premiums and cost-sharing amounts lower-income people would otherwise be responsible for.

4. Paying: The Public Plan

Instead of providing employee coverage themselves, employers could elect to contribute to a state-administered public plan covering their employees. The contribution would be about 5 - 8 percent of payroll, with 7 percent viewed as most likely. Employees would contribute 20 percent of the actuarial value of coverage. Lower-income people (earning under $27,000 for a family of four) would be subsidized by the public plan.

Public plan benefits would be essentially the same as the basic private plan's. Because medical benefit cost is related more closely to demographics other than salary (for example, age), employers with a high concentration of low-paid employees may find it more economical to pay into the public plan than to provide their own coverage. This would be particularly true if the workforce were both older and lower paid.

In addition to covering people for whom employers contribute, the public plan would cover the unemployed and would replace Medicaid (except for long-term care benefits).

A major concern about the public plan is whether the employer contribution could stay within the predicted 5 - 8 percent range. The employer contribution looks an awful lot like a payroll tax. Under the constitution only Congress can authorize taxes. However, this bill would delegate authority to raise the contribution tax to the Secretary of Health and Human Services. Some fear that antiselection and other factors would result in poor experience in the public plan and sharply escalating employer contributions, which HHS could quickly increase without Congressional approval. A more general concern, one observer noted, is that any government insurance plan (whether state, federal, or combined) would be administered with the efficiency of the Post Office, the cost-effectiveness of the Pentagon, and the compassion of the IRS.

5. Cost Containment

A special concern of the legislation's sponsors is cost containment. They hope that one result of the bill's universal coverage provisions would be to reduce the high fees that providers charge people who can pay, to make up for "uncompensated care" (expenses incurred by people who can't pay).

A major portion of the legislation (110 pages) is devoted to specific initiatives designed to contain costs.

The bill takes a three-pronged approach by attempting to regulate unnecessary care, administrative costs, and price and utilization.

Reducing Unnecessary or Ineffective Care

The government would develop provider practice guidelines, and government programs would be required to follow them in utilization review activities.

Providers who are certified by state agencies as "practicing efficient, quality care" would be exempt from insurer utilization review.

Technology assessment and managed care also would be encouraged. State barriers to managed care would be preempted. Small business and the public plan would be guaranteed access to managed care techniques.

Eliminating Unnecessary Administrative Costs

The legislation's sponsors feel that mandated standardized claim forms would be easier for doctors and other providers to complete, and therefore would reduce costs. Additional administrative savings are projected from the elimination of medical underwriting (evaluation of insurance applicants' health) and more stable coverage (avoiding plan installation and termination costs) in the small business market.

Small insurance companies would be required to combine into consortia for claims processing to achieve economies of scale, facilitate electronic processing, and reduce the number of different insurers health care providers must deal with. It appears that the consortia boards of directors would be made up of insurers, providers, and consumers appointed under state guidelines.

Price and Volume Controls

An independent agency (to be called the Federal Health Expenditure Board and intended to have the stature and independence of the Federal Reserve Board) would be established to set national and local health expenditure goals, in total and by health care industry sector. The Board would convene providers and purchasers to conduct negotiations on rates and other

methods of achieving expenditure goals. Negotiators could recommend adjustments of the goals. The Board would publish recommended rates and other measures to achieve the goals for purchaser and provider use. Recommended rates and other measures would be binding (i.e., enforceable by civil penalties on providers) if negotiations were successful, but apparently could be overridden by the state- level consortia of insurance companies, which could use other methods to achieve the Board's goals.

The Board also would release data to help consumers evaluate provider quality and efficiency.

Experimental programs for reducing abuse of the medical malpractice system and research for general cost control would be established.

6. Implications

Much of the employer community has accepted, at least in theory, the concept of "play or pay." They understand that a failure to provide coverage for the approximately 35 million (mostly employed) uninsured people within the current system will spark demands for a government takeover of the private health insurance industry. But since most large companies already provide at least the minimum mandated benefits required under the proposal, the new law would have very little effect on them.

The government's attempts to contain costs systemwide is sure to stir wider concern, however. The problem of the uninsured is caused primarily by the high cost of health care. If the government's cost containment program isn't effective, the larger issue of skyrocketing costs will remain unresolved. And the prognosis for this program is iffy at best.

Under the bill, the government would develop practice guidelines, partially effective in 1992, for clinical conditions that "have a significant variation in the frequency or type of treatment provided." This is a worthy goal since it is intended to promote consistency and quality in medical standards. However, the field of practice guidelines is still very much in its infancy and it is hard to see how they can significantly reduce the cost of thousands of different clinical treatments in the near future.

The proposal also would empower state agencies to certify some providers as "practicing efficient, quality care," exempting them from utilization review activities. Again, this is a worthy goal, but the standards necessary to measure efficiency and quality are today quite fuzzy.

Finally, the proposal would establish an independent agency to set national and local health expenditure goals and negotiate with providers and payors on the methods necessary to achieve these. This would represent a significant expansion of federal regulatory powers in setting payment rates, which to date has largely been left to the states. In fact, the federal government would be wise to study further the systems a few states have designed to achieve these exact goals -- with mixed results at best.

In sum, the Democratic proposal would solve the problem of the uninsured --though at what long-term cost we don't know. Although the cost containment goals are admirable, the efficiency and quality standards on which they are based are essentially undeveloped at this point. In addition, regulating payment rates as a means of controlling costs has a dubious track record at best.

7. Conclusion

The 350-page bill is an ambitious attempt to address one of the most difficult issues of the 1990s. Some feel the bill's magnitude would require a national debate, perhaps in the context of a Presidential campaign, before Congress could act. Others say the nation's health care needs shouldn't depend on election dates. It has even been suggested that given the divergence of opinion and political nature of the controversy, we could wind up with an exhaustive debate on an initiative that dies with a presidential veto. As one politician noted, the problem is largely defined by the fact that the vast majority of Americans wants a high quality, widely available health system, but an even larger majority doesn't want to pay for it.

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fuel assistance, library hours, fire protection services, and other programs at the same time that they must spend thousands and sometimes millions of dollars to address problems associated with drinking water contamination and sewage treatment.

I wish there was a way we could help all communities facing these problems, not just those under 5,000 in population. However, I certainly understand the need to establish a reasonable cutoff point at this time in order to set up a workable program, and in Maine this standard will cover about 90 percent of Maine's communities. I will continue to work on solutions to the financial burdens faced by Maine's larger communities in the hope of devising a reasonable approach to compliance with Federal environmental laws.

I believe Maine's small communities and their residents will benefit significantly from the provisions of the STEP Act. A priority sysem needs to be established so that the most important work is accomplished first. Towns will still have to comply with the laws that have been enacted to address serious water, sewer, toxic waste, and other problems. However, ratepayers—especially the elderly and poor—will not be too heavily burdened with increased costs under this legislation. A more reasonable and gradual approach to compliance will relieve these citizens from the burden of immediate rate increases of 50 percent, 100 percent, and more.

Senators JEFFORDS and CONRAD are to be commended for their initiative on this issue. I am joining them in their effort because I believe small towns need some real assistance in dealing with the many requierments they face now and will continue to face in the future. This legislation is a starting point for discussion on this issue, and we welcome all comments in an effort to provide the best solution to this difficult problem.

I hope this legislation will receive the attention it deserves in the Senate, and I commend it to my colleagues for their consideration.

By Mr. MITCHELL (for himself, Mr. KENNEDY, Mr. RIEGLE, and Mr. ROCKEFELLER):

S. 1227. A bill to amend the Public Health Service Act, the Social Security Act, and the Internal Revenue Code of 1986 to provide affordable health care of all Americans, to reduce health care costs, and for other purposes; by unanimous consent ordered held at the desk until the close of business on June 7, 1991.

HEALTHAMERICA: AFFORDABLE HEALTH CARE FOR ALL AMERICANS ACT

Mr. MITCHELL. Mr. President, today I join with a number of my colleagues to introduce comprehensive legislation to reform the Nation's health care system to assure access to affordable health care for all Americans.

This legislation is the culmination of nearly 2 years of work by the Senate working group on the uninsured, and reflects input from a wide range of interest groups including health-care providers, insurers, consumer groups, the States, and many others.

Access to affordable, quality health care should be a right for all Americans, not merely a luxury for those who have the economic means to purchase health insurance. As many as 37 million Americans have no health care coverage, and millions more have insurance coverage which is inadequate to protect them against the costs of serious illness.

Furthermore, the rising cost of health insurance threatens coverage for all who are currently insured. The Department of Labor estimates that nearly 1 million Americans lose their health insurance coverage each year, often because their employers drop coverage because of the rising costs of premiums, or because insurers refuse to cover persons with preexisting conditions.

The problem of the uninsured is not principally a problem of the poor; the Office of Management and Budget estimates that 70 percent of the uninsured are above the poverty level.

Nor is the lack of health insurance coverage principally a problem if the unemployed—two-thirds of the uninsured are working persons or their dependents whose jobs do not provide what was once considered a routine benefit—health insurance.

One-third of the uninsured are children—one of four children in the United States has no health insurance. If we ignore the health care of our children now, it will cost us more to deal with the effects later.

The underlying crisis in our Nation's health care system is the rapidly rising cost which is eroding the very foundation of the system for all Americans, regardless of income.

Clearly, the tremendous amount of money our Nation is spending on health care is not buying quality health care for all Americans. We must find a way to bring health care costs under control or we risk adding millions more to the rolls of the uninsured, and ultimately face a total collapse of the health care system.

In 1990, the United States spent $671 billion on health care, approximately 12.2 percent of gross national product, up from 11.6 percent—$604 billion—in 1989. Real per capita health expenditures have not only risen dramatically in the United States, they have also far exceeded the per capita expenditures of all other industrialized nations.

The United States per capita spending on health is approximately one-third higher than Canada's, double the spending of Japan and the former West Germany, and three times the amount spent in the United Kingdom.

Yet, in spite of the amount of GNP spent on health care and our Nation's advances in medical treatment and technology, our health outcomes compare poorly with many other industrialized nations. When the United States is compared with Canada in health status, the Canadians fare better in lower infant mortality rates, lower maternal mortality rates, lower mortality rates for low-risk and moderate-risk surgery, and higher life expectancy for both men and women.

It is not enough that we find a way to add those who are uninsured to the existing health care system. We must make fundamental reform in that system including effective cost containment efforts and insurance market reform.

I believe we must build upon the existing public-private health care system which asks employers to share the responsibility of providing access to health care for their employees and their dependents.

Currently that burden is not shared equitably by all employers. While it is often difficult for small businesses to provide health coverage to their employees and their dependents, most already do so. Health insurance coverage is offered by 80 percent of businesses with 25 or fewer employees; coverage is offered in 46 percent of businesses with 10 or fewer employees.

Unfortunately it has become more difficult and more expensive for small business to insure their employees. If we are going to expect small business to provide health coverage to their employees, we must make it more affordable do so.

The legislation we are introducing today will require all employers to either provide private health insurance to their employees or contribute to a public program which will provide coverage. This "play or pay" model will be phased-in over a 5 year period in an effort to give small employers an opportunity to adjust to the new requirement.

Businesses with employees between 25 to 100 will be required to play or pay after 4 years of the bill's enactment if fewer than 75 percent of employees in small businesses not previously insured are not covered. This requirement also applies to firms with fewer than 25 employees after 5 years.

The legislation also includes a number of provisions which are intended to provide financial assistance to small businesses in the form of tax credits to help them adjust to the new requirements.

Small businesses with fewer than 60 employees would be provided with a 25-percent credit on the first $3,000 of health insurance expenses for each full-time employee with an income under $20,000, except for high-profit firms. The 25-percent tax credit would be in addition to the deduction currently available for the cost of such insurance.

The bill also increases the tax deduction for self-employed firms from 25 to

100 percent for the cost of health insurance. New businesses will be given a grace period of 2 years with no play or pay requirement. In the third year, new businesses will pay one-half of the payroll contribution.

Small businesses that have not previously provided coverage will be allowed to use Medicare reimbursement rules for the first 5 years. Medicare rules will result in lower costs to businesses purchasing private insurance for their employees.

In addition, this legislation includes a provision to reform the small group insurance market. This reform is critical to small businesses who currently cannot afford insurance or whose employees are excluded from coverage because of preexisting conditions.

The insurance market reform provisions will provide for the continued regulation of health insurance by States within new, Federal standards. The Federal standards are designed to remove barriers to access to group health insurance, promote equity in insurance premiums, and improve the affordability of coverage for small employers.

While this legislation places significant responsibility on employers to expand access to health insurance through the workplace, it recognizes that the Federal and State governments must share the burden in reforming the health care system and assuring access to care for all of our citizens. Even under the best case scenario, not all Americans will have access to employer-based health insurance.

Therefore, our legislation also reforms and expands the existing public program. A new public program called AmeriCare, will replace the existing Medicaid Program for all services except long-term care. All persons who are not eligible for employer-based health insurance will be eligible to receive health benefits through AmeriCare.

AmeriCare is a dramatically new public program. Federal standards will be set for eligibility, benefits, and reimbursement. Traditional categorical eligibility and income requirements for eligibility under Medicaid will be eliminated under AmeriCare.

Benefits under AmeriCare will be identical to those provided in the employer-based basic benefit package. Persons with incomes below 100 percent of poverty will have their out-of-pocket costs completely subsidized by the Federal Government. Persons with incomes between 100 to 200 percent will have out-of-pocket costs subsidized on a sliding scale.

Most importantly, provider reimbursement rates will be set using Medicare rules. This improvement in reimbursement will eliminate the problem of access to providers currently faced by Medicaid beneficiaries.

We propose that AmeriCare be jointly financed by the Federal and State governments with administration at the State level. Because we are concerned about the financial burdens faced by many States, our proposal includes an enhanced Federal match for AmeriCare, to be phased-out after 5 years.

While this legislation is primarily intended to assure access to health care for all Americans by assuring each person a means of payment for care, we are aware some persons with health insurance coverage may not have access to a delivery system, particularly in rural or urban underserved areas.

In an effort to respond to this problem, we have included a provision to expand the Community Health Centers system throughout the United States, which includes both rural and urban centers. While this expansion does not fully address the problems with the current health-care delivery system, it is an attempt to recognize the problem and begin to improve access to health-care providers for persons in medically underserved areas.

If this legislation is to accomplish our goal of providing quality, affordable health care for all Americans it must have as its underlying foundation meaningful cost containment. The cost containment provisions included in this bill are intended to put in place a structure which will result in significant reductions in the rate of increases throughout the system.

Over the last decade a variety of cost containment strategies have been attempted by both the government and private sectors. These strategies have had mixed results, but overall there appears to have been little impact on the growth in total health spending.

In the development of this legislation, we have evaluated these cost containment strategies and have sought additional ones. It is important that we look at the entire health care system—at both the price and volume of services. In the past, controlling costs in one segment of the health-care market has often meant cost shifting to other payers.

Our legislation includes the establishment of a National Health Care Expenditure Board, designed as an independent agency which establishes voluntary annual goals for national health care expenditure totals and convenes negotiations between purchasers and providers of care.

Working in conjunction with the National Health Care Expenditure Board, each State will be required to establish a State consortium, which must enroll insurers with a small share of the market for the purpose of reducing administrative costs. State consortia may add optional functions including negotiating rates for providers and allocation of capital, among other functions; within the overall annual goal set by the National Health Care Expenditure Board.

In our effort to contain health-care costs, we must have better information about what we as a nation want to pay for. We must assure that each dollar spent gives us its best return. I believe that we can get more value for the over $600 billion we spend each year on health care.

It is estimated that between 10 to 30 percent of treatment for illnesses provided by physicians is either unnecessary or ineffective.

We believe that the outcomes research initiatives being conducted through the Agency for Health Care Policy and Research, will improve the quality of care while reducing or eliminating unnecessary or ineffective treatments. Therefore, our legislation includes an expanded effort for outcomes research and the development of practice guidelines.

Similarly, we must evaluate new and existing technology in the same way if we are going to control the rapidly escalating costs of MRI's, CT Scans, and other revolutionary technologies in medicine.

Our bill includes an expanded effort in technology assessment through the Office of Technology Assessment and with Federal grants to private entities to encourage research in the private sector. The information gathered through the improved technology assessment would be taken into consideration by both public and private payers in setting reimbursement for technology and making decisions about coverage.

The legislation also includes managed care initiatives in both the private sector and in AmeriCare.

While there are different estimates as to the extent of the problem—we are convinced that the administrative costs of the existing private health care industry are excessive. We believe that cost savings can and must be achieved in this area and have therefore, included a provision to require the Secretary of Health and Human Resources to collect, analyze and disseminate data and move toward uniform billing and electronic claims processing.

Our Nation's health care system is on the critical list. If we do not work together in good faith to control the soaring costs of care and to provide access to care for millions of Americans now uncovered, we will all fall victim to the collapse of the system.

Reforming the health care system will be difficult. While most believe there is a serious problem, few can agree on the solution. A perfect solution does not exist. Some argue that the United States should adopt a Canadian model. Others argue that tax incentives to businesses with no requirement to provide coverage is the answer.

The legislation we are introducing today represents a compromise between those two views, keeping in mind our own traditions and values as Americans. A new health care system for our Nation must be developed based on our own needs, history and

traditions. Every nation with comprehensive health care for all of its citizens has developed a system over time which is unique to that nation. These systems have evolved as our system must evolve.

I believe the time to act is now. Health care reform is critical if we are going to assure that all Americans are ready for the challenges of the 21st century. Children must be healthy and alert in order to learn. As our citizens live longer we must assure that their health is good and their lives are productive.

I look forward to working with my colleagues in the Congress to enact meaningful health care reform in this Congress. I challenge the Bush administration to work with the Congress to accomplish this goal which is vital for the future of our nation.

I ask unanimous consent that a summary of the bill, and the text of the bill be printed in the RECORD.

There being no objection, the material was ordered to be printed in the RECORD, as follows:

S. 1227

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,

SECTION 1. SHORT TITLE; TABLE OF CONTENTS.

(a) SHORT TITLE.—This Act may be cited as the "HealthAmerica: Affordable Health Care for All Americans Act".

(b) REFERENCE TO ACT.—Hereafter this Act may be referred to as the "HealthAmerica Act".

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

Sec. 1. Short title; table of contents.

TITLE I—AMENDMENTS TO PUBLIC HEALTH SERVICE ACT

Sec. 101. Basic health benefits for employees and their families.

Sec. 102. Obligation to secure health insurance.

TITLE II—REQUIREMENTS FOR HEALTH BENEFIT PLANS

Sec. 201. Requirements for health benefit plans.

TITLE III—SPECIAL ASSISTANCE FOR SMALL AND MEDIUM-SIZED BUSINESS

Sec. 301. Preemption of State mandated benefit laws.

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Sec. 411. Federal Health Expenditure Board.

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Sec. 421. State purchasing consortia.

Subtitle D—Cost Control Grant Program

Sec. 431. Cost Control Grant Program.

Subtitle E—Malpractice Reform

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Sec. 451. Establishment of a quality improvement board.

Subtitle G—Use of Practice Guidelines in Federal Health Insurance and Service Programs

Sec. 461. Use of practice guidelines in Federal health insurance and service programs.

Subtitle H—National Standards for the Promotion of Managed Care

Sec. 471. National standards for the promotion of managed care.

Subtitle I—Expansion of Technology Assessment

Sec. 481. Expansion of technology assessment.

TITLE V—CONTRIBUTION TO PUBLIC PLAN BY EMPLOYERS NOT PROVIDING HEALTH COVERAGE

Sec. 501. Contribution by employers not providing required private health benefit plans.

TITLE VI—ASSURING PROVISION OF HEALTH BENEFITS TO ALL AMERICANS

Sec. 601. Establishment of AmeriCare.

TITLE VII—DEVELOPMENT OF HEALTH SERVICE CAPACITY

Sec. 701. Grants for expansion of availability of primary care services.

TITLE VIII—EFFECTIVE DATE

Sec. 801. Effective date.

Sec. 802. Policy respecting additional benefits.

TITLE I—AMENDMENTS TO PUBLIC HEALTH SERVICE ACT

SEC. 101. BASIC HEALTH BENEFITS FOR EMPLOYEES AND THEIR FAMILIES.

(a) REQUIREMENT.—The Public Health Service Act is amended—

(1) by redesignating title XXVII (42 U.S.C. 300cc et seq.) as title XXVIII; and

(2) by inserting after title XXVI the following new title:

"TITLE XXVII—BASIC HEALTH BENEFITS FOR EMPLOYEES AND THEIR FAMILIES

"PART A—REQUIREMENTS OF HEALTH BENEFITS

"SEC. 2701. HEALTH BENEFITS.

"(a) REQUIREMENT.—

"(1) IN GENERAL.—Except as provided in part B, each employer shall—

"(A) enroll each of its employees (other than part-time employees) and their families in a health benefit plan in accordance with part B; or

"(B) make a contribution under title V of the HealthAmerica Act, for the coverage for such employees and their families under the public health insurance plan established under title XXI of the Social Security Act.

"(2) PART-TIME EMPLOYEES.—In meeting the requirements of paragraph (1) with respect to part-time employees, an employer may, except as provided in part B—

"(A) enroll all of its part-time employees and their families as required under paragraph (1)(A); or

"(B) make a contribution to the public health insurance plan referred to in paragraph (1)(B) on behalf of all such employees.

"(3) LIMITATION.—An employer providing health insurance coverage for pregnancy-related services and for services for children in the 1-year period prior to the date of enactment of this section may not terminate coverage for such services or reduce the financial contribution provided for the cost of coverage for such services prior to the time such employer is required to provide or contribute to coverage under paragraph (1).

"(b) COORDINATION WITH PUBLIC HEALTH INSURANCE PLAN.—An employer making a contribution for coverage under the public health insurance plan as provided for in subsection (a)(1)(B) shall follow such procedures as the Secretary may prescribe to facilitate the enrollment of its employees in such public health insurance plan. Such procedures shall include—

"(1) the distribution of enrollment forms and information to employees;

"(2) notifying in writing each employee of the availability of premium and cost-sharing subsidies for low-income families;

"(3) notifying the State in which an employee resides concerning the identity of an employee on behalf of whom a contribution is being made;

"(4) submitting enrollment forms and information to the State agency administering the public health insurance plan established under title XXI of the Social Security Act on behalf of the employee and the employee's family, if required by the State in which the employee resides;

"(5) withholding, in the form of payroll deductions, an employee's share of the public health insurance plan premium and submitting such withholding to the administering State agency on behalf of the employee, if required by the State in which the employee resides; and

"(6) notifying the appropriate administering State agency of the public health insurance plan when an employee ceases to be an employee.

"(c) ENFORCEMENT.—Any employer that does not comply with subsections (a) and (b) shall be subject to section 2732.

"(d) DEFINITIONS.—The terms used in this section shall have the meanings prescribed for such terms by section 2713.".

(b) CONFORMING AMENDMENTS.—

(1) Sections 2701 through 2714 of the Public Health Service Act (42 U.S.C. 300cc through 300cc-15) are redesignated as sections 2801 through 2814, respectively.

(2)(A) Sections 465(f) and 497 of such Act (42 U.S.C. 286(f) and 289(f)) are amended by striking out "2701" each place that such appears and inserting in lieu thereof "2801".

(B) Section 305(i) of such Act (42 U.S.C. 242c(i)) is amended by striking out "2711" each place such appears and inserting in lieu thereof "2811".

SEC. 102. OBLIGATION TO SECURE HEALTH INSURANCE.

(a) FEDERAL PROGRAMS.—Beginning with the seventh full year after the date of enactment of this Act, to be eligible for benefits under a Federal program, an individual seeking benefits under such program shall certify to the administrator of such program that such individual and the dependents of such individual possess health insurance coverage that meets the applicable minimum standards under this Act.

(b) INTERNAL REVENUE EXEMPTIONS.—To be eligible to claim the exemption amount to which an individual is entitled under section 151 of the Internal Revenue Code of 1986, such individual shall certify, as part of the personal income tax return filed by such individual with the Internal Revenue Service, that such individual is covered under a health insurance plan that meets the applicable minimum standards under this Act. A parent shall make such certification on behalf of a dependent child.

TITLE II—REQUIREMENTS FOR HEALTH BENEFIT PLANS

SEC. 201. REQUIREMENTS FOR HEALTH BENEFIT PLANS.

Title XXVII of the Public Health Service Act (as added by section 101) is amended by adding at the end thereof the following new part:

"PART B—REQUIREMENTS FOR HEALTH BENEFIT PLANS

"Subpart 1—Requirement and Definitions

"SEC. 2711. REQUIREMENT TO ENROLL EMPLOYEES AND FAMILIES.

"(a) IN GENERAL.—This part shall apply to employers required to enroll employees and their families in health benefit plans under section 2701(a).

"(b) TYPES OF PLANS PERMITTED.—Except as required under chapter 2 of subtitle A of title III of the HealthAmerica Act (relating to small and medium-sized business insurance), an employer may meet the requirements of this part by means of enrollment in any health benefit plan.

"(c) EXCEPTION FOR EMPLOYERS IN HAWAII.—Employers that have employees in the State of Hawaii shall be exempt from the requirements of this part with respect to such employees, for so long as the Hawaii Prepaid Health Care Act (Hawaii Rev. Stat. Chapter 393) remains in effect. This subsection shall not apply if the proportion of the population with health care coverage provided under such Act that is at least actuarially equivalent to the coverage required under this title is, or becomes, less than that required to be provided in other States under this title or the HealthAmerica Act.

"SEC. 2712. COVERAGE OF EMPLOYEES AND FAMILY MEMBERS.

"(a) REQUIREMENT.—Except as permitted under subsections (b) and (d) and section 2723(c)—

"(1) the enrollment of an employee in a health benefit plan under this part shall include the enrollment of the family of such employee in the plan; and

"(2) the enrollment of an employee or the family of an employee in a health benefit plan may not be waived by the employee.

"(b) EXCEPTIONS TO AVOID DUPLICATE FAMILY COVERAGE.—

"(1) SPOUSE OR PARENT EMPLOYED.—An employee may waive enrollment in a health benefit plan under this part for the spouse or a child of the employee but only for such period as the employee demonstrates that such spouse or child, respectively, is actually covered under a health benefit plan.

"(2) CHILD EMPLOYED.—A child who is employed (or a parent on behalf of the child) may waive enrollment in a health benefit plan provided by the employer of such child during any period in which the child otherwise is covered under a health benefit plan.

"(c) NONDISCRIMINATION BASED ON FAMILY STATUS.—An employer shall not fail or refuse to hire, and shall not discharge or otherwise discriminate against, any individual because the individual has a spouse or child that would be required under this part to be enrolled by such employer in a health benefit plan.

"(d) WAIVER IN CASE OF MULTIPLE EMPLOYERS.—In the case of an individual who is an employee with respect to more than one employer and who is required to enroll in a health benefit plan, such employee may waive enrollment in the health benefit plan of any such employer, but only if such employee is, and certifies to the employer that such employee is, enrolled in the health benefit plan of one employer.

"SEC. 2713. DEFINITIONS.

"(a) IN GENERAL.—Unless otherwise specifically provided, as used in this title:

"(1) CHILD.—The term 'child' means, with respect to an employee, an individual—

"(A) who—

"(i) is under 19 years of age;

"(ii) is under 23 years of age and a full-time student; or

"(iii) is an unmarried, dependent child, regardless of age, who is incapable of self-support as a result of a mental or physical disability that existed prior to the individual reaching 22 years of age; and

"(B)(i) who is the biological, adopted, or foster child of the employee or the spouse of the employee, or of the dependent child of the employee or the spouse of the employee;

"(ii) who is the legal ward of the employee or the spouse of the employee; or

"(iii) with respect to whom the employee or spouse of the employee, stands in loco parentis during the course of an adoption application.

"(2) EMPLOYEE.—

"(A) IN GENERAL.—Except as otherwise provided in this paragraph, the term 'employee' means, with respect to an employer, an individual who normally performs at least 1 hour of service per week for that employer.

"(B) HANDICAPPED WORKERS.—The term 'employee' does not include an individual described in section 14(c) of the Fair Labor Standards Act of 1938 (29 U.S.C. 214(c)).

"(C) CERTAIN EMPLOYEES.—The term 'employee' means, with respect to an employer described in section 3(37) of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1002(37)), an individual who performs—

"(i) 17.5 hours or more of service per week for the employer; or

"(ii) an equivalent amount of service during a 1-, 3-, or 6-month period for the employer, as determined under regulations issued by the Secretary.

"(D) LESS-THAN-FULL-TIME EMPLOYEE DEFINED.—The term 'less-than-full-time employee' means, with respect to an employer, an employee who normally performs on a monthly basis less than 25 hours of service per week but more than 17.5 hours per week for that employer.

"(E) CONSULTANTS AND CONTRACTORS.—The term 'employee' shall include an individual who is a consultant or independent contractor of an employer if the Secretary determines that the consulting arrangement or contract was entered into to avoid the requirements of this part.

"(F) PART-TIME EMPLOYEE.—The term 'part-time employee' means, with respect to an employer, an individual who normally performs on a monthly basis—

"(i) less than 17.5 hours per week; and

"(ii) 1 hour or more per week for that employer.

"(3) EMPLOYER.—

"(A) IN GENERAL.—Except as otherwise provided in this paragraph, the term 'employer' means—

"(i) an entity that is required to pay the individuals it employs the minimum wage prescribed by section 6 of the Fair Labor Standards Act of 1938 (29 U.S.C. 206) (or would be required to pay such wage but for the dollar volume standards prescribed in section 3(s) of such Act (29 U.S.C. 203(s)) or the exemptions prescribed in section 13(a) of such Act (29 U.S.C. 213(a)); and

"(ii) any State or political subdivision thereof, or any agency or instrumentality thereof; but such term does not include the Federal Government or a subdivision thereof.

"(B) OWNER-OPERATORS.—An owner-operator of a business shall be considered to be both an employer and employee with respect to himself or herself if the owner-operator has one or more other employees.

"(C) SMALL AND MEDIUM-SIZED EMPLOYERS.—The term 'small employer' means, with respect to a calendar year, an employer that normally employs fewer than 25 employees during the calendar year, and the term 'medium-sized employer' means, with respect to a calendar year, an employer that normally employs 25 or more employees, but not more than 100 employees, during the calendar year.

"(D) APPLICATION OF CONTROLLED GROUP RULES.—Section 607(4) of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1167(4)) shall apply in the determination under this part of whether an employer is a small or medium-sized employer and the number of employees an employer normally employs.

"(E) FAMILY FARMERS.—

"(i) PRICE SUPPORT GREATER THAN 70 PERCENT OF PARITY.—The term 'employer' shall not include the owner or operator of a family farm unless the level of agricultural prices, or the minimum level of agricultural price support provided by the Secretary of Agriculture for loans and purchases, for the major commodity produced on the farm is equal to or greater than 70 percent of the parity price of the commodity as maintained by the Secretary during the preceding 2 crop years.

"(ii) PRICE SUPPORT LESS THAN 70 PERCENT OF PARITY.—Owners and operators of a family farm who do not receive minimum agricultural price support through loans and purchases that is equal to or greater than 70 percent of parity for the major commodity produced on the farm from the Secretary of Agriculture for the preceding crop year shall be included within the definition of the term 'employer' only if, based on a national referendum conducted by the Secretary of Agriculture, a majority of the owners and operators vote in favor of mandatory participation in the small business insurance program provided by part C and the HealthAmerica Act.

"(iii) NO COVERED EMPLOYEES.—Owners and operators of family farms with no employees required to be enrolled in health benefit plans under this part, shall be included in the definition of 'employee' under this part if, based on a national referendum conducted by the Secretary of Agriculture, a majori-

ty of farmers in the commodity up vote in favor of mandatory participa in the small business insurance progr provided by part C and the HealthAmeric Act.

"(iv) DEFINITION OF FAMILY FARM.—As used in this subparagraph, the term 'family farm' means a farm with respect to which—

"(I) the operator or the family of the operator, or both (or, if the operator is a cooperative, corporation, partnership, or joint operation, the members, stockholders, partners, or joint operators, respectively) devote substantial amount of time daily to the management or operation of the farm;

"(II) a majority of the hours of labor required annually for the (farm and nonfarm) enterprise of the farm is provided by the operator or the family of the operator, or both (or, if the operator is a cooperative, corporation, partnership, or joint operation, by the members, stockholders, partners, or joint operators, respectively, and the families of such individuals); and

"(III) the value of the gross annual sales of agricultural commodities produced on the farm is not more than $750,000.

"(4) FAMILY AND FAMILY MEMBER.—The terms 'family' and 'family member' mean, with respect to an employee, the spouse and children of the employee.

"(5) HEALTH BENEFIT PLAN.—The term 'health benefit plan' means an employee welfare benefit plan (as defined in section 3(1) of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1002(1)) that—

"(A) provides medical care to participants or beneficiaries directly or through insurance, reimbursement, or otherwise; and

"(B) meets the requirements of section 2721.

"(6) INSURER.—The term 'insurer' means an entity qualified under the laws of a State to offer insurance or provide health benefits in that State.

"(7) MANAGED CARE.—

"(A) MANAGED CARE ENTITY.—The term 'managed care entity' means an insurer, health maintenance organization, preferred provider organization, dental plan organization, or other entity licensed to do business in a State, that markets managed care plans to groups or individuals or an employer, labor union or other State licensed entity that provides managed care plans for its employees or members.

"(B) MANAGED CARE PLAN.—The term 'managed care plan' means a health benefit plan—

"(i) in which the insurer—

"(I) utilizes explicit standards for the selection and recertification of participating providers;

"(II) has organizational arrangements, established in accordance with regulations of the Secretary, for an ongoing quality assurance program for its health services, which program (aa) stresses health outcomes, and (bb) provides review by physicians and other health professionals of the process followed in the provision of health services; and

"(III) contains significant incentives to use the participating providers and procedures provided for by the plan; and

"(ii) which, if it limits coverage of services to those provided by participating providers or permits deductibles and coinsurance with respect to basic health services provided by persons who are not participating providers which are in excess of those permitted under health benefit plans—

"(I) has a sufficient number and distribution of participating providers to assure that all covered items and services are (aa) available and accessible to each enrollee, within the area served by the plan, with reasonable promptness and in a manner which assures continuity, and (bb) when medically necessary, available and accessible twenty-four hours a day and seven days a week; and

"(II) provides benefits for covered items and services not furnished by participating providers if the items and services are medically necessary and immediately required because of an unforeseen illness, injury, or condition.

"(C) PARTICIPATING PROVIDER.—The term 'participating provider' means a physician, hospital, health maintenance organization, pharmacy, laboratory, or other appropriately licensed provider of health care services or supplies, that has entered into an agreement with a managed care entity to provide such services or supplies to a patient enrolled in a managed care plan.

"(D) UTILIZATION REVIEW.—The term 'utilization review' means a program for reviewing the necessity and appropriateness of health care services provided or proposed to be provided to a patient.

"(8) MENTAL DISORDER.—The term 'mental disorder' has the same meaning given such term in the International Classification of Diseases, 9th Revision, Clinical Modification.

"(9) NONGOVERNMENTAL EMPLOYER.—The term 'nongovernmental employer' means an employer not described in paragraph (3)(A)(ii).

"(10) PHYSICIAN SERVICES.—The term 'physician services' means professional medical services lawfully provided by a physician under State medical practice acts, and includes professional services provided by a dentist, licensed advanced-practice nurse, optometrist, podiatrist, or chiropractor acting within the scope of their practices (as determined under State law) if such services would be treated as physician services if furnished by a physician, except as provided in section 2722(e).

"(11) STATE.—

"(A) IN GENERAL.—The term 'State' means each of the several States and the District of Columbia.

"(B) ELECTION.—If the Governor of the Commonwealth of Puerto Rico or of any territory of the United States certifies to the President that Puerto Rico or such territory has enacted legislation stating that Puerto Rico or such territory desires to be included under the provisions of this Act, Puerto Rico or such territory shall be included under the definition of State for the purposes of this part beginning with January 1 of the first calendar year which begins later than 90 days after the President receives such notification.

"Subpart 2—Requirements for Health Benefit Plans

"SEC. 2721. GENERAL REQUIREMENTS; PERMITTING ACTUARIALLY EQUIVALENT PLANS.

"(a) GENERAL REQUIREMENTS.—Subject to subsections (b) and (c), in order for a health benefit plan to meet the requirements of this section, such plan shall—

"(1) provide benefits for items and services in accordance with section 2722;

"(2) provide coverage of employees and family enrolled in the plan in accordance with section 2723; and

"(3) provide for premiums, deductibles, copayments, and coinsurance in accordance with section 2724.

"(b) ACTUARIALLY EQUIVALENT PLANS PERMITTED.—

"(1) VARIATIONS IN PREMIUMS, DEDUCTIBLES, AND COST-SHARING.—A health benefit plan shall meet the requirements of this section, notwithstanding that such plan does not meet one or more of the requirements of section 2724 (relating to premiums, deductibles, copayments, coinsurance, and limit on out-of-pocket expenses) if the actuarial value of benefits provided under the plan (as defined in paragraph (8)) is not less than the equivalent of the actuarial value of benefits provided under the plan that would have applied if the plan met the requirements described in subsection (a).

"(2) MINIMUM REQUIREMENTS.—Nothing in this subsection shall be construed as not requiring each plan—

"(A) to meet the requirements of section 2723; or

"(B) to establish a limit on out-of-pocket expenses under section 2724(d), except that this subparagraph shall not be construed to require the establishment of the out-of-pocket limit described in section 2724(d)(5)(B).

"(3) MENTAL HEALTH BENEFITS.—Notwithstanding any other provision of this part or of the Health America Act, a health benefit plan may meet the requirements of section 2722(a)(6) by including payment for any reasonable combination of benefits described in subparagraphs (A) and (B) of such section if the plan includes payment for—

"(A) benefits the value of which is at least actuarially equivalent to the value of the benefits for which payment is otherwise required under such subparagraphs; and

"(B) both types of benefits described in each such subparagraph.

"(4) ADVISORY BOARD.—

"(A) ESTABLISHMENT.—The Secretary shall establish an Advisory Board to provide advice to the Secretary concerning the development of actuarial equivalency standards and such other matters relating to the administration of this part as the Secretary or the Board considers appropriate.

"(B) MEMBERSHIP.—The Advisory Board shall consist of 15 members appointed by the Secretary, of whom—

"(i) four members shall be representatives of employers, who shall be experienced in the administration of and knowledgeable about health insurance and actively engaged in the management or design of health insurance programs, of which—

"(I) two members shall be representatives of large businesses, as determined by the Secretary; and

"(II) two members shall be representatives of small and medium-sized businesses;

"(ii) two members shall be representatives of labor organizations, who shall possess qualifications of the type required for representatives under clause (i);

"(iii) four members shall be representatives of the insurance industry, at least one of whom shall be knowledgeable about small group policies;

"(iv) two members shall be actuaries, who shall be experienced in the administration of and knowledgeable about health insurance programs; and

"(v) three members shall be representatives of consumers not described in clauses (i) through (iv).

"(C) TERMS.—Each member of the Advisory Board shall serve for a term of 4 years, except that members initially appointed shall serve for staggered terms, as designated by the Secretary. A member may serve on the Board after the expiration of the term of the member until a successor has taken office as a member of the Board.

"(D) COMPENSATION.—The members of the Advisory Board may be allowed travel expenses, including per diem in lieu of subsistence, as authorized by section 5703 of title 5, United States Code, while away from their homes or regular places of business, for each day (including travel time) during which they are attending meetings or conferences of the Advisory Board or otherwise engaged in the business of the Board.

"(E) DEVELOPMENT OF ACTUARIAL EQUIVALENCY VARIATIONS.—Not later than 6 months before the effective date of this part, the Advisory Board shall develop and transmit to the Secretary—

"(i) at least three model health plans each with an actuarial value of benefits that is equivalent to the actuarial value of benefits of a basic plan (as defined in paragraph (9));

"(ii) a table of actuarial equivalency describing permitted expansions in covered services and variations in copayments, deductibles, limits on out-of-pocket expenses, and an employer's share of the premium or premiums under a health plan, as a percentage increase or decrease in the actuarial value of the basic plan, with the table describing as many expansions and variations as practicable in order to facilitate compliance with this section; and

"(iii) recommendations for procedures to facilitate the process by which an employer may certify actuarial equivalency for plan variations not provided in the model health plans or the table of actuarial equivalency and for the certification of multiple plans offered by the same employer.

"(F) REVIEW OF CHANGES.—The Advisory Board shall review proposed changes to the basic benefit package required of health benefit plans and transmit a cost benefit analysis of such changes, along with recommendations, to the appropriate committees of Congress and the Secretary.

"(5) TABLE OF ACTUARIAL EQUIVALENCY.—The Secretary shall publish, at least 3 months prior to the effective date of this part, a table that specifies the percentage increase or decrease in the actuarial value of benefits under a health benefit plan providing only the required benefits that would result from variations in covered services, copayments, deductibles, limits on out-of-pocket expenses, an employer's share of the premium or premiums under a health benefit plan, or any combination thereof. The table shall describe as many variations as feasible. In developing the table, the Secretary shall consider the recommendations of the Advisory Board established under paragraph (4).

"(6) COMPLIANCE WITH FIDUCIARY DUTIES.—In the case of health benefit plan variations for which relative actuarial values are not expressly provided for in the table published under paragraph (5) or in the case of variations in which one or more elements of covered services, copayments, deductibles, and limits on out-of-pocket expenses are given a relative actuarial value by the plan administrator that is different from that provided by such table, the plan shall not be considered out of compliance with this section—

"(A) if, under a process consistent with the duties of a fiduciary under part 4 of title I of the Employee Retirement Income Security Act of 1974, it is established that, and an actuary meeting credentials established by the American Academy of Actuaries or by the Secretary has certified that, the actuarial value of the benefits of the plan is at least equivalent to the actuarial value of the benefits of a basic plan; and

"(B) until and unless the Secretary has determined that such variations are not in compliance with the requirements of this section.

"(7) MULTIPLE PLANS.—In the case of an employer that has a health benefit plan that meets the requirements of paragraph (5)(A) or is otherwise determined to have an actuarial value of benefits that is at least equivalent to the actuarial value of a basic plan, the Secretary shall establish by regulation streamlined procedures for the approval of additional health benefit plans the actuarial value of the benefits of which is at least equivalent to the actuarial value of the benefits of the approved health benefit plan.

"(8) ACTUARIAL VALUE OF BENEFITS DEFINED.—For purposes of this subsection, the "actuarial value of benefits" of a plan is the amount by which the total of the amounts payable as benefits under the plan exceeds the amount of the premiums, deductibles, copayments, and coinsurance payable by the employee under the plan, as determined on an actuarial basis per enrollee for a plan year.

"(9) BASIC PLAN DEFINED.—For purposes of this subsection, the term 'basic plan' means a health benefit plan that only provides the basic benefits required under this part.

"SEC. 2722. REQUIREMENTS RELATING TO COVERED ITEMS AND SERVICES.

"(a) IN GENERAL.—Except as otherwise provided in this section, a health benefit plan shall include payment for—

"(1) inpatient and outpatient hospital care, except that treatment for a mental disorder is subject to the special limitations described in paragraph (6)(A);

"(2) inpatient and outpatient physician services, except that psychotherapy or counseling for a mental disorder is subject to the special limitations described in paragraph (6)(B);

"(3) diagnostic tests;

"(4) prenatal care and well-baby care provided to children who are 1 year of age or younger;

"(5) preventive services, limited to—

"(A) well child care;

"(B) pap smears; and

"(C) mammograms; and

"(6)(A) inpatient hospital care for a mental disorder for not less than 45 days per year, except that days of partial hospitalization or residential care may be substituted for days of inpatient care according to a ratio established by the Secretary; and

"(B) outpatient psychotherapy and counseling for a mental disorder for not less than 20 visits per year provided by a provider who is acting within the scope of State law and who—

"(i) is a physician; or

"(ii) meets the standards of subsection (g)(2)(B) and is a duly licensed or certified clinical psychologist or a duly licensed or certified clinical social worker, a duly licensed or certified equivalent mental health professional, or a clinic or center providing duly licensed or certified mental health services.

"(b) EXCEPTIONS.—Subsection (a) shall not be construed as requiring a plan to include payment for—

"(1) items and services that are not medically necessary;

"(2) routine physical examinations or preventive care (other than care and services described in paragraphs (4) and (5) of subsection (a); or

"(3) experimental services and procedures, except that this paragraph shall not apply to routine medical costs associated with peer-reviewed and approved protocols conducted in connection with peer-reviewed and approved research programs, pursuant to standards established by the Secretary.

"(c) AMOUNT, SCOPE, AND DURATION OF CERTAIN BENEFITS.—Except as provided in subsection (b), a health benefit plan shall place no limits on the amount, scope, or duration of benefits described in paragraphs (1) through (3) of subsection (a).

"(d) AMOUNT, SCOPE, AND DURATION OF PREVENTIVE SERVICES.—A health benefit plan may limit the amount, scope, and duration of preventive services described in subsection (a)(5) pursuant to regulations of the Secretary specifying the amount, scope, and duration of such care. The Secretary shall develop such regulations after consultation with appropriate medical experts.

"(e) LIMITATIONS.—

"(1) PANELS AND MANAGED CARE SYSTEMS.—Nothing in this title or the HealthAmerica Act, shall prohibit a health benefit plan from providing benefits for the items and services described in this section through a managed care system, and from selecting particular health care providers or types, classes, or categories of health care providers to participate in such managed care system. Such managed care system shall provide, in accordance with regulations issued by the Secretary, reasonable access to care by plan enrollees.

"(2) DIFFERENT LEVELS OF PAYMENTS.—Nothing in this title or the HealthAmerica Act, shall prohibit a health benefit plan from establishing a different level of payments for reimbursement for different health care providers furnishing the benefits for the items and services described in this section.

"(3) HEALTH CARE PROVIDERS.—Nothing in this title or the HealthAmerica Act, shall be construed to require a health benefit plan to utilize any health care provider (or type, class, or category of health care provider) to provide benefits for the items and services described in this section that were provided by the plan before the effective date of this part, other than the health care providers being utilized by the health benefit plan on such effective date, except that this paragraph shall not apply to duly licensed or certified clinical psychologists (acting within the scope of State law) after the end of the 5-year period beginning on the effective date of this part. This paragraph shall not apply to plans offered under part C.

"(4) DENIAL OF PAYMENT TO EXCLUDED PROVIDERS.—Nothing in this title or the HealthAmerica Act, shall require a health benefit plan to make payment to any health care provider that is excluded from participation in any Federal health care program.

"(f) BASIS OF PAYMENT MAY DIFFER FROM ACTUAL CHARGES.—The requirement of payment for services described in subsection (a) shall not prevent an employer from establishing a fee schedule or other basis of payment that is different from actual charges, but only if such fee schedule or other basis provides, pursuant to regulations of the Secretary, for payment at a level sufficient to achieve adequate access to services covered by the plan without additional out-of-pocket expenses for the covered service (but for copayments and deductibles permitted under section 2724).

"(g) MENTAL HEALTH CARE.—

"(1) INPATIENT CARE.—Subject to the provisions of subsection (e), inpatient hospital care described in subsection (a)(6)(A) shall include reimbursement for professional care provided to the individual while the individual is receiving such inpatient care, by a physician or duly licensed or certified clinical psychologist operating within the scope of practice of the physician or psychologist, as determined appropriate under State law. Nothing in this subsection shall be construed to modify hospital practices with regard to scope of practice, admitting privileges, or billing arrangements.

"(2) OUTPATIENT CARE.—

"(A) USE OF PROVIDERS.—Subject to the provisions of subsection (e), a health benefit plan that provided benefits with respect to outpatient psychotherapy described in subsection (a)(6)(B) prior to January 1, 1991, shall not be required under such subsection to provide benefits for outpatient psychotherapy provided by any health care provider (or type, class, or category of health care provider) described in subsection

(a)(6)(B)(ii), other than duly licensed or certified clinical psychologists and health care providers being utilized by the plan on January 1, 1991. This subparagraph shall not apply to plans offered under part C.

"(B) STANDARDS FOR CERTAIN PROVIDERS.—The Secretary shall establish standards that providers referred to in subsection (a)(6)(B)(ii) must meet to be eligible for payment under a health benefit plan and such standards shall require that such providers have training and education equivalent to a licensed clinical social worker (as defined in title XVIII of the Social Security Act).

"(h) STUDIES.—

"(1) SERVICES.—The Secretary shall periodically review the appropriateness of the preventive services required to be covered under this section and prepare and submit to the appropriate committees of Congress a report concerning any recommendations for changes in the list of such services that are required to be covered.

"(2) COVERAGE FOR CERTAIN SERVICES.—Not later than 1 year after the date of enactment of this part, the Secretary shall prepare and submit to the appropriate committees of Congress a report concerning the cost-effectiveness and desirability of coverage of colorectal cancer screening, prostate cancer screening, osteoporosis screening, and outpatient prescription drugs.

"SEC. 2723. REQUIREMENTS RELATING TO TIMING OF COVERAGE AND PROHIBITION OF PREEXISTING CONDITION LIMITATIONS.

"(a) DATE OF INITIAL COVERAGE.—In the case of an employee (and family members) enrolled under a health benefit plan provided by an employer, the coverage under the plan shall begin not later than the latest of the following:

"(1) 30 days after the date on which the employee first performs an hour of service as an employee of that employer, or in a case where an employer does not provide immediate coverage under the plan, on the day on which an employee who has performed an hour of service for the employer agrees to pay 100 percent of the normal employer and employee premium for the period prior to the normal beginning of coverage under the plan. The employer shall notify the employee on the first day on which the employee first performs an hour of service for the employer of the rights of the employee under this subsection.

"(2) The first day on which the employer is required to meet the requirements of this part.

"(3) In the case of an employer described in section 2713(a)(2)(C)—

"(A) 90 days after the date on which the employee first performs an hour of plan-covered service as an employee of the employer, except that if the initial waiting period is greater than 30 days, coverage under the plan shall continue for an equivalent period after the last day on which the employee performs an hour of plan-covered service as an employee of the employer; or

"(B) 180 days after the date on which the employee first performs an hour of plan-covered service, except that if the initial waiting period is greater than 30 days, coverage under the plan shall continue for an equivalent period after the last day on which the employee performs an hour of plan-covered service.

"(4) Subject to section 2712(b), in the case of a child, coverage applies for any period during which the employee, who is the parent of the child, is covered.

"(b) PROHIBITION OF PREEXISTING CONDITION PROVISIONS.—A health benefit plan shall not exclude or otherwise limit any individual from coverage under the plan on the basis that the individual has (or at any time has had) any disease, disorder, or condition.

"(c) RIGHT TO WAIVE ENROLLMENT.—

"(1) LESS-THAN-FULL-TIME OR PART-TIME EMPLOYEES WITH INCREASED PREMIUMS.—In the case of a less-than-full-time or part-time employee who is subject to, and is charged, an increased premium under section 2724(b)(5), the employee may, notwithstanding any other provision of this part, waive enrollment under this part. Such waiver shall be exercised in such form and manner as the Secretary shall specify and shall terminate on the date the employee is no longer being subject to, and charged, such an increased premium.

"(2) EMPLOYER CONTRIBUTION TO PUBLIC HEALTH INSURANCE PLAN.—In the case of a less-than-full-time or part-time employee who waives enrollment under paragraph (1), the employer shall, in a manner required by the Secretary, make a payment under title V of the HealthAmerica Act equal to the minimum amount the employer would have made towards the actuarial cost of coverage of the employee if the employee had not waived such enrollment.

"(d) CONTINUED COVERAGE.—If an employee's coverage or coverage for the family members of an employee would normally terminate during a period of hospitalization, such coverage shall continue until the employee or family member is discharged from the hospital.

"SEC. 2724. REQUIREMENTS RELATING TO PREMIUMS, DEDUCTIBLES, COPAYMENTS, COINSURANCE, AND LIMIT ON OUT-OF-POCKET EXPENSES.

"(a) ENROLLEE COST-SHARING PERMITTED.—A health benefit plan may require an enrollee to pay for premiums, deductibles, copayments, and coinsurance amounts for coverage under the plan, but only if such premiums, deductibles, copayments, and coinsurance do not exceed the limitations imposed under this section.

"(b) LIMITATION ON PREMIUMS.—

"(1) MONTHLY PREMIUM LIMITED TO 20 PERCENT OF ACTUARIAL RATE.—

"(A) IN GENERAL.—Subject to paragraphs (4) and (5), a health benefit plan shall not require an employee to pay a premium—

"(i) for coverage for a period of longer than one month; or

"(ii) the amount of which on a monthly basis exceeds 20 percent of the monthly actuarial rate defined under subparagraph (B).

"(B) MONTHLY ACTUARIAL RATE DEFINED.—For purposes of this subsection, the term 'monthly actuarial rate' means, with respect to a health benefit plan in a plan year, the average monthly per enrollee amount that the employer providing the plan estimates, based on actuarial calculations conducted in conformity with requirements established by the Secretary, for enrollees under the plan during the year, would be necessary to pay for the total benefits required under the plan (including administrative costs for the provision of such benefits and an appropriate amount for a contingency margin) during the year.

"(C) APPLICATION ON BASIS OF FAMILY STATUS.—For purposes of this paragraph, a health benefits plan may provide for the premium to be applied, and the monthly actuarial rate to be computed—

"(i) separately for employees who have family members covered under the plan and for employees who do not have family members covered under the plan; and

"(ii) with respect to employees with such covered family members, separately—

"(I) for employees who have a covered spouse and one or more covered children;

"(II) for employees who have a covered spouse but no covered children; and

"(III) for employees who do not have a covered spouse but have one or more covered children.

"(D) ADJUSTMENT FOR COVERED SPOUSE WITH OTHER COVERAGE.—For purposes of this paragraph, if a health benefit plan charges an employee for a share of the premium, the plan shall establish a separate premium category (or categories) for family coverage in the case of a covered spouse who is receiving primary health insurance coverage from another health benefit plan. The premium for such categories shall be established based on actual or projected plan experience or according to a formula established by the Secretary, and shall take into account the reduction in health insurance costs resulting from such coverage.

"(E) ADJUSTMENT OF PREMIUMS FOR EMPLOYED RETIREES UNDER HEALTH BENEFIT PLANS.—If an employer provides a health benefit plan with respect to retirees and the plan charges a retiree for a share of the premium of the plan, in the case of such a retiree who is enrolled as an employee (or dependent) under another health benefit plan under this part, the health benefit plan with respect to the retiree shall provide for an adjustment of the amount of the premium paid by the retiree to take into account the reduction in health insurance costs resulting from such coverage.

"(2) PAYMENT OF PREMIUMS.—An employee enrolled under a health benefit plan is liable for payment of premiums required under that plan in accordance with this subsection.

"(3) WITHHOLDING PERMITTED.—No provision of State law shall prevent an employer of an employee enrolled under a health benefit plan established under this part from withholding the amount of any premium due by the employee from the payroll of the employee.

"(4) SPECIAL RULE FOR LESS-THAN-FULL-TIME EMPLOYEES.—In the case of a less-than-full-time employee (as defined in section 2713(3)(D)), a health benefit plan may require the employee to pay a premium the amount of which (on a monthly basis) does not exceed—

"(A) 100 percent, minus

"(B) 80 percent, multiplied by the ratio of—

"(i) the average number of hours per week the employee is normally employed by the employer in the calendar quarter; to

"(ii) 25,

of the monthly actuarial rate (as defined in paragraph (1)(B)).

"(5) PART-TIME EMPLOYEES.—In the case of a part-time employee, a health benefit plan may require the employee to pay a premium amount that does not exceed 50 percent of the monthly actuarial rate (as defined in paragraph (1)(B)).

"(c) LIMITATION ON DEDUCTIBLES.—

"(1) IN GENERAL.—Except as permitted under paragraph (2), a health benefit plan shall not provide, for benefits provided in any plan year, for a deductible amount that exceeds—

"(A) with respect to benefits payable for items and services furnished to any employee with no family member enrolled under the plan, for a plan year beginning in—

"(i) the first calendar year that begins more than 1 year after the effective date of this Act, $250; or

"(ii) for a subsequent calendar year, the limitation of deductions specified in this subparagraph for the previous calendar year increased by the percentage increase in the consumer price index for all urban consumers (United States city average, as pub-

lished by the Bureau of Labor Statistics) for the 12-month period ending on September 30 of the preceding calendar year; and

"(B) with respect to benefits payable for items and services furnished to any employee with a family member enrolled under the plan, for a plan year beginning in—

"(i) the first calendar year that begins more than 1 year after the effective date of this part, $250 per family member and $500 per family; or

"(ii) for a subsequent calendar year, the limitation of deductions specified in this subparagraph for the previous calendar year increased by the percentage increase in the consumer price index for all urban consumers (United States city average, as published by the Bureau of Labor Statistics) for the 12-month period ending on September 30 of the preceding calendar year.

If the limitation of deductions computed under subparagraph (A)(ii) or (B)(ii) is not a multiple of $10, it shall be rounded to the next highest multiple of $10.

"(2) WAGE-RELATED DEDUCTIBLE.—A health benefit plan may provide for any other deductible amount instead of the limitations under—

"(A) paragraph (1)(A), if such amount does not exceed (on an annualized basis) 1 percent of the total wages paid to the employee in the plan year; or

"(B) paragraph (1)(B), if such amount does not exceed (on an annualized basis) 1 percent per family member or 2 percent per family of the total wages paid to the employee in the plan year.

"(d) LIMITATION ON COPAYMENTS AND COINSURANCE.—

"(1) IN GENERAL.—Subject to paragraphs (2) through (4), a health benefit plan shall not—

"(A) require the payment of any copayment or coinsurance for an item or service for which coverage is required by this part in an amount that exceeds 20 percent of the cost of the item or service; or

"(B) require the payment of any copayment or coinsurance for items and services required under section 2722 to be furnished in a plan year for an employee after the employee has incurred out-of-pocket expenses under the plan that are equal to the out-of-pocket limit (as defined in paragraph (5)(B)).

"(2) EXCEPTION FOR PREFERRED PROVIDERS.—If a health benefit plan establishes reasonable classifications of participating and nonparticipating providers of items and services, the plan may require payments in excess of the amount permitted under paragraph (1) in the case of items and services furnished by nonparticipating providers.

"(3) EXCEPTION FOR IMPROPER UTILIZATION.—A health benefit plan may provide for copayment or coinsurance in excess of the amount permitted under paragraph (1) for any item or service that an individual obtains without complying with any reasonable procedures established by the plan to ensure the efficient and appropriate utilization of covered services.

"(4) MENTAL HEALTH CARE.—In the case of care provided under section 2722(a)(6)(B), a health benefit plan shall not require payment of any copayment or coinsurance for an item or service for which coverage is required by this part in an amount that exceeds 50 percent of the cost of the item or service.

"(5) LIMIT ON OUT-OF-POCKET EXPENSES.—

"(A) OUT-OF-POCKET EXPENSES DEFINED.—As used in this section, the term 'out-of-pocket expenses' means, with respect to an employee in a plan year, amounts payable under the plan as deductibles and coinsurance with respect to items and services provided under the plan and furnished in the plan year on behalf of the employee and family covered under the plan.

"(B) OUT-OF-POCKET LIMIT DEFINED.—As used in this section and except as provided in subparagraph (C), the term 'out-of-pocket limit' means for a plan year beginning in—

"(i) the first calendar year that begins more than 1 year after the effective date of this part, $3,000; or

"(ii) for a subsequent calendar year, the out-of-pocket limit specified in this subparagraph for the previous calendar year increased by the percentage increase in the consumer price index for all urban consumers (United States city average, as published by the Bureau of Labor Statistics) for the 12-month period ending on September 30 of the preceding calendar year.

If the out-of-pocket limit computed under clause (ii) is not a multiple of $10, it shall be rounded to the next highest multiple of $10.

"(C) ALTERNATIVE OUT-OF-POCKET LIMIT.—A health benefit plan may provide for an out-of-pocket limit other than that defined in subparagraph (B) if, for a plan year with respect to an employee and the family of the employee, the limit does not exceed (on an annualized basis) 10 percent of the total wages paid to the employee in the plan year.

"SEC. 2725. ENROLLEE PROTECTION.

"(a) ADMINISTRATION.—

"(1) INSURANCE COMMISSIONER.—The requirements and standards established under this section shall be administered in a State by the insurance commissioner of that State, or by any other State agency, as designated by the chief executive officer of the State.

"(2) NONCOMPLIANCE.—If the State fails to comply with the requirements of paragraph (1), or, in the judgment of the Secretary, fails to adequately perform the administrative functions required under such paragraph, the Secretary shall assume the administrative responsibilities and duties required under such paragraph in that State.

"(b) INFORMATIONAL REQUIREMENT.—

"(1) SUMMARY OF HEALTH PLAN.—

"(A) REQUIREMENT.—Not later than 30 days after the date on which the coverage of an employee under a health benefit plan under this part begins, the employer of such employee shall provide the employee with a copy of the health benefit plan and a summary of such plan in accordance with subparagraph (B).

"(B) CONTENTS.—The plan and summary provided under subparagraph (A) shall be written in a manner reasonably assumed to be understandable by the average individual. Such summary and plan shall be sufficiently accurate and comprehensive to reasonably apprise individuals of their rights and obligations under the plan.

"(2) AVAILABILITY OF SUBSIDY.—Not later than 30 days after the date on which coverage of an employee under a health benefit plan under this part begins, the employer shall notify the employee of the availability of low-income subsidies for employees, through the public health insurance plan established under title XXI of the Social Security Act, to cover all or part of the cost of the employee's share of the premium for such health benefit plan and of any cost-sharing under such plan. Such notification shall be provided in such form as the Secretary shall require.

"(3) CHANGES IN PLAN.—An employee shall be notified in writing of any changes in the terms of their health benefit plan, not less than 30 days in advance of the implementation of such changes.

"(4) FAILURE TO PAY PREMIUMS.—With respect to a health benefit plan, the insurer issuing such plan shall notify the employee and the Secretary of the failure of the employer to make timely premium payments on behalf of the employee and the employee's family members as required under such plan. Such notification shall be provided not less that 30 days prior to any termination of coverage by the insurer as the result of such nonpayment of premiums.

"(5) FINANCIAL STATEMENT.—An employee shall be entitled to receive, on request, a copy of the most recent financial statement prepared for the health benefit plan under which such employee is covered. An employee shall be entitled to no more than one such request during each 1-year period.

"(6) AVAILABILITY OF INFORMATION.—

"(A) FILING WITH SECRETARY AND PROVISION TO STATES.—A copy of each health benefit plan provided under this part, and any additional information prepared under this subsection concerning such plans, shall be filed with the Secretary who shall make such information available to the State or States in which the employees eligible for benefits under such plans are employed.

"(B) PROVISION TO EMPLOYEES.—Employees not receiving the information required under this subsection may request such information from the State, or, if the program in such State is administered by the Secretary, from the Secretary.

"(c) STANDARDS AND TECHNICAL ASSISTANCE.—

"(1) MODEL PLANS AND SUMMARIES.—Not later than 9 months after the date of enactment of this part, the Secretary shall establish and make available model language for health benefit plans and the summaries of such plans.

"(2) PLAN INFORMATION.—Not later than 9 months after the date of enactment of this part, the Secretary shall promulgate regulations that describe the health benefit plan information that shall be provided to employees under this section, that shall include—

"(A) the name and address of the administrator of the plan;

"(B) the requirements of the plan with respect to eligibility;

"(C) the benefits to be provided under the plan;

"(D) the procedures for filing claims for benefits under the plan;

"(E) the procedures for appealing the denial of any claim filed under the plan; and

"(F) other information determined appropriate by the Secretary.

"(d) RIGHT TO ASSISTANCE.—

"(1) DESIGNATION OF INDIVIDUAL.—Each health benefit plan provided under this part shall designate an appropriate individual or individuals who shall be available to answer questions concerning the plan or the applicable plan requirements.

"(2) TIMELY RESPONSE.—Employees shall have the right to receive a timely written response to any questions that such employees may submit concerning their rights under the health benefits plan. Employees shall be able to rely on such written responses.

"(3) ASSISTANCE BY ADMINISTERING AUTHORITY.—The authority designated under subsection (a) shall provide assistance to employees in that State with respect to their rights under such plans and under Federal or State law.

"(e) RIGHT TO REVIEW DENIED CLAIMS.—

"(1) NOTICE.—An administrator under a health benefit plan under this part shall provide an employee with written notice concerning the denial of a claim submitted

by such employee. Such notice shall include the reasons for such denial.

"(2) PROCESS FOR REVIEW.—Each health benefit plan provided under this part shall utilize a fair process for the timely review of claims denied under such plan.

"(3) CLAIM FOR CARE NEEDED FOR LIFE-THREATENING ILLNESS.—In cases in which the failure to provide health care promptly would be life-threatening or result in a risk of permanent disability, the beneficiary under the health benefit plan shall be entitled to a decision as to whether care will be provided under such plan not later than 1 day after supplying the insurer with all requested information. In the event of a denial of coverage for such care, the beneficiary shall be entitled to an expedited review of an appeal of such denial within 5 days.

"(4) APPEALS.—Individuals shall be entitled to appeal the denial of a claim submitted by such individual to the authority administering the requirements and standards under subsection (a). The Secretary shall promulgate regulations establishing procedures to be utilized for appealing denials of claims under a health benefit plan under this part that are similar to the procedures established under title XVIII of the Social Security Act for appealing denials of claims under such title XVIII, including the right to a trial de novo.

"(f) RIGHT TO CHOICE.—

"(1) NONMANAGED CARE PLANS.—An employer may offer its employees a nonmanaged care plan that meets the requirements of this part as well as a managed care plan.

"(2) USE OF PROVIDERS.—If a nonmanaged care plan is not offered by an employer, the managed care plan or plans offered by such employer shall permit the utilization of providers not participating in the plan for services otherwise covered under the plan. If an employee elects to utilize such out-of-plan providers, the plan may provide for cost sharing that shall not exceed 200 percent of the normal cost-sharing imposed under the plan or 200 percent of the cost-sharing permitted under the minimum plan established under this part, whichever is greater.

"(g) RIGHT TO CONFIDENTIALITY OF MEDICAL RECORDS.—Health benefit plans under this title shall provide for the confidentiality of any medical records released under such plan.

"Subpart 3—Regulations and Enforcement

"SEC. 2731. REGULATIONS.

"(a) PROPOSED RULES.—Not later than 4 months after the date of enactment of this part, the Secretary shall publish in the Federal Register a notice of proposed rulemaking to carry out this part.

"(b) FINAL RULES.—Not later than 9 months after the date of enactment of this part, the Secretary shall promulgate final rules to carry out this part. Such notice and final rules shall be made in accordance with section 553 of title 5, United States Code.

"(c) EFFECT OF FAILURE TO PROMULGATE RULES.—The failure of the Secretary to promulgate final rules under this part shall not relieve any person or entity to which the provisions of this part apply of any obligations under this part.

"SEC. 2732. ENFORCEMENT.

"(a) CIVIL MONEY PENALTY AGAINST PRIVATE EMPLOYERS.—

"(1) 15 PERCENT OF TOTAL WAGES.—Any employer that does not comply with section 2712(c) or the requirements of section 2701(a) in any calendar year shall be subject to a civil penalty of not more than 15 percent of the total amount of the expenditures of the employer for wages for employees in that year.

"(2) INVESTIGATIONS.—The Secretary may conduct investigation under this section. In conducting such investigations, the Secretary—

"(A) shall have reasonable access to examine evidence of any person or entity being investigated; and

"(B) may, if necessary, compel by subpoena the attendance of witnesses and the production of evidence at any designated place.

"(3) ASSESSMENT PROCEDURE.—A civil money penalty under this subsection shall be assessed by the Secretary and collected in a civil action brought by the United States in a United States district court. The Secretary shall not assess such a penalty on an employer until the employer has been given notice and an opportunity for a hearing on such charge.

"(4) AMOUNT OF PENALTY.—In determining the amount of the penalty, or the amount agreed on in settlement, the Secretary shall consider the gravity of the noncompliance and the demonstrated good faith of the employer charged in attempting to achieve rapid compliance after notification of noncompliance by the Secretary.

"(5) JUDICIAL REVIEW.—In any civil action brought to review the assessment of such a penalty or to collect such a penalty, the court shall, at the request of any party to such action, hold a trial de novo on the assessment of the penalty, unless in a prior action such a trial de novo was held on the assessment.

"(6) USE OF AMOUNTS COLLECTED.—Civil money penalties collected under this subsection shall be credited to the account maintained to provide health benefits under the program established under title XXI of the Social Security Act.

"(b) LIABILITY TO INDIVIDUALS FOR DAMAGES.—Any employer that knowingly does not comply with section 2712(c) or the requirements of section 2701(a) shall be liable for damages (including health care costs incurred) to the employee or the family of the employee resulting from such failure to comply. Such an employee or family member may bring a civil action to recover damages resulting from an employers failure to comply with such requirements.".

TITLE III—SPECIAL ASSISTANCE FOR SMALL AND MEDIUM-SIZED BUSINESSES

SEC. 301. PREEMPTION OF STATE MANDATED BENEFIT LAWS.

(a) IN GENERAL.—Section 514(b)(2) of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1144(b)(2)) is amended—

(1) in subparagraph (A), by striking out "subparagraph (B)" and inserting in lieu thereof "subparagraphs (B) and (C)"; and

(2) by adding at the end thereof the following new subparagraph:

"(C) Nothing in subparagraph (A) shall be construed to exempt from subsection (a) any provision of the law of any State to the extent that such provision regulates, or otherwise provides any requirement relating to, the benefits to be provided under contracts or policies of insurance issued to or under a health benefit plan under part B of title XXVII of the Public Health Service Act.".

(b) CONFORMING AMENDMENT.—Paragraph (1) of section 3 of such Act (29 U.S.C. 1002(1)) is amended by adding at the end thereof the following new sentence: "Such terms include a health benefit plan established in accordance with part B of title XXVII of the Public Health Service Act.".

Subtitle A—Reform of Small Group Insurance

SEC. 311. GROUP HEALTH INSURANCE STANDARDS.

(a) PUBLIC HEALTH SERVICE ACT.—Title XXVII of the Public Health Service Act (as added under section 101 and amended by section 201) is further amended by adding at the end thereof the following new part:

"PART C—GROUP HEALTH INSURANCE STANDARDS

"Subpart 1—General Standards; Definitions

"SEC. 2741. APPLICATION OF REQUIREMENTS TO HEALTH BENEFIT PLANS.

"(a) PLAN UNDER STATE REGULATORY PROGRAM OR CERTIFIED BY THE SECRETARY.—

"(1) IN GENERAL.—No health benefit plan may be issued in a State on or after the effective date specified in subsection (c) (and no new contract may be offered under such plan with respect to any small employer beginning on or after such effective date) unless—

"(A) the Secretary determines that the State has established a regulatory program that provides for the application and enforcement of the applicable standards established under section 2742 (to carry out the requirements of this part) and that meets the requirements of section 2742(b) by such effective date, or

"(B) if the State has not established such a program, the plan has been certified by the Secretary (in accordance with such procedures as the Secretary establishes) as meeting the applicable standards established under section 2742 by such effective date.

"(2) PLAN DISAPPROVED UNDER LOOK-BEHIND AUTHORITY.—If the Secretary determines, under section 2742(c), that a health benefit plan does not meet the applicable requirements of this part on or after such effective date, regardless of whether or not the State has taken any action with respect to such noncompliance, no new contracts may be offered to small employers under the plan on or after the date of the determination.

"(b) SANCTIONS.—

"(1) COMPLAINTS AND INVESTIGATIONS.—The Secretary shall establish procedures—

"(A) for individuals and entities to file written, signed complaints with the Secretary respecting potential violations of the requirements of this part;

"(B) for the investigation of those complaints which have a substantial probability of validity; and

"(C) for the investigation of such other violations of the requirements of this part as the Secretary determines to be appropriate.

"(2) AUTHORITY IN INVESTIGATIONS.—In conducting investigations and hearings under this subsection—

"(A) agents of the Secretary and administrative law judges shall have reasonable access to examine evidence of any person or entity being investigated; and

"(B) administrative law judges, may, if necessary, compel by subpoena the attendance of witnesses and the production of evidence at any designated place or hearing. In case of contumacy or refusal to obey a subpoena lawfully issued under this subsection and upon application of the Secretary, an appropriate district court of the United States may issue an order requiring compliance with such subpoena and any failure to obey such order may be punished by such court as a contempt thereof.

"(3) HEARING.—

"(A) IN GENERAL.—Before imposing an order described in paragraph (4) against a carrier under this subsection for a violation of the requirements of this part, the Secretary shall provide the carrier with notice and, upon request made within a reasonable time (of not less than 30 days, as established by the Secretary) of the date of the notice, a hearing respecting the violation.

"(B) CONDUCT OF HEARING.—Any hearing so requested shall be conducted before an administrative law judge. If no hearing is so requested, the Secretary's imposition of the

order shall constitute a final and unappealable order.

"(C) ISSUANCE OF ORDERS.—If the administrative law judge determines, upon the preponderance of the evidence received, that a carrier named in the complaint has violated the requirements of this part, the administrative law judge shall state the findings of fact and issue and cause to be served on such carrier an order described in paragraph (4).

"(4) ENFORCEMENT AND CIVIL MONEY PENALTY.—

"(A) ENFORCEMENT.—Subject to the provisions of this paragraph, an order issued under this subsection—

"(i) shall require the carrier—

"(I) to cease and desist from such violations; and

"(II) to pay a civil penalty as required in paragraph (9); and

"(ii) may require the carrier to take such other corrective action as is appropriate.

"(B) CORRECTIONS WITHIN 30 DAYS.—No order shall be imposed under this subsection by reason of any violation if the carrier establishes to the satisfaction of the Secretary that—

"(i) such violation was due to reasonable cause and not to willful neglect; and

"(ii) such violation is corrected within the 30-day period beginning on earliest date the carrier knew, or exercising reasonable diligence could have known, that such a violation was occurring.

"(C) WAIVER BY SECRETARY.—In the case of a violation which is due to reasonable cause and not to willful neglect, the Secretary may waive part or all of the civil money penalty imposed by paragraph (9) to the extent that payment of such penalty would be grossly excessive relative to the violation involved and to the need for deterrence of violations.

"(5) ADMINISTRATIVE APPELLATE REVIEW.—The decision and order of an administrative law judge under this subsection shall become the final agency decision and order of the Secretary unless, within 30 days, the Secretary modifies or vacates the decision and order, in which case the decision and order of the Secretary shall become a final order under this subsection.

"(6) JUDICIAL REVIEW.—A carrier adversely affected by a final order issued under this subsection may, within 45 days after the date the final order is issued, file a petition in the Court of Appeals for the appropriate circuit for review of the order.

"(7) ENFORCEMENT OF ORDERS.—If a carrier fails to comply with a final order issued under this section against the carrier, the Secretary shall file a suit to seek compliance with the order in any appropriate district court of the United States. In any such suit, the validity and appropriateness of the final order shall not be subject to review.

"(8) USE OF AMOUNTS COLLECTED.—Civil money penalties collected under this subsection shall be credited to the AmeriCare Trust Fund.

"(9) AMOUNT OF CIVIL MONEY PENALTY.—The amount of any civil money penalty imposed under this subsection shall not exceed $25,000 for each carrier with respect to which a violation occurs. Such amount may take into account the penalties imposed by a State with respect to the same such violation.

"(10) NOTICE TO CARRIER IN THE CASE OF INSURED PLANS.—As part of any order issued under this subsection in the case of a health benefit plan, the order shall require that notice be provided to the carrier of the findings in the order.

"(11) LOSS OF STATUS AS A HEALTH BENEFIT PLAN.—If a carrier is not in compliance with subsection (a) and is not determined to have come into compliance with the applicable standards within 30 days after the date of the initial determination of such a violation, such carrier shall be subject to the provisions of this subsection.

"(c) EFFECTIVE DATE.—The effective date specified in this subsection is January 1 of the third full year that begins after the date of the enactment of this subpart.

"SEC. 2742. ESTABLISHMENT OF STANDARDS.

"(a) ESTABLISHMENT OF STANDARDS.—

"(1) NAIC.—The Secretary shall request the NAIC—

"(A) to develop specific standards, in the form of a model Act and model regulations, to implement the requirements of this part; and

"(B) to report to the Secretary on such development;

by not later than October 1 of the year following the year in which this part is enacted. If the NAIC develops such standards within such period and the Secretary finds that such standards implement the requirements of this part, such standards shall be the standards applied under section 2741.

"(2) SECRETARY.—If the NAIC fails to develop and report on such standards by such date or the Secretary finds that such standards do not implement the requirements of this part, the Secretary shall develop and publish, by not later than November 15 of the year following the year in which this part is enacted, such standards. Such standards shall then be the standards applied under section 2741.

"(b) ADDITIONAL ELEMENTS OF REGULATORY PROGRAMS.—

"(1) IN GENERAL.—A State regulatory program shall include the following:

"(A) The enforcement under the program—

"(i) shall be designed in a manner so as to secure compliance with the standards within 30 days after the date of a finding of noncompliance with such standards; and

"(ii) shall provide for notice to the Secretary in cases where such compliance is not secured within such 30-day period.

"(B) A toll-free telephone number which provides—

"(i) for a system for the receipt and disposition of consumer complaints or inquiries regarding compliance of health benefit plans with the requirements of this part; and

"(ii) information to small employers and consumers about carriers that offer health benefit plans in the area covered by the regulatory authority.

Such system shall provide for the recording of consumer complaint in accordance with a uniform methodology developed by the NAIC and recognized by the Secretary.

"(2) SECRETARIAL AUTHORITY.—In the case of a State without a regulatory program approved under subsection (a), the Secretary shall provide for the establishment of the toll-free telephone information and complaint system described in paragraph (1).

"(c) SECRETARIAL REVIEW.—

"(1) PERIODIC REVIEW OF STATE REGULATORY PROGRAMS.—The Secretary periodically shall review State regulatory programs to determine if they continue to meet the standards referred to in subsection (a) and the requirements of subsection (b). If the Secretary finds that a State regulatory program no longer meets such standards and requirements, before making a final determination, the Secretary shall provide the State an opportunity to adopt such a plan of correction as would permit the program to continue to meet such standards and requirements. If the Secretary makes a final determination that the State regulatory program, after such an opportunity, fails to meet such standards and requirements, the Secretary shall assume responsibility under section 2741(a)(1)(B) with respect to plans in the State.

"(2) LOOK-BEHIND AUTHORITY.—In the case of a State with a regulatory program found by the Secretary to meet the standards and requirements under this part, the Secretary nonetheless is authorized to determine whether or not health benefit plans offered by carriers in the State have failed to comply with the applicable requirements of this part.

"(d) GAO AUDITS.—The Comptroller General shall conduct periodic audits on a sample of State regulatory programs to determine their compliance with the requirements of this section. The Comptroller General shall report to the Secretary and Congress on the findings in such audits.

"SEC. 2743. TRANSITIONAL REQUIREMENTS APPLICABLE TO ALL HEALTH BENEFIT PLANS ISSUED TO SMALL EMPLOYERS.

"(a) APPLICATION.—The requirements of this section shall apply only to health benefit plans offered to small employers during the period that begins on the effective date of this part and ends in the case of a small employer, on the date that begins the fifth full year after the date of enactment of this part.

"(b) NO DISCRIMINATION BASED ON HEALTH STATUS FOR CERTAIN SERVICES.—

"(1) IN GENERAL.—Except as provided under paragraph (2), health benefit plans offered to small employers by carriers may not deny, limit, or condition the coverage under (or benefits of) the plan with respect to basic health services based on the health status, claims experience, receipt of health care, medical history, or lack of evidence of insurability, of an individual.

"(2) TREATMENT OF PREEXISTING CONDITION EXCLUSIONS FOR ALL SERVICES.—

"(A) IN GENERAL.—Subject to the succeeding provisions of this paragraph, health benefit plans provided to small employers by carriers may exclude coverage with respect to services related to treatment of a preexisting condition, but the period of such exclusion may not exceed 6 months.

"(B) NONAPPLICATION TO NEWBORNS AND SUNSET OF PREEXISTING CONDITION EXCLUSIONS FOR BASIC HEALTH SERVICES.—The exclusion of coverage permitted under subparagraph (A) shall not apply to—

"(i) services furnished to newborns, or

"(ii) basic health services furnished on or after July 1 of the sixth full year beginning after the date of the enactment of this part.

"(C) CREDITING OF PREVIOUS COVERAGE.—

"(i) IN GENERAL.—A health benefit plan issued to a small employer by a carrier shall provide that if an individual under such plan is in a period of continuous coverage (as defined in clause (ii)(I)) with respect to particular services as of the date of initial coverage under such plan, any period of exclusion of coverage with respect to a preexisting condition for such services or type of services shall be reduced by 1 month for each month in the period of continuous coverage.

"(ii) DEFINITIONS.—As used in this subparagraph:

"(I) PERIOD OF CONTINUOUS COVERAGE.—The term 'period of continuous coverage' means, with respect to particular services, the period beginning on the date an individual is enrolled under a health benefit plan issued to a small employer by a carrier which provides the same or substantially similar benefits with respect to such services and ends on the date the individual is not so enrolled for a continuous period of more than 3 months.

"(II) PREEXISTING CONDITION.—The term 'preexisting condition' means, with respect to coverage under a health benefit plan issued to a small employer by a carrier, a condition which has been diagnosed or treated during the 3-month period ending on the day before the first date of such coverage, except that such term does not include a condition which was first diagnosed or treated during a period of continuous coverage.

"(iii) STANDARDS FOR SIMILAR BENEFITS.—The standards established under section 2742 shall establish such criteria for determining if benefits are substantially similar as may be necessary to carry out this subparagraph.

"(c) PERMITTING COVERAGE DURING WAITING PERIOD.—

"(1) IN GENERAL.—If a health benefit plan issued to a small employer by a carrier imposes a waiting period before an eligible individual may be covered under the plan, the plan—

"(A) must make available to the individual coverage (including coverage of dependents) equivalent to the coverage available to the employee upon the completion of any applicable waiting period; and

"(B) may not impose for such coverage charges that exceed the cost under the plan of providing such coverage with respect to the employee if such waiting period did not apply.

Nothing in this paragraph shall be construed as requiring a health benefit plan issued to a small employer by a carrier to make coverage available to an individual who no longer has an employment relationship (or who is the spouse or dependent of such an individual) with respect to the plan.

"(2) ELIGIBLE INDIVIDUAL DEFINED.—In paragraph (1), the term 'eligible individual' means, with respect to a health benefit plan, an individual who, but for a waiting period, would be eligible for immediate coverage under the plan.

"SEC. 2744. DEFINITIONS.

"(a) HEALTH BENEFIT PLAN AND OTHER DEFINITIONS RELATING TO HEALTH PLANS.—As used in this part:

"(1) HEALTH BENEFIT PLAN.—The term 'health benefit plan' means any hospital or medical expense incurred policy or certificate, hospital or medical service plan contract, health maintenance subscriber contract, other employee welfare plan (as defined in the Employee Retirement Income Security Act of 1964), or any other health insurance arrangement, and includes an employment-related reinsurance plan (as defined in paragraph (3)), but does not include—

"(A) accident-only, credit, dental, or disability income insurance,

"(B) coverage issued as a supplement to liability insurance,

"(C) worker's compensation or similar insurance, or

"(D) automobile medical-payment insurance;

that is offered by a carrier.

"(2) SMALL EMPLOYER.—The term 'small employer' means, with respect to a calendar year, an employer that normally employs fewer than 100 employees on during the calendar year.

"(3) MANAGED CARE PLAN.—The term 'managed care plan' has the same meaning given such term by section 2713(7).

"(4) REINSURANCE PLAN.—The term 'reinsurance plan' means any reinsurance or similar mechanism that underwrites a portion of the risk for a health benefit plan, if the mechanism is offered directly to a small employer.

"(5) SELF-INSURED HEALTH BENEFIT PLAN.—The term 'self-insured health benefit plan' means a health benefit plan in which the small employer or employment-related group assumes the underwriting risk for the plan (whether or not there is any reinsurance or similar mechanism to underwrite a portion of that risk).

"(b) CARRIER; HEALTH MAINTENANCE ORGANIZATION; AND OTHER DEFINITIONS RELATING TO CARRIERS.—As used in this part:

"(1) CARRIER.—The term 'carrier' means any person that offers a health benefit plan, whether through insurance or otherwise, including a licensed insurance company, a prepaid hospital or medical service plan, a health maintenance organization, a self-insurer carrier, a reinsurance carrier, and a multiple small employer welfare arrangement (a combination of small employers associated for the purpose of providing health benefit plan coverage for their employees).

"(2) EMPLOYER CARRIER.—The term 'employer carrier'—

"(A) means any carrier which offers health benefit plans, and

"(B) includes (unless the context otherwise requires)—

"(i) a self-insurer carrier offering such a plan, or

"(ii) a reinsurance carrier offering an health benefit plan that is an reinsurance plan.

"(3) HEALTH MAINTENANCE ORGANIZATION.—The term 'health maintenance organization' has the meaning given the term 'eligible organization' in section 1876(b) of the Social Security Act.

"(4) REINSURANCE CARRIER.—The term 'reinsurance carrier' means the entity assuming responsibility for underwriting under an employment-related reinsurance plan; but does not include a carrier insofar as it directly offers a health benefit plan.

"(5) SELF-INSURER CARRIER.—The term 'self-insurer carrier' means a carrier that is not a licensed insurance company, a prepaid hospital or medical service plan, or a health maintenance organization, that offers a health benefit plan directly with respect to an employment-related group.

"(c) GENERAL DEFINITIONS.—As used in this part:

"(1) APPLICABLE REGULATORY AUTHORITY.—The term 'applicable regulatory authority' means, with respect to a health benefit plan offered in a State, the State commissioner or superintendent of insurance or other State authority responsible for regulation of health insurance, or, if the Secretary is exercising authority under section 2741(a)(1)(B) in the State, the Secretary.

"(2) BLOCK OF BUSINESS.—The term 'block of business' means all, or a distinct grouping of, small employers as shown on the records of the small employer carrier, if established consistent with section 2752(b)(3).

"(3) COMMUNITY.—The term 'community' means a geographic area designated by the Secretary as—

"(A) encompassing one or more adjacent metropolitan statistical areas; or

"(B) the remaining area within each State (that is not designated within any community under subparagraph (A));

except that the Secretary may designate an entire State as a community if such a designation would better carry out the purposes of this part. The Secretary from time to time may change the boundaries of communities designated under subparagraph (A) or (B) for such purposes. There shall be no administrative or judicial review of the designation of communities under this subsection.

"(4) FULL-TIME EMPLOYEE.—The term 'full-time employee' means, with respect to an employer, an employee who normally performs on a monthly basis at least 25 hours of service per week for that employer.

"(5) NAIC.—The term 'NAIC' means the National Association of Insurance Commissioners.

"(6) REFERENCE PREMIUM RATE.—The term 'reference premium rate' means, for each block of business for a rating period in a community, the lowest premium rate charged or which could have been charged by the small employer carrier to small employers in that block under a rating system for that block of business in the community for health benefit plans with the same or similar coverage. The reference premium rate is determined without regard to any adjustment for age or sex described in section 2752(c) and without regard to any adjustment effected under section 2752(d).

"(7) STATE.—The term 'State' means the 50 States and the District of Columbia.

"Subpart 2—Small Employer Health Insurance Reform

"SEC. 2751. ENROLLMENT PRACTICE AND GUARANTEED RENEWABILITY REQUIREMENTS FOR HEALTH BENEFIT PLANS ISSUED TO SMALL EMPLOYERS.

"(a) REGISTRATION WITH APPLICABLE REGULATORY AUTHORITY.—

"(1) IN GENERAL.—Each carrier (as defined in section 2744(b)(1)) shall register with the applicable regulatory authority for each State in which it issues or offers a health benefit plans to small employers.

"(2) NO PREEMPTION OF STATE INFORMATION REQUIREMENTS.—Nothing in paragraph (1) shall be construed as preventing the applicable regulatory authority from requiring, in the case of carriers that are not self-insurance carriers, such additional information in conjunction with, or apart from, the registration required under paragraph (1) as the applicable regulatory authority may be authorized to require under State law.

"(b) GUARANTEED ISSUE.—

"(1) IN GENERAL.—Subject to the succeeding provisions of this subsection, a carrier that offers a health benefit plan (including a reinsurance plan) to small employers located in a community must offer the same plan to any other small employer located in the community.

"(2) TREATMENT OF HEALTH MAINTENANCE ORGANIZATIONS.—

"(A) GEOGRAPHIC LIMITATIONS.—A health maintenance organization may deny coverage under a health benefit plan to a small employer whose employees are located outside the service area of the organization, but only if such denial is applied uniformly without regard to health status or insurability.

"(B) SIZE LIMITS.—A health maintenance organization may apply to the applicable regulatory authority to cease enrolling new small employer groups in its health benefit plan (or in a geographic area served by the plan) if it can demonstrate that its financial or administrative capacity to serve previously enrolled groups and individuals (and additional individuals who will be expected to enroll because of affiliation with such previously enrolled groups) will be impaired if it is required to enroll new groups.

"(3) GROUNDS FOR REFUSAL TO ISSUE OR RENEW.—

"(A) IN GENERAL.—A carrier may refuse to issue or renew or terminate a health benefit plan under this part only for—

"(i) nonpayment of premiums,

"(ii) fraud or misrepresentation, and

"(iii) failure to meet minimum participation rates (consistent with subparagraph (B)).

"(B) MINIMUM PARTICIPATION RATES.—A carrier may require, within the transition

period described in section 2743(a), with respect to a health benefit plan, that a minimum percentage of full-time, permanent employees eligible to enroll under the plan be enrolled, so long as such percentage is enforced uniformly for all employment groups of comparable size.

"(c) MINIMUM PLAN PERIOD.—A carrier may not offer to, or issue with respect to, a small employer a health benefit plan with a term of less than 12 months.

"(d) GUARANTEED RENEWABILITY.—

"(1) IN GENERAL.—

"(A) GENERAL RULE.—Subject to the succeeding provisions of this subsection, a carrier shall ensure that a health benefit plan issued to a small employer be renewed, at the option of the small employer, unless the plan is terminated for the reasons specified in subsection (a)(3)(A) or under subparagraph (B).

"(B) TERMINATION OF BLOCK OF BUSINESS.—A carrier need not renew a health benefit plan with respect to such a small employer if the carrier—

"(i) is terminating the block of business that includes the plan; and

"(ii) provides notice to the small employer covered under the plan of such termination at least 90 days before the date of expiration of the plan.

In the case of such a termination, the carrier may not provide for issuance of any health benefit plan in any block of business during the 5-year period beginning on the date of termination of such block of business.

"(C) CONSTRUCTION RESPECTING ADDITIONAL STATE DISCLOSURE REQUIREMENTS.—Subparagraph (B)(ii) shall not be construed as preventing the applicable regulatory authority from specifying the information to be included in the notice under such subparagraph or in requiring such notice to be provided at an earlier date.

"(2) NOTICE AND SPECIFICATION OF RATES AND ADMINISTRATIVE CHANGES.—

"(A) NOTICE.—A carrier offering health benefit plans to small employers shall provide for notice, at least 30 days before the date of expiration of the health benefit plan, of the terms for renewal of the plan. Except with respect to rates and administrative changes, the terms of renewal (including benefits) shall be the same as the terms of issuance.

"(B) RENEWAL RATES SAME AS ISSUANCE RATES.—The carrier may change the terms for such renewal, but the premium rates charged with respect to such renewal shall be the same as that for a new issue.

"(C) RATES CANNOT CHANGE MORE OFTEN THAN MONTHLY.—

"(i) IN GENERAL.—A carrier may not change the premium rates established with respect to health benefit plans offered for any block of business more often than monthly.

"(ii) APPLICATION OF NEW RATES.—A carrier that offers health benefit plans to small employers which becomes effective in a month, shall ensure that the premium rates established under clause (i) for that month shall apply to all months during the 12-month period beginning with that month. In the case of a plan renewal which is effective for a 12-month period beginning with a month, the premium rates established under clause (i) with respect to that month shall apply to all months during 12-month renewal period.

"(3) PERIOD OF RENEWAL.—The period of renewal of each health benefit plan offered by a carrier to a small employer shall be for a period of not less than 12 months.

"SEC. 2752. RATING PRACTICES FOR HEALTH BENEFIT PLANS OFFERED TO SMALL EMPLOYERS.

"(a) COHESIVE RATING SYSTEM AND ACTUARIAL CERTIFICATION.—

"(1) IN GENERAL.—The premiums (including reference premium rate, as defined in section 2744(c)(6), age adjustments under subsection (c), and reductions provided under subsection (d)) for all health benefit plans offered to small employers by carriers shall—

"(A) be established based on a single cohesive rating system which is applied consistently for all small employer groups and is designed not to treat groups, after the second effective year (as defined in subsection (f)), differently based on health status or risk status; and

"(B) be actuarially certified annually.

"(2) ACTUARIAL CERTIFIED DEFINED.—For purposes of paragraph (1)(B), a health benefit plan is considered to be 'actuarially certified' if there is a written statement, by a member of the American Academy of Actuaries or other individual acceptable to the applicable regulatory authority that a carrier is in compliance with this section, based upon the individual's examination, including a review of the appropriate records and of the actuarial assumptions and methods utilized by the carrier in establishing premium rates for applicable health benefit plans.

"(b) USE OF COMMUNITY-RATING.—

"(1) IN GENERAL.—Except as provided in paragraph (2) and subsection (c):

"(A) COMMUNITY RATING WITHIN A BLOCK OF BUSINESS.—The reference premium rate charged for health benefit plans offered with similar benefits to small employers in a community within a block of business for a type of family enrollment (described in subsection (e)) shall be the same for all small employers.

"(B) LIMITING VARIATION ON REFERENCE PREMIUM RATES AMONG BLOCKS OF BUSINESS.—

"(i) IN GENERAL.—Except as provided in clause (iii), the reference premium rate charged for health benefit plans offered with similar benefits to small employers in any community for a type of family enrollment for the most expensive block of business shall not exceed 120 percent of such rate charged for such plan for the same type of family enrollment for the least expensive block of business.

"(ii) ROLE OF REGULATORY AUTHORITY.—An applicable regulatory authority that is a State may reduce or eliminate the percent variation otherwise permitted under clause (i).

"(iii) EXCEPTION.—Clause (i) shall not apply to health benefit plans offered by carriers to small employers in a block of business—

"(I) if the block is one for which the carrier does not reject, and never has rejected, small employers included within the definition of small employers eligible for the block of business or otherwise eligible employees and dependents who enroll on a timely basis,

"(II) the carrier does not involuntarily transfer, and never has involuntarily transferred, a health benefit plan into or out of the block of business, and

"(III) that block of business was available for purchase as of the date of the enactment of this part.

"(2) TRANSITION.—Notwithstanding paragraph (1)—

"(A) during the first effective year (as defined in subsection (f)), the premium rate under a health benefit plan issued by a carrier to any small employer may be as much as, but may not exceed, 150 percent of the reference premium rate for such plans in the same community for similar benefits in the same block of business; or

"(B) during the second effective year, the premium rate under such a policy for any small employer may be as much as, but may not exceed, 122 percent of the reference premium rate for such plans in the same community for similar benefits in the same block of business.

"(3) ESTABLISHMENT OF BLOCKS OF BUSINESS.—For the purpose of establishing premiums for small employer health benefit plans with similar coverage, the carrier may establish blocks of business based only on one or more of the following characteristics:

"(A) Plans that are marketed by clearly different sales forces.

"(B) Plans that have been acquired from another carrier as a distinct group.

"(C) Plans that are managed care plans.

"(D) Plans within another distinct group, if the applicable regulatory authority finds that establishment of such a group will enhance the efficiency and fairness of the small employer insurance marketplace.

"(c) ADJUSTMENTS TO COMMUNITY-RATING.—

"(1) IN GENERAL.—Subject to paragraph (2), a health benefit plan offered by a carrier to a small employer may provide for an adjustment to the reference premium rate based on the age and gender of covered individuals. Any such adjustment shall be applied by the carrier consistently to all small employers, except that gender adjustments may only be made during the transition period.

"(2) LIMITATION ON ADJUSTMENT.—

"(A) IN GENERAL.—The adjustment under paragraph (1) may not result, with respect to health benefit plans with similar benefits offered by carriers to small employers in the same block of business in a community, in a premium rate for the most expensive age group exceeding the applicable percent (as defined in subparagraph (B)) of the premium rate for the least expensive age group.

"(B) APPLICABLE PERCENT DEFINED.—In subparagraph (A) but subject to subparagraph (C), the term 'applicable percent' means—

"(i) for the first effective year (as defined in subsection (f)), 200 percent,

"(ii) for the second effective year, 150 percent, and

"(iii) for any subsequent year, 110 percent.

"(C) ROLE OF REGULATORY AUTHORITY.—An applicable regulatory authority that is a State may reduce or eliminate the applicable percent otherwise applied.

"(d) ADJUSTMENT IN RATES PERMITTED IN CASE OF MEDICARE REIMBURSEMENT ELECTION.—A health benefit plan offered by a carrier to a small employer may compute premiums based upon a percentage of the reference premium rate otherwise applicable if the small employer to which the plan is being offered makes the reimbursement election described in section 2744. Any such adjustment shall be applied consistently to all small employers.

"(e) TYPES OF FAMILY ENROLLMENT.—Each health benefit plan offered by a carrier to a small employer shall permit enrollment of (and shall compute premiums separately for) individuals based on each of the following beneficiary classes:

"(1) 1 adult.

"(2) A married couple without children.

"(3) 1 adult and 1 child.

"(4) A married couple with 1 or more children, or 1 adult with 2 or more children.

"(f) EFFECTIVE YEARS DEFINED.—In this section, the terms 'first effective year' and 'second effective year' mean the third and fourth full years beginning after the date of the enactment of this part.

"(g) EXCEPTION FOR SELF-INSURED CARRIERS.—The requirements of this section shall apply to reinsurance carriers and health benefit plans offered by such carriers to small employers.

"SEC. 2753. BASIC BENEFIT PACKAGE FOR HEALTH BENEFIT PLANS OFFERED TO SMALL EMPLOYERS.

"(a) IN GENERAL.—

"(1) BENEFITS AND COST-SHARING IN HEALTH BENEFIT PLANS.—Except as provided in paragraph (2) and in section 2743(a), no health benefit plan offered by carriers to small employers may be issued to a small employer unless—

"(A) the plan provides for benefits for all basic health services as defined in part B;

"(B) the plan does not impose cost-sharing with respect to basic health services in excess of the deductibles and coinsurance permitted under part B respect to such services; and

"(C) the carrier makes available to the small employer a health benefit plan that, subject to paragraph (2)(C), only provides the benefits for basic health services and the maximum cost-sharing consistent with subparagraphs (A) and (B).

"(2) EXCEPTIONS.—

"(A) REQUIRED OFFERING DOES NOT APPLY TO HMO'S.—Paragraph (1)(C) shall not apply to a health maintenance organization.

"(B) ADDITIONAL, OPTIONAL MINIMUM SERVICES.—In meeting the requirement of paragraph (1)(C), a health benefit plan offered by a carrier to a small employer may include such additional items and services as the carrier can demonstrate to the satisfaction of the applicable regulatory authority that inclusion of such items and services will facilitate appropriate hospital discharges or avoid unnecessary hospitalization.

"(b) MANAGED CARE OPTION.—If a carrier (other than a health maintenance organization or reinsurance carrier) offers health benefit plans to an employer that is not a small employer, in a community a health benefit plan that is a managed care plan, the carrier must make available to small employers in the community a health benefit plan that is such a managed care plan.

"(c) EXCEPTION FOR REINSURANCE CARRIERS AND PLANS.—The requirements of this section shall not apply to reinsurance carriers and reinsurance plans.

"(d) STANDARDIZATION OF BENEFIT PACKAGES.—The NAIC shall develop a model to standardize benefits to be made available under health benefit plans offered by carriers to small employers in order to promote consumer understanding and comparison among such plans.

"SEC. 2754. TIME-LIMITED MEDICARE REIMBURSEMENT OPTION FOR HEALTH BENEFIT PLANS OFFERED TO SMALL EMPLOYERS NOT PREVIOUSLY OFFERING INSURANCE COVERAGE.

"(a) OPTION MUST BE OFFERED.—Each carrier offering a health benefit plan to small employers meeting the requirements of section 351(a) of the HealthAmerica Act shall offer the small employer the option of having payment under the plan made for basic health benefits at rates no higher than the payment rates established under part B for such services. The provisions of section 1848(g)(3) of the Social Security Act shall not be considered to apply under this subsection.

"(b) APPLICATION OF MEDICARE BILLING LIMITATIONS.—In the case of a small employer that elects the option offered under subsection (a) with respect to a health benefit plan, the limitations on charges that may be made under medicare shall apply to individuals receiving benefits under the plan.

"(c) EXCEPTION FOR REINSURANCE PLAN.—Subsection (a) shall not apply to reinsurance plans.

"SEC. 2755. MISCELLANEOUS DISCLOSURE AND RECORD-KEEPING REQUIREMENTS FOR HEALTH BENEFIT PLANS OFFERED TO SMALL EMPLOYERS.

"(a) DISCLOSURE.—

"(1) GENERAL DISCLOSURE.—Each carrier offering health benefit plans to small employers shall disclose to each small employer before issuing such a plan the following:

"(A) The availability (pursuant to the requirement of section 2753(a)(1)(C)) of a plan including only basic benefits.

"(B) Whether any plan that is a managed care plan or provides for a utilization review program, or both, is available, as required under section 2753(b).

"(C) The option of electing the reimbursement rules, as required under section 2754.

"(D) The limits, imposed under section 2752, on the premiums permitted to be charged for such plans.

"(E) The rights of guaranteed issue and renewability provided under section 2751.

Such disclosure shall be in addition to any disclosure required generally of health benefit plans under part B.

"(2) SPECIFIC DISCLOSURE UPON REQUEST.—Each carrier offering health benefit plans to small employers shall disclose to small employer, upon request, information concerning the blocks of business established with respect to such plans and the applicable premiums for such plans.

"(3) STANDARD FORMAT.—The disclosure under paragraph (1) shall be made in a uniform format established by the Secretary, after consultation with the NAIC.

"(4) EXCEPTIONS.—Paragraph (1) (other than subparagraphs (D) and (E)) shall not apply to a reinsurance carrier with respect to a reinsurance plan.

"(b) INFORMATION FILED WITH APPLICABLE REGULATORY AUTHORITY.—

"(1) IN GENERAL.—Each carrier offering health benefit plans to small employers shall disclose to the applicable regulatory authority, in a manner specified by the Secretary, information concerning—

"(1) blocks of business established; and

"(2) applicable premiums for health benefit plans.

"(2) ADDITIONAL INFORMATION.—Nothing in this subsection shall be construed as limiting the information which an applicable regulatory authority may require to be reported by carriers.

"SEC. 2756. NONAPPLICATION IN PUERTO RICO AND THE TERRITORIES.

"This subpart shall not apply outside the 50 States or the District of Columbia.

"Subpart 3—Encouraging Development of Reinsurance Systems

"SEC. 2758. ENCOURAGING DEVELOPMENT OF REINSURANCE SYSTEMS.

"(a) DEVELOPMENT OF MODELS.—

"(1) IN GENERAL.—Not later than October 1 of the year following the year in which this part is enacted, the NAIC shall develop several models of legislation for the enactment of reinsurance systems that may be used by States with respect to health insurance policies (including health benefit plans offered to small employers).

"(2) SPECIFIC MODELS.—Such models shall include at least 1 of each of the following 3 models:

"(A) A model providing for voluntary participation by insurers.

"(B) A model providing for insurer participation on a retrospective basis.

"(C) A model providing for the case management of services for individual claims or groups which are reinsured through the system.

"(3) TERMS OF MODELS.—Each of the models—

"(A) shall be consistent with the provisions of this part (including those relating to community-rated premiums), and

"(B) shall include deductibles and coinsurance which—

"(i) limit the amount of risk ceded to the reinsurance system; and

"(ii) encourage insurers to manage health care costs.

"(b) PROTECTION OF HEALTH MAINTENANCE ORGANIZATIONS UNDER REINSURANCE SYSTEMS.—No State may establish or enforce a reinsurance system with respect to health insurance policies unless the system provides for an adjustment in reinsurance premiums (or, in the event of losses to the system, assessments) charged to health maintenance organizations that takes into account—

"(1) the higher premiums charged by such organizations due to the greater coverage provided by such organizations as required by law,

"(2) the limitations under title XIII on the amount of risk which such an organization can reinsure, and

"(3) the ability of such organizations to manage risk internally.

"(c) EFFECTIVE DATE.—This section shall take effect on the date of the enactment of this part.".

(b) SOCIAL SECURITY ACT.—The Social Security Act is amended by inserting after title XII the following new title:

"TITLE XIII—GROUP HEALTH INSURANCE STANDARDS

"PART A—GENERAL STANDARDS; DEFINITIONS

"APPLICATION OF REQUIREMENTS TO HEALTH BENEFIT PLANS

"SEC. 1301. (a) PLAN UNDER STATE REGULATORY PROGRAM OR CERTIFIED BY THE SECRETARY.—

"(1) IN GENERAL.—No health benefit plan may be issued in a State on or after the effective date specified in subsection (c) (and no new contract may be offered under such plan with respect to any small employer beginning on or after such effective date) unless—

"(A) the Secretary determines that the State has established a regulatory program that provides for the application and enforcement of the applicable standards established under section 1302 (to carry out the requirements of this title) and that meets the requirements of section 1302(b) by such effective date, or

"(B) if the State has not established such a program, the plan has been certified by the Secretary (in accordance with such procedures as the Secretary establishes) as meeting the applicable standards established under section 1302 by such effective date.

"(2) PLAN DISAPPROVED UNDER LOOK-BEHIND AUTHORITY.—If the Secretary determines, under section 1302(c), that a health benefit plan does not meet the applicable requirements of this title on or after such effective date, regardless of whether or not the State has taken any action with respect to such noncompliance, no new contracts may be offered to small employers under the plan on or after the date of the determination.

"(b) SANCTIONS.—

"(1) COMPLAINTS AND INVESTIGATIONS.—The Secretary shall establish procedures—

"(A) for individuals and entities to file written, signed complaints with the Secretary respecting potential violations of the requirements of this title;

"(B) for the investigation of those complaints which have a substantial probability of validity; and

"(C) for the investigation of such other violations of the requirements of this title as the Secretary determines to be appropriate.

"(2) AUTHORITY IN INVESTIGATIONS.—In conducting investigations and hearings under this subsection—

"(A) agents of the Secretary and administrative law judges shall have reasonable access to examine evidence of any person or entity being investigated; and

"(B) administrative law judges, may, if necessary, compel by subpoena the attendance of witnesses and the production of evidence at any designated place or hearing.

In case of contumacy or refusal to obey a subpoena lawfully issued under this subsection and upon application of the Secretary, an appropriate district court of the United States may issue an order requiring compliance with such subpoena and any failure to obey such order may be punished by such court as a contempt thereof.

"(3) HEARING.—

"(A) IN GENERAL.—Before imposing an order described in paragraph (4) against a carrier under this subsection for a violation of the requirements of this title, the Secretary shall provide the carrier with notice and, upon request made within a reasonable time (of not less than 30 days, as established by the Secretary) of the date of the notice, a hearing respecting the violation.

"(B) CONDUCT OF HEARING.—Any hearing so requested shall be conducted before an administrative law judge under section 201. If no hearing is so requested, the Secretary's imposition of the order shall constitute a final and unappealable order.

"(C) ISSUANCE OF ORDERS.—If the administrative law judge determines, upon the preponderance of the evidence received, that a carrier named in the complaint has violated the requirements of this title, the administrative law judge shall state the findings of fact and issue and cause to be served on such carrier an order described in paragraph (4).

"(4) ENFORCEMENT AND CIVIL MONEY PENALTY.—

"(A) ENFORCEMENT.—Subject to the provisions of this paragraph, an order issued under this subsection—

"(i) shall require the carrier—

"(I) to cease and desist from such violations; and

"(II) to pay a civil penalty as required in paragraph (9); and

"(ii) may require the carrier to take such other corrective action as is appropriate.

"(B) CORRECTIONS WITHIN 30 DAYS.—No order shall be imposed under this subsection by reason of any violation if the carrier establishes to the satisfaction of the Secretary that—

"(i) such violation was due to reasonable cause and not to willful neglect; and

"(ii) such violation is corrected within the 30-day period beginning on earliest date the carrier knew, or exercising reasonable diligence could have known, that such a violation was occurring.

"(C) WAIVER BY SECRETARY.—In the case of a violation which is due to reasonable cause and not to willful neglect, the Secretary may waive part or all of the civil money penalty imposed by paragraph (9) to the extent that payment of such penalty would be grossly excessive relative to the violation involved and to the need for deterrence of violations.

"(5) ADMINISTRATIVE APPELLATE REVIEW.—The decision and order of an administrative law judge under this subsection shall become the final agency decision and order of the Secretary unless, within 30 days, the Secretary modifies or vacates the decision and order, in which case the decision and order of the Secretary shall become a final order under this subsection.

"(6) JUDICIAL REVIEW.—A carrier adversely affected by a final order issued under this subsection may, within 45 days after the date the final order is issued, file a petition in the Court of Appeals for the appropriate circuit for review of the order.

"(7) ENFORCEMENT OF ORDERS.—If a carrier fails to comply with a final order issued under this section against the carrier, the Secretary shall file a suit to seek compliance with the order in any appropriate district court of the United States. In any such suit, the validity and appropriateness of the final order shall not be subject to review.

"(8) USE OF AMOUNTS COLLECTED.—Civil money penalties collected under this subsection shall be credited to the AmeriCare Trust Fund.

"(9) AMOUNT OF CIVIL MONEY PENALTY.—The amount of any civil money penalty imposed under this subsection shall not exceed $25,000 for each carrier with respect to which a violation occurs. Such amount may take into account the penalties imposed by a State with respect to the same such violation.

"(10) NOTICE TO CARRIER IN THE CASE OF INSURED PLANS.—As part of any order issued under this subsection in the case of a health benefit plan, the order shall require that notice be provided to the carrier of the findings in the order.

"(11) LOSS OF STATUS AS A HEALTH BENEFIT PLAN.—If a carrier is not in compliance with subsection (a) and is not determined to have come into compliance with the applicable standards within 6 months after the date of the initial determination of such a violation, such carrier shall be subject to the provision of this subsection.

"(12) EXCISE TAX.—A carrier that is not in compliance with subsection (a) shall be subject to the tax described in section 4980C of the Internal Revenue Code of 1986.

"(c) EFFECTIVE DATE.—The effective date specified in this subsection is January 1 of the third full year that begins after the date of the enactment of this part.

"ESTABLISHMENT OF STANDARDS

"SEC. 1302. (a) ESTABLISHMENT OF STANDARDS.—

"(1) NAIC.—The Secretary shall request the NAIC—

"(A) to develop specific standards, in the form of a model Act and model regulations, to implement the requirements of this title; and

"(B) to report to the Secretary on such development;

by not later than October 1 of the year following the year in which this title is enacted. If the NAIC develops such standards within such period and the Secretary finds that such standards implement the requirements of this title, such standards shall be the standards applied under section 1301.

"(2) SECRETARY.—If the NAIC fails to develop and report on such standards by such date or the Secretary finds that such standards do not implement the requirements of this title, the Secretary shall develop and publish, by not later than November 15 of the year following the year in which this title is enacted, such standards. Such standards shall then be the standards applied under section 1301.

"(b) ADDITIONAL ELEMENTS OF REGULATORY PROGRAMS.—

"(1) IN GENERAL.—A State regulatory program shall include the following:

"(A) The enforcement under the program—

"(i) shall be designed in a manner so as to secure compliance with the standards within 30 days after the date of a finding of noncompliance with such standards; and

"(ii) shall provide for notice to the Secretary in cases where such compliance is not secured within such 30-day period.

"(B) A toll-free telephone number which provides—

"(i) for a system for the receipt and disposition of consumer complaints or inquiries regarding compliance of health benefit plans with the requirements of this title; and

"(ii) information to small employers and consumers about carriers that offer health benefit plans in the area covered by the regulatory authority.

Such system shall provide for the recording of consumer complaints in accordance with a uniform methodology developed by the NAIC and recognized by the Secretary.

"(2) SECRETARIAL AUTHORITY.—In the case of a State without a regulatory program approved under subsection (a), the Secretary shall provide for the establishment of the toll-free telephone information and complaint system described in paragraph (1).

"(c) SECRETARIAL REVIEW.—

"(1) PERIODIC REVIEW OF STATE REGULATORY PROGRAMS.—The Secretary periodically shall review State regulatory programs to determine if they continue to meet the standards referred to in subsection (a) and the requirements of subsection (b). If the Secretary finds that a State regulatory program no longer meets such standards and requirements, before making a final determination, the Secretary shall provide the State an opportunity to adopt such a plan of correction as would permit the program to continue to meet such standards and requirements. If the Secretary makes a final determination that the State regulatory program, after such an opportunity, fails to meet such standards and requirements, the Secretary shall assume responsibility under section 1301(a)(1)(B) with respect to plans in the State.

"(2) LOOK-BEHIND AUTHORITY.—In the case of a State with a regulatory program found by the Secretary to meet the standards and requirements under this title, the Secretary nonetheless is authorized to determine whether or not health benefit plans offered by carriers in the State have failed to comply with the applicable requirements of this title.

"(d) GAO AUDITS.—The Comptroller General shall conduct periodic audits on a sample of State regulatory programs to determine their compliance with the requirements of this section. The Comptroller General shall report to the Secretary and Congress on the findings in such audits.

"TRANSITIONAL REQUIREMENTS APPLICABLE TO ALL HEALTH BENEFIT PLANS ISSUED TO SMALL EMPLOYERS

"SEC. 1303. (a) APPLICATION.—The requirements of this section shall apply only to health benefit plans offered to small employers during the period that begins on the effective date of this title and ends in the case of a small employer, on the date that begins the fifth full year after the date of enactment of this title.

"(b) NO DISCRIMINATION BASED ON HEALTH STATUS FOR CERTAIN SERVICES.—

"(1) IN GENERAL.—Except as provided under paragraph (2), health benefit plans offered to small employers by carriers may not deny, limit, or condition the coverage under (or benefits of) the plan with respect to basic health services based on the health status, claims experience, receipt of health care, medical history, or lack of evidence of insurability, of an individual.

"(2) TREATMENT OF PREEXISTING CONDITION EXCLUSIONS FOR ALL SERVICES.—

"(A) IN GENERAL.—Subject to the succeeding provisions of this paragraph, health benefit plans provided to small employers by carriers may exclude coverage with respect to services related to treatment of a

preexisting condition, but the period of such exclusion may not exceed 6 months.

"(B) NONAPPLICATION TO NEWBORNS AND SUNSET OF PREEXISTING CONDITION EXCLUSIONS FOR BASIC HEALTH SERVICES.—The exclusion of coverage permitted under subparagraph (A) shall not apply to—

"(i) services furnished to newborns, or

"(ii) basic health services furnished on or after July 1 of the sixth full year beginning after the date of the enactment of this title.

"(C) CREDITING OF PREVIOUS COVERAGE.—

"(i) IN GENERAL.—A health benefit plan issued to a small employer by a carrier shall provide that if an individual under such plan is in a period of continuous coverage (as defined in clause (ii)(I)) with respect to particular services as of the date of initial coverage under such plan, any period of exclusion of coverage with respect to a preexisting condition for such services or type of services shall be reduced by 1 month for each month in the period of continuous coverage.

"(ii) DEFINITIONS.—As used in this subparagraph:

"(I) PERIOD OF CONTINUOUS COVERAGE.—The term 'period of continuous coverage' means, with respect to particular services, the period beginning on the date an individual is enrolled under a health benefit plan issued to a small employer by a carrier which provides the same or substantially similar benefits with respect to such services and ends on the date the individual is not so enrolled for a continuous period of more than 3 months.

"(II) PREEXISTING CONDITION.—The term 'preexisting condition' means, with respect to coverage under a health benefit plan issued to a small employer by a carrier, a condition which has been diagnosed or treated during the 3-month period ending on the day before the first date of such coverage, except that such term does not include a condition which was first diagnosed or treated during a period of continuous coverage.

"(iii) STANDARDS FOR SIMILAR BENEFITS.—The standards established under section 1302 shall establish such criteria for determining if benefits are substantially similar as may be necessary to carry out this subparagraph.

"(c) PERMITTING COVERAGE DURING WAITING PERIOD.—

"(1) IN GENERAL.—If a health benefit plan issued to a small employer by a carrier imposes a waiting period before an eligible individual may be covered under the plan, the plan—

"(A) must make available to the individual coverage (including coverage of dependents) equivalent to the coverage available to the employee upon the completion of any applicable waiting period; and

"(B) may not impose for such coverage charges that exceed the cost under the plan of providing such coverage with respect to the employee if such waiting period did not apply.

Nothing in this paragraph shall be construed as requiring a health benefit plan issued to a small employer by a carrier to make coverage available to an individual who no longer has an employment relationship (or who is the spouse or dependent of such an individual) with respect to the plan.

"(2) ELIGIBLE INDIVIDUAL DEFINED.—In paragraph (1), the term 'eligible individual' means, with respect to a health benefit plan, an individual who, but for a waiting period, would be eligible for immediate coverage under the plan.

"DEFINITIONS

"SEC. 1304. (a) HEALTH PLAN AND OTHER DEFINITIONS RELATING TO HEALTH PLANS.—As used in this title:

"(1) HEALTH BENEFIT PLAN.—The term 'health benefit plan' means any hospital or medical expense incurred policy or certificate, hospital or medical service plan contract, health maintenance subscriber contract, other employee welfare plan (as defined in the Employee Retirement Income Security Act of 1964), or any other health insurance arrangement, and includes an employment-related reinsurance plan (as defined in paragraph (3)), but does not include—

"(A) accident-only, credit, dental, or disability income insurance,

"(B) coverage issued as a supplement to liability insurance,

"(C) worker's compensation or similar insurance, or

"(D) automobile medical-payment insurance;

that is offered by a carrier.

"(2) SMALL EMPLOYER.—The term 'small employer' means, with respect to a calendar year, an employer that normally employs fewer than 100 employees on during the calendar year.

"(3) MANAGED CARE PLAN.—The term 'managed care plan' has the same meaning given such term by section 2108(a)(6).

"(4) REINSURANCE PLAN.—The term 'reinsurance plan' means any reinsurance or similar mechanism that underwrites a portion of the risk for a health benefit plan, if the mechanism is offered directly to a small employer.

"(5) SELF-INSURED HEALTH BENEFIT PLAN.—The term 'self-insured health benefit plan' means a health benefit plan in which the small employer or employment-related group assumes the underwriting risk for the plan (whether or not there is any reinsurance or similar mechanism to underwrite a portion of that risk).

"(b) CARRIER; HEALTH MAINTENANCE ORGANIZATION; AND OTHER DEFINITIONS RELATING TO CARRIERS.—As used in this title:

"(1) CARRIER.—The term 'carrier' means any person that offers a health benefit plan, whether through insurance or otherwise, including a licensed insurance company, a prepaid hospital or medical service plan, a health maintenance organization, a self-insurer carrier, a reinsurance carrier, and a multiple small employer welfare arrangement (a combination of small employers associated for the purpose of providing health benefit plan coverage for their employees).

"(2) EMPLOYER CARRIER.—The term 'employer carrier'—

"(A) means any carrier which offers health benefit plans, and

"(B) includes (unless the context otherwise requires)—

"(i) a self-insurer carrier offering such a plan, or

"(ii) a reinsurance carrier offering a health benefit plan that is a reinsurance plan.

"(3) HEALTH MAINTENANCE ORGANIZATION.—The term 'health maintenance organization' has the meaning given the term 'eligible organization' in section 1876(b).

"(4) REINSURANCE CARRIER.—The term 'reinsurance carrier' means the entity assuming responsibility for underwriting under an employment-related reinsurance plan, but does not include a carrier insofar as it directly offers a health benefit plan.

"(5) SELF-INSURER CARRIER.—The term 'self-insurer carrier' means a carrier that is not a licensed insurance company, a prepaid hospital or medical service plan, or a health maintenance organization, that offers a health benefit plan directly with respect to an employment-related group.

"(c) GENERAL DEFINITIONS.—As used in this title:

"(1) APPLICABLE REGULATORY AUTHORITY.—The term 'applicable regulatory authority' means, with respect to a health benefit plan offered in a State, the State commissioner or superintendent of insurance or other State authority responsible for regulation of health insurance; or, if the Secretary is exercising authority under section 1301(a)(1)(C)(ii) in the State, the Secretary.

"(2) BLOCK OF BUSINESS.—The term 'block of business' means all, or a distinct grouping of, small employers as shown on the records of the small employer carrier, if established consistent with section 1312(b)(3).

"(3) COMMUNITY.—The term 'community' means a geographic area designated by the Secretary as—

"(A) encompassing one or more adjacent metropolitan statistical areas; or

"(B) the remaining area within each State that is not designated within any community under subparagraph (A));

except that the Secretary may designate an entire State as a community if such a designation would better carry out the purposes of this title. The Secretary from time to time may change the boundaries of communities designated under subparagraph (A) or (B) for such purposes. There shall be no administrative or judicial review of the designation of communities under this subsection.

"(4) FULL-TIME EMPLOYEE.—The term 'full-time employee' means, with respect to an employer, an employee who normally performs on a monthly basis at least 25 hours of service per week for that employer.

"(5) NAIC.—The term 'NAIC' means the National Association of Insurance Commissioners.

"(6) REFERENCE PREMIUM RATE.—The term 'reference premium rate' means, for each block of business for a rating period in a community, the lowest premium rate charged or which could have been charged by the small employer carrier to small employers in that block under a rating system for health benefit plans with the same or similar coverage. The reference premium rate is determined without regard to any adjustment for age or sex described in section 1312(c) and without regard to any adjustment offered under section 1312(d).

"(7) STATE.—The term 'State' means the 50 States and the District of Columbia.

"PART II—SMALL EMPLOYER HEALTH INSURANCE REFORM

"ENROLLMENT PRACTICE AND GUARANTEED RENEWABILITY REQUIREMENTS FOR HEALTH BENEFIT PLANS OFFERED TO SMALL EMPLOYERS

"SEC. 1311. (a) REGISTRATION WITH APPLICABLE REGULATORY AUTHORITY.—

"(1) IN GENERAL.—Each carrier (as defined in section 1304(b)(1)) shall register with the applicable regulatory authority for each State in which it issues or offers a health benefit plan to small employers.

"(2) NO LIMITATION OF STATE INFORMATION REQUIREMENTS.—Nothing in paragraph (1) shall be construed as preventing the applicable regulatory authority from requiring, in the case of carriers that are not self-insurance carriers, such additional information in connection with, or apart from, the registration required under paragraph (1) as the applicable regulatory authority may be authorized to require under State law.

"(b) GUARANTEED ISSUE.—

"(1) IN GENERAL.—Subject to the succeeding provisions of this subsection, a carrier

that offers a health benefit plan (including a reinsurance plan) to small employers located in a community must offer the same plan to any other small employer located in the community.

"(2) TREATMENT OF HEALTH MAINTENANCE ORGANIZATIONS.—

"(A) GEOGRAPHIC LIMITATIONS.—A health maintenance organization may deny coverage under a health benefit plan to a small employer whose employees are located outside the service area of the organization, but only if such denial is applied uniformly without regard to health status or insurability.

"(B) SIZE LIMITS.—A health maintenance organization may apply to the applicable regulatory authority to cease enrolling new small employer groups in its health benefit plan (or in a geographic area served by the plan) if it can demonstrate that its financial or administrative capacity to serve previously enrolled groups and individuals (and additional individuals who will be expected to enroll because of affiliation with such previously enrolled groups) will be impaired if it is required to enroll new groups.

"(3) GROUNDS FOR REFUSAL TO ISSUE OR RENEW.—

"(A) IN GENERAL.—A carrier may refuse to issue or renew or terminate a health benefit plan under this part only for—

"(i) nonpayment of premiums,

"(ii) fraud or misrepresentation, and

"(iii) failure to meet minimum participation rates (consistent with subparagraph (B)).

"(B) MINIMUM PARTICIPATION RATES.—A carrier may require, within the transition period described in section 1303(a), with respect to a health benefit plan, that a minimum percentage of full-time, permanent employees eligible to enroll under the plan be enrolled, so long as such percentage is enforced uniformly for all employment groups of comparable size.

"(c) MINIMUM PLAN PERIOD.—A carrier may not offer to, or issue with respect to, a small employer a health benefit plan with a term of less than 12 months.

"(d) GUARANTEED RENEWABILITY.—

"(1) IN GENERAL.—

"(A) GENERAL RULE.—Subject to the succeeding provisions of this subsection, a carrier shall ensure that a health benefit plan issued to a small employer be renewed, at the option of the small employer, unless the plan is terminated for the reasons specified in subsection (a)(3)(A) or under subparagraph (B).

"(B) TERMINATION OF BLOCK OF BUSINESS.—A carrier need not renew a health benefit plan with respect to such a small employer if the carrier—

"(i) is terminating the block of business that includes the plan; and

"(ii) provides notice to the small employer covered under the plan of such termination at least 90 days before the date of expiration of the plan.

In the case of such a termination, the carrier may not provide for issuance of any health benefit plan in any block of business during the 5-year period beginning on the date of termination of such block of business.

"(C) CONSTRUCTION RESPECTING ADDITIONAL STATE DISCLOSURE REQUIREMENTS.—Subparagraph (B)(ii) shall not be construed as preventing the applicable regulatory authority from specifying the information to be included in the notice under such subparagraph or in requiring such notice to be provided at an earlier date.

"(2) NOTICE AND SPECIFICATION OF RATES AND ADMINISTRATIVE CHANGES.—

"(A) NOTICE.—A carrier offering health benefit plans to small employers shall provide for notice, at least 30 days before the date of expiration of the health benefit plan, of the terms for renewal of the plan. Except with respect to rates and administrative changes, the terms of renewal (including benefits) shall be the same as the terms of issuance.

"(B) RENEWAL RATES SAME AS ISSUANCE RATES.—The carrier may change the terms for such renewal, but the premium rates charged with respect to such renewal shall be the same as that for a new issue.

"(C) RATES CANNOT CHANGE MORE OFTEN THAN MONTHLY.—

"(i) IN GENERAL.—A carrier may not change the premium rates established with respect to health benefit plans offered for any block of business more often than monthly.

"(ii) APPLICATION OF NEW RATES.—A carrier that offers health benefit plans to small employers which becomes effective in a month, shall ensure that the premium rates established under clause (i) for that month shall apply to all months during the 12-month period beginning with that month. In the case of a plan renewal which is effective for a 12-month period beginning with a month, the premium rates established under clause (i) with respect to that month shall apply to all months during 12-month renewal period.

"(3) PERIOD OF RENEWAL.—The period of renewal of each health benefit plan offered by a carrier to a small employer shall be for a period of not less than 12 months.

"RATING PRACTICES FOR HEALTH BENEFIT PLANS OFFERED TO SMALL EMPLOYERS

"SEC. 1312. (a) COHESIVE RATING SYSTEM AND ACTURIAL CERTIFICATION.—

"(1) IN GENERAL.—The premiums (including reference premium rate, as defined in section 1304(c)(6), age adjustments under subsection (c), and reductions provided under subsection (d)) for all health benefit plans offered to small employers by carriers shall—

"(A) be established based on a single cohesive rating system which is applied consistently for all small employer groups and is designed not to treat groups, after the second effective year (as defined in subsection (f)), differently based on health status or risk status; and

"(B) be actuarially certified annually.

"(2) ACTUARIAL CERTIFIED DEFINED.—For purposes of paragraph (1)(B), a health benefit plan is considered to be 'actuarially certified' if there is a written statement, by a member of the American Academy of Actuaries or other individual acceptable to the applicable regulatory authority that a carrier is in compliance with this section, based upon the individual's examination, including a review of the appropriate records and of the actuarial assumptions and methods utilized by the carrier in establishing premium rates for applicable health benefit plans.

"(b) USE OF COMMUNITY-RATING.—

"(1) IN GENERAL.—Except as provided in paragraph (2) and subsection (c):

"(A) COMMUNITY RATING WITHIN A BLOCK OF BUSINESS.—The reference premium rate charged for health benefit plans offered with similar benefits to small employers in a community within a block of business for a type of family enrollment (described in subsection (e)) shall be the same for all small employers.

"(B) LIMITING VARIATION ON REFERENCE PREMIUM RATES AMONG BLOCKS OF BUSINESS.—

"(i) IN GENERAL.—Except as provided in clause (iii), the reference premium rate charged for health benefit plans offered with similar benefits to small employers in any community for a type of family enrollment for the most expensive block of business shall not exceed 120 percent of such rate charged for such plan for the same type of family enrollment for the least expensive block of business.

"(ii) ROLE OF REGULATORY AUTHORITY.—An applicable regulatory authority that is a State may reduce or eliminate the percent variation otherwise permitted under clause (i).

"(iii) EXCEPTION.—Clause (i) shall not apply to health benefit plans offered by carriers to small employers in a block of business—

"(I) if the block is one for which the carrier does not reject, and never has rejected, small employers included within the definition of small employers eligible for the block of business or otherwise eligible employees and dependents who enroll on a timely basis,

"(II) the carrier does not involuntarily transfer, and never has involuntarily transferred, a health benefit plan into or out of the block of business, and

"(III) that block of business was available for purchase as of the date of the enactment of this title.

"(2) TRANSITION.—Notwithstanding paragraph (1)—

"(A) during the first effective year (as defined in subsection (f)), the premium rate under a health benefit plan issued by a carrier to any small employer may be as much as, but may not exceed, 150 percent of the reference premium rate for such plans in the same community for similar benefits in the same block of business; or

"(B) during the second effective year, the premium rate under such a policy for any small employer may be as much as, but may not exceed, 122 percent of the reference premium rate for such plans in the same community for similar benefits in the same block of business.

"(3) ESTABLISHMENT OF BLOCKS OF BUSINESS.—For the purpose of establishing premiums for small employer health benefit plans with similar coverage, the carrier may establish blocks of business based only on one or more of the following characteristics:

"(A) Plans that are marketed by clearly different sales forces.

"(B) Plans that have been acquired from another carrier as a distinct group.

"(C) Plans that are managed care plans.

"(D) Plans within another distinct group, if the applicable regulatory authority finds that establishment of such a group will enhance the efficiency and fairness of the small employer insurance marketplace.

"(c) ADJUSTMENTS TO COMMUNITY-RATING.—

"(1) IN GENERAL.—Subject to paragraph (2), a health benefit plan offered by a carrier to a small employer may provide for an adjustment to the reference premium rate based on the age and gender of covered individuals. Any such adjustment shall be applied by the carrier consistently to all small employers, except that adjustment based on gender may only be made during the transition period.

"(2) LIMITATION ON ADJUSTMENT.—

"(A) IN GENERAL.—The adjustment under paragraph (1) may not result, with respect to health benefit plans with similar benefits offered by carriers to small employers in the same block of business in a community, in a premium rate for the most expensive age group exceeding the applicable percent (as defined in subparagraph (B)) of the premium rate for the least expensive age group.

"(B) APPLICABLE PERCENT DEFINED.—In subparagraph (A) but subject to subparagraph (C), the term 'applicable percent' means—

"(i) for the first effective year (as defined in subsection (f)) 200 percent,

"(ii) for the second effective year, 150 percent, and

"(iii) for any subsequent year, 110 percent.

"(C) ROLE OF REGULATORY AUTHORITY.—An applicable regulatory authority that is a State may reduce or eliminate the applicable percent otherwise applied.

"(d) ADJUSTMENT IN RATES PERMITTED IN CASE OF MEDICARE REIMBURSEMENT ELECTION.—A health benefit plan offered by a carrier to a small employer may compute premiums based upon a percentage of the reference premium rate otherwise applicable if the small employer to which the plan is being offered makes the reimbursement election described in section 1314. Any such adjustment shall be applied consistently to all small employers.

"(e) TYPES OF FAMILY ENROLLMENT.—Each health benefit plan offered by a carrier to a small employer shall permit enrollment of (and shall compute premiums separately for) individuals based on each of the following beneficiary classes:

"(1) 1 adult.

"(2) A married couple without children.

"(3) 1 adult and 1 child.

"(4) A married couple with 1 or more children, or 1 adult with 2 or more children.

"(f) EFFECTIVE YEARS DEFINED.—In this section, the terms 'first effective year' and 'second effective year' mean the third and fourth full years beginning after the date of the enactment of this part.

"(g) EXCEPTION FOR SELF-INSURED CARRIERS.—The requirements of this section shall apply to reinsurance carriers and health benefit plans offered by such carriers to small employers.

"BASIC BENEFIT PACKAGE FOR HEALTH BENEFIT PLANS OFFERED TO SMALL EMPLOYERS

"SEC. 1313. (a) IN GENERAL.—

"(1) BENEFITS AND COST-SHARING IN HEALTH BENEFIT PLANS.—Except as provided in paragraph (2) and in section 1303(a), no health benefit plan offered by carriers to small employers may be issued to a small employer unless—

"(A) the plan provides for benefits for all basic health services as defined in section 1182(1);

"(B) the plan does not impose cost-sharing with respect to basic health services in excess of the deductibles and coinsurance permitted under section 2103 with respect to such services; and

"(C) the carrier makes available to the small employer a health benefit plan that, subject to paragraph (2)(C), only provides the benefits for basic health services and the maximum cost-sharing consistent with subparagraphs (A) and (B).

"(2) EXCEPTIONS.—

"(A) REQUIRED OFFERING DOES NOT APPLY TO HMO'S.—Paragraph (1)(C) shall not apply to a health maintenance organization.

"(B) ADDITIONAL, OPTIONAL MINIMUM SERVICES.—In meeting the requirement of paragraph (1)(C), a health benefit plan offered by a carrier to a small employer may include such additional items and services as the carrier can demonstrate to the satisfaction of the applicable regulatory authority that inclusion of such items and services will facilitate appropriate hospital discharges or avoid unnecessary hospitalization.

"(b) MANAGED CARE OPTION.—If a carrier (other than a health maintenance organization or reinsurance carrier) offers health benefit plans to employers that are not small employers, in a community a health benefit plan that is a managed care plan, the carrier must make available to small employers in the community a health benefit plan that is such a managed care plan.

"(c) EXCEPTION FOR REINSURANCE CARRIERS AND PLANS.—The requirements of this section shall not apply to reinsurance carriers and reinsurance plans.

"(d) STANDARDIZATION OF BENEFIT PACKAGES.—The NAIC shall develop a model to standardize benefits to be made available under health benefit plans offered by carriers to small employers in order to promote consumer understanding and comparison among such plans.

"TIME-LIMITED MEDICARE REIMBURSEMENT OPTION FOR HEALTH BENEFIT PLANS OFFERED TO SMALL EMPLOYERS NOT PREVIOUSLY OFFERING INSURANCE COVERAGE

"SEC. 1314. (a) OPTION MUST BE OFFERED.—Each carrier offering a health benefit plan to small employers meeting the requirements of section 351(a) of the HealthAmerica Act shall offer the small employer the option of having payment under the plan made for basic health services at rates no higher than the payment rates established under title XVIII for such benefits. The provisions of section 1848(g)(3) shall not be considered to apply under this subsection.

"(b) APPLICATION OF MEDICARE BILLING LIMITATIONS.—In the case of a small employer that elects the option offered under subsection (a) with respect to a health benefit plan, the limitations on charges that may be made under medicare shall apply to individuals receiving benefits under the plan. The sanctions imposed under the medicare program (and title XI), including exclusion under such program and the imposition of civil money penalties for violations of such limitations, apply to violations of the limitations imposed under this subsection.

"(c) EXCEPTION FOR REINSURANCE PLAN.—Subsection (a) shall not apply to reinsurance plans.

"MISCELLANEOUS DISCLOSURE AND RECORDKEEPING REQUIREMENTS FOR HEALTH BENEFIT PLANS OFFERED TO SMALL EMPLOYERS

"SEC. 1315. (a) DISCLOSURE.—

"(1) GENERAL DISCLOSURE.—Each carrier offering health benefit plans to small employers shall disclose to each small employer before issuing such a plan the following:

"(A) The availability (pursuant to the requirement of section 1313(a)(1)(C)) of a plan including only basic benefits.

"(B) Whether any plan that is a managed care plan or provides for a utilization review program, or both, is available, as required under section 1313(b).

"(C) The option of electing the reimbursement rules, as required under section 1314.

"(D) The limits, imposed under section 1312, on the premiums permitted to be charged for such plans.

"(E) The rights of guaranteed issue and renewability provided under section 1311.

Such disclosure shall be in addition to any disclosure required generally of health benefit plans under section 2725 of the Public Health Service Act.

"(2) SPECIFIC DISCLOSURE UPON REQUEST.—Each carrier offering health benefit plans to small employers shall disclose to small employer, upon request, information concerning the blocks of business established with respect to such plans and the applicable premiums for such plans.

"(3) STANDARD FORMAT.—The disclosure under paragraph (1) shall be made in a uniform format established by the Secretary, after consultation with the NAIC.

"(4) EXCEPTIONS.—Paragraph (1) (other than subparagraphs (D) and (E)) shall not apply to a reinsurance carrier with respect to a reinsurance plan.

"(b) INFORMATION FILED WITH APPLICABLE REGULATORY AUTHORITY.—

"(1) IN GENERAL.—Each carrier offering health benefit plans to small employers shall disclose to the applicable regulatory authority, in a manner specified by the Secretary, information concerning—

"(1) blocks of business established; and

"(2) applicable premiums for health benefit plans.

"(2) ADDITIONAL INFORMATION.—Nothing in this subsection shall be construed as limiting the information which an applicable regulatory authority may require to be reported by carriers.

"NONAPPLICATION IN PUERTO RICO AND THE TERRITORIES

"SEC. 1316. This part shall not apply outside the 50 States or the District of Columbia.

"PART C—ENCOURAGING DEVELOPMENT OF REINSURANCE SYSTEMS

"ENCOURAGING DEVELOPMENT OF REINSURANCE SYSTEMS

"SEC. 1321. (a) DEVELOPMENT OF MODELS.—

"(1) IN GENERAL.—Not later than October 1 of the year following the year in which this title is enacted, the NAIC shall develop several models of legislation for the enactment of reinsurance systems that may be used by States with respect to health insurance policies (including health benefit plans offered to small employers).

"(2) SPECIFIC MODELS.—Such models shall include at least 1 of each of the following 3 models:

"(A) A model providing for voluntary participation by insurers.

"(B) A model providing for insurer participation on a retrospective basis.

"(C) A model providing for the case management of services for individual claims or groups which are reinsured through the system.

"(3) TERMS OF MODELS.—Each of the models—

"(A) shall be consistent with the provisions of this title (including those relating to community-rated premiums), and

"(B) shall include deductibles and coinsurance which—

"(i) limit the amount of risk ceded to the reinsurance system; and

"(ii) encourage insurers to manage health care costs.

"(b) PROTECTION OF HEALTH MAINTENANCE ORGANIZATIONS UNDER REINSURANCE SYSTEMS.—No State may establish or enforce a reinsurance system with respect to health insurance policies unless the system provides for an adjustment in reinsurance premiums (or, in the event of losses to the system, assessments) charged to health maintenance organizations that takes into account—

"(1) the higher premiums charged by such organizations due to the greater coverage provided by such organizations as required by law,

"(2) the limitations under title XIII of the Public Health Service Act on the amount of risk which such an organization can reinsure, and

"(3) the ability of such organizations to manage risk internally.

"(c) EFFECTIVE DATE.—This section shall take effect on the date of the enactment of this title.".

Subtitle B—Tax Equity for Small and Medium-Sized Business

SEC. 321. DEDUCTIBLE HEALTH COVERAGE PROVISIONS.

(a) INCREASE IN DEDUCTIBLE HEALTH INSURANCE COSTS FOR SELF-EMPLOYED INDIVIDUALS WITHOUT EMPLOYEES.—

(1) IN GENERAL.—Paragraph (1) of section 162(l) of the Internal Revenue Code of 1986 (relating to special rules for health insurance costs of self-employed individuals) is amended by striking out "25 percent" and all that follows and inserting in lieu thereof "100 percent of—

"(A) the cost of the lowest cost plan meeting the requirements of the subtitle A of title III of the HealthAmerica Act available in the geographic area in which the individual resides or conducts business, or

"(B) if such individual is enrolled in AmeriCare, the cost of AmeriCare,

paid during the taxable year for the taxpayer, his spouse, and dependents.".

(2) EFFECTIVE DATE.—The amendment made by this subsection shall apply to taxable years beginning in the third full calendar year after the date of enactment of this Act.

(b) DEDUCTION ALLOWABLE FOR CERTAIN GROUP HEALTH PLAN CONTRIBUTIONS BY SELF-EMPLOYED INDIVIDUALS.—

(1) IN GENERAL.—Section 162 of the Internal Revenue Code of 1986 (relating to trade or business expenses) is amended by redesignating subsection (m) as subsection (n) and by inserting after subsection (l) (relating to special rules for health insurance costs of self-employed individuals) the following new subsection:

"(m) DEDUCTION ALLOWABLE FOR CERTAIN GROUP HEALTH PLAN CONTRIBUTIONS FOR THE BENEFIT OF SELF-EMPLOYED INDIVIDUALS.—

"(1) IN GENERAL.—For purposes of this section and sections 212, 104, 105, and 106, in the case of a qualified group health plan which provides medical care benefits for any self-employed individual—

"(A) such individual shall be treated as an employee,

"(B) the employer of such individual shall be the person treated as the employer under section 301(c)(4), and

"(C) contributions to such plan for medical benefits for such individual shall be treated as meeting the requirements of subsection (a) and section 212 to the extent such contributions during the taxable year do not exceed the lowest per employee contribution for employees working 25 hours a week or more to the plan made by the employer during such year.

"(2) DEDUCTION CANNOT EXCEED TAXABLE INCOME FROM ACTIVITY.—The deduction allowed to any individual by reason of this subsection for any taxable year shall not exceed the portion of the taxable income of such individual (determined without regard to this subsection) for such year which is allocable or apportionable to such individual's interest in the employer.

"(3) QUALIFIED GROUP HEALTH PLAN.—

"(A) IN GENERAL.—For purposes of this subsection, the term 'qualified group health plan' means, with respect to any self-employed individual, any group health plan (as defined in section 5000(b)(1)) of an employer if—

"(i) such plan is not a self-insured plan, and

"(ii) such plan meets the requirements of subparagraphs (B) and (C).

"(B) ONE-HALF OF PARTICIPANTS MUST BE EMPLOYEES WHO ARE NOT SELF-EMPLOYED INDIVIDUALS OR EMPLOYEE FAMILY MEMBERS OF SUCH INDIVIDUALS.—

"(i) IN GENERAL.—A plan meets the requirements of this subparagraph with respect to any self-employed individual only if at least half of the participants in the plan (on each day of the taxable year of such individual) are employees who are not—

"(I) self-employed individuals to whom a deduction is allowable by reason of this subsection with respect to contributions to such plan, or

"(II) family members of any self-employed individual described in subclause (I).

"(ii) FAMILY MEMBER.—For purposes of clause (i), the term 'family member' means, with respect to an individual, such individual's brothers and sisters (whether by the whole or half blood), spouse, ancestors, and lineal descendants.

"(C) SELF-INSURED PLAN.—The term 'self-insured plan' means any plan under which medical care benefits are not provided under a policy of accident and health insurance.

"(4) LOWEST PER EMPLOYEE CONTRIBUTION.—

"(A) IN GENERAL.—For purposes of this subsection, the term 'lowest per employee contribution' means, with respect to any taxable year of a self-employed individual, the smallest contribution made by the employer during such taxable year to the plan with respect to any employee—

"(i) who is not a self-employed individual,

"(ii) with respect to whom a contribution to the plan was made during such year, and

"(iii) who is in the same category of coverage as the self-employed individual.

"(B) CATEGORIES OF COVERAGE.—For purposes of subparagraph (A), the categories of coverage are—

"(i) self only, and

"(ii) self and family.

"(C) SELF-EMPLOYED INDIVIDUALS WHO ARE PARTICIPANTS FOR LESS THAN ENTIRE TAXABLE YEAR.—In the case of a self-employed individual who is a participant in the plan for less than the entire taxable year, the lowest per employee contribution applicable to such individual shall be the same portion of amount determined under subparagraph (A) as the portion of the taxable year during which such individual was a participant in the plan bears to the entire taxable year.

"(D) SPECIAL RULES.—For purposes of subparagraph (A)—

"(i) only contributions for coverage during the taxable year shall be taken into account, and

"(ii) the contributions with respect to any employee who is not a participant in the plan for the entire taxable year shall be determined on an annualized basis.

"(5) OTHER DEFINITIONS.—For purposes of this subsection—

"(A) SELF-EMPLOYED INDIVIDUAL.—The term 'self-employed individual' has the meaning given such term by section 301(c)(1)(B).

"(B) MEDICAL CARE BENEFITS.—The term 'medical care benefits' means, with respect to any self-employed individual, compensation for the medical care (as defined in section 213(d)) of such individual, the spouse of such individual, and dependents of such individual.

"(C) DEPENDENT.—The term 'dependent' has the meaning given such term by section 152. Any child to whom section 152(e) applies shall be treated as a dependent of both parents.

"(6) SPECIAL RULES.—

"(A) COORDINATION WITH SECTION 213.—Any amount allowed as a deduction by reason of this subsection shall not be treated as an amount paid for medical care under section 213.

"(B) AGGREGATION OF EMPLOYER PLANS.—If any self-employed individual is a participant in 2 or more qualified group health plans of the employer, all such plans shall be treated as 1 plan for purposes of this subsection.".

(2) TECHNICAL AMENDMENT.—Subsection (g) of section 105 of the Internal Revenue Code of 1986 (relating to self-employed individual not considered an employee) is amended by striking out "For purposes of this section" and inserting in lieu thereof "Except as provided in section 162(m)(1), for purposes of this section".

(3) EFFECTIVE DATE.—The amendments made by this subsection shall apply to taxable years beginning in the third full year after the date of enactment of this Act.

SEC. 322. EXCISE TAX FOR VIOLATION OF HEALTH BENEFIT PLAN REQUIREMENTS.

(a) IN GENERAL.—

(1) IN GENERAL.—Chapter 43 of the Internal Revenue Code of 1986 (relating to qualified pension, etc., plans) is amended by adding at the end thereof the following new section:

"SEC. 4980C. VIOLATION OF HEALTH BENEFIT PLAN REQUIREMENTS.

"(a) IMPOSITION OF TAX.—There is hereby imposed a tax on an entity's violation of subsection (a) of section 1301 of the Social Security Act. The determination of whether there has been such a violation shall be made by the Secretary of Health and Human Services under such section.

"(b) AMOUNT OF TAX.—The tax imposed by subsection (a) shall be equal to 25 percent of the amounts received by the entity (during the period such a violation persists) for providing any health plan for all blocks of business in all communities.

"(c) LIABILITY FOR TAX.—The tax imposed by this section shall be paid by the entity.

"(d) EXCEPTIONS.—

"(1) CORRECTIONS WITHIN 30 DAYS.—No tax shall be imposed by subsection (a) by reason of any violation if—

"(A) such violation was due to reasonable cause and not to willful neglect, and

"(B) such violation is corrected within the 30-day period beginning on earliest date the entity knew, or exercising reasonable diligence could have known, that such a violation was occurring.

"(2) WAIVER BY SECRETARY.—In the case of a violation which is due to reasonable cause and not to willful neglect, the Secretary may waive part or all of the tax imposed by subsection (a) to the extent that payment of such tax would be excessive relative to the violation involved.

"(e) DEFINITIONS.—For purposes of this section, the definitions in title XXIII of the Social Security Act shall apply under this section.".

(2) CLERICAL AMENDMENT.—The table of sections for chapter 43 of such Code is amended by adding at the end thereof the following new item:

"Sec. 4980C. Violation of health plan requirements.".

(b) EFFECTIVE DATE.—The amendments made by subsection (a) shall become effective on January 1 of the 4th year beginning after the date of the enactment of this Act.

Subtitle C—Opportunity for Voluntary Provision of Coverage

SEC. 331. MEDIUM-SIZED EMPLOYERS.

(a) EMPLOYERS WITH BETWEEN 25 AND 100 EMPLOYEES.—

(1) IN GENERAL.—No medium-sized employer shall be required to provide a health benefit plan under section 2701 of the Public Health Service Act or make a contribution in lieu of coverage under title V of this Act until the fifth calendar year after the date of enactment of this Act.

(2) APPLICATION OF REQUIREMENTS.—If, during the fourth calendar year after the date of enactment of this Act, the Secretary finds that the total number of employees, excluding part-time employees, of all such employers that have no employment-based health insurance coverage provided through the employers of such employees has been reduced to 25 percent or less of the number of such uninsured employees that existed during the calendar year in which this Act was enacted, the requirement to provide coverage or make a contribution under title V shall apply to employers described in paragraph (1).

(3) PERCENTAGES DURING SUBSEQUENT YEARS.—An employer described in paragraph

(1) shall provide the health benefits coverage under this Act, or an amendment made by this Act, or make a contribution under title V if the percentage of the uninsured employees during the fifth calendar year or any subsequent calendar year after the date of the enactment of this Act is more than the 25 percent level described in paragraph (2).

(b) UNINSURED EMPLOYEES.—

(1) YEAR OF ENACTMENT.—For purposes of subsection (a), employees shall be considered uninsured during the calendar year in which this Act is enacted if such employees are not covered under any employment-based health insurance coverage provided through their employer.

(2) FOURTH YEAR.—For purposes of subsection (a), employees shall be considered uninsured during the fourth calendar year after the date of the enactment of this Act if such employees are not covered under any employment-based health insurance coverage provided through their employer that meets the requirements of this Act and the amendments made by this Act.

SEC. 332. MEASUREMENT SURVEYS.

(a) ANNOUNCEMENT.—Not later than 6 months after the date of enactment of this Act, the Secretary shall publish in the Federal Register an announcement of the survey or surveys to be used by such Secretary in the coverage level of employees described in section 331, and the criteria that will be used to determine such level.

(b) CRITERIA.—The announcement of criteria under subsection (a) shall include a determination, based on the availability of the most reliable survey data available, as to whether the determination of the coverage level shall be based on a measurement of insurance coverage at a point in time or during the course of all or part of a calendar year.

(c) APPLICATION OF ACT.—If the percentage of uninsured employees in the fourth calendar year after the date of the enactment of this Act is equal to or less than the 25 percent level described in section 331(a), the Secretary shall repeat the measurement of such coverage level annually and if, in any calendar year, the Secretary does not find that the number of employees who do not have employer provided health insurance coverage is equal to or less than such 25 percent level, the requirements of this Act or section 2701 of the Public Health Service Act shall apply to all employers described in section 331(a).

SEC. 333. SMALL EMPLOYERS.

Sections 331 and 332 shall apply to small employers, except that the requirement to provide coverage or make a contribution in lieu of coverage under title V shall not be applied until the sixth calendar year after the date of enactment of this Act, and the Secretary shall make the determinations required under such sections to be made in the fourth calendar year, in the fifth calendar year after the date of enactment of this Act.

SEC. 334. FAILURE TO MAKE SURVEYS.

The failure of the Secretary to make the surveys required under this subtitle shall not relieve an employer of the obligation of such employer to provide coverage or make a contribution in lieu of coverage absent a finding by the Secretary that the coverage target has been met.

Subtitle D—Small Business Tax Credit

SEC. 341. ALLOWANCE OF A CREDIT FOR SMALL AND MEDIUM-SIZED BUSINESS GROUP HEALTH PLAN EXPENDITURES.

(a) IN GENERAL.—Subpart D of part IV of subchapter A of chapter 1 of the Internal Revenue Code of 1986 (relating to business related credits) is amended by inserting at the end thereof the following new section:

"SEC. 45. SMALL BUSINESS GROUP HEALTH PLAN EXPENDITURES.

"(a) ALLOWANCE OF CREDIT.—

"(1) IN GENERAL.—For purposes of section 38, in the case of an eligible small business, the amount of the qualified group health plan credit for the taxable year shall be an amount equal to the applicable percentage of the qualified group health plan expenditures for such taxable year.

"(2) APPLICABLE PERCENTAGE DEFINED.—

"(A) IN GENERAL.—For purposes of paragraph (1), the term 'applicable percentage' means 25 percent reduced (but not below 0 percent) by 5 percent for—

"(i) each employee of the eligible small business in excess of 40, or

"(ii) each .1 by which the expanded profit ratio of such business exceeds 1.

"(B) COORDINATION OF MULTIPLE PHASEOUTS.—If an eligible small business is subject to subparagraphs (A)(i) and (A)(ii), the applicable percentage shall be determined by multiplying the resulting applicable percentage under subparagraph (A)(i) (expressed as a percentage of the credit remaining) by such applicable percentage under subparagraph (A)(ii).

"(C) EXPANDED PROFIT RATIO.—

"(i) IN GENERAL.—For purposes of this paragraph, the term 'expanded profit ratio' means the expanded profit of the eligible small business for the taxable year divided by the qualified group health plan expenditures of such business for such year.

"(ii) EXPANDED PROFIT.—For purposes of clause (i), the term 'expanded profit' means the sum of—

"(I) the taxable income of the eligible small business,

"(II) the amount of earned income exceeding the applicable contribution base (as defined in section 3121(x)(1)) for each 5-percent owner of such business, plus

"(III) the total amount of interest and dividends distributed to all owners of such business.

"(b) QUALIFIED GROUP HEALTH PLAN EXPENDITURES; ELIGIBLE SMALL BUSINESS.—For purposes of this section—

"(1) QUALIFIED GROUP HEALTH PLAN EXPENDITURES.—

"(A) IN GENERAL.—The term 'qualified group health plan expenditures' means the aggregate amount of expenditures paid or incurred by the eligible small business for the taxable year for coverage of its employees under a group health plan (as defined in section 5000(b)(1)) which is a health benefit plan (as defined in section 2713(a)(5) of the Public Health Service Act to the extent such expenditures do not exceed $3,000 for each employee, reduced (but not below zero) by 5 percent for each $250 (or fraction thereof) by which the amount of wages paid to such employee by the eligible small business in such taxable year exceeds $15,000.

"(B) LIMIT INDEXED.—In the case of any taxable year beginning in a calendar year after the effective date of this section, the $3,000 amount in subparagraph (A) shall be increased by an amount equal to

"(i) such amount, multiplied by

"(ii) the increase (if any) in the wage index for such calendar year.

"(2) ELIGIBLE SMALL BUSINESS.—

"(A) IN GENERAL.—The term 'eligible small business' means any person which, on an average business day during the preceding taxable year, had no more than 60 employees.

"(B) AGGREGATION RULES.—All members of the same controlled group of corporations (within the meaning of section 52(a)) and all persons under common control (within the meaning of section 52(b)) shall be treated as 1 person.

"(C) EMPLOYEE.—The term 'employee'—

"(i) shall include a self-employed individual as defined in section 401(c)(1), but

"(ii) shall not include an employee who works less than 25 hours per week.

"(c) COORDINATION WITH DEDUCTION.—Any deduction allowable under this chapter for any qualified group health plan expenditures shall be in addition to any credit under section 38 attributable to such expenditures.".

(b) CONFORMING AMENDMENTS.—

(1) Section 38(b) of such Code is amended—

(A) by striking "plus" at the end of paragraph (6),

(B) by striking "plus" at the end of paragraph (7), and inserting a comma and "plus", and

(C) by adding at the end thereof the following new paragraph:

"(8) the small business group health plan expenditures credit determined under section 45.".

(2) The table of sections for subpart D of part IV of subchapter A of chapter 1 of such Code is amended by inserting after the item relating to section 44 the following new item:

"Sec. 45. Small business group health plan expenditures."

(c) EFFECTIVE DATE.—The amendments made by this section shall apply to taxable years beginning in the third full calendar year after the date of the enactment of this Act.

Subtitle E—Additional Assistance to Small and Medium-Sized Businesses

SEC. 351. OPPORTUNITY TO BUY COVERAGE AT MEDICARE RATES.

(a) ELIGIBILITY.—Businesses with fewer than 100 employees that have not provided coverage to their employees in the calendar year preceding the date of enactment of this Act shall be eligible to buy private health insurance coverage from a small or medium-sized business insurer under which providers of health care services are paid at rules based on Medicare rates as provided for in part C of title XXVII of the Public Health Service Act and title XIII of the Social Security Act, for a period of not to exceed 5 years.

(b) DEFINITION.—As used in this section the term "not provided coverage in the calendar year preceding the date of enactment of this Act" means, with respect to a business, that less than 25 percent of employees working more than 17.5 hours per week for the business received coverage from the business in each of the years.

SEC. 352. SPECIAL PROVISION FOR NEW SMALL BUSINESSES.

In the case of a small employer that normally employs 24 or fewer employees during a year, and that has been an employer for not more than 3 years, such employer shall not be required to provide coverage under this Act or the amendment made by this Act or make a contribution in lieu of coverage under title V for the first two years in which the employer has been an employer. Such employer shall be permitted to meet the requirements of part B of title XXVII of the Public Health Service Act by making a contribution at a rate that is ½ of the rate that would otherwise be required to be paid under this Act.

SEC. 353. SMALL AND MEDIUM-SIZED BUSINESS ADVISORY COMMITTEE.

(a) ESTABLISHMENT.—The Secretary shall establish a small and medium-sized business advisory committee (hereafter referred to in this section as the "committee") that shall provide advice to such Secretary and to the appropriate committees of Congress con-

cerning all provisions of this Act that relate to small and medium-sized businesses.

(b) MEMBERSHIP.—

(1) IN GENERAL.—The Secretary shall jointly appoint individuals to serve on the committee, of which—

(A) seven individuals shall be representatives of small or medium-sized businesses;

(B) two individuals shall be representatives of employees of small or medium-sized businesses;

(C) two individuals shall be knowledgeable concerning the small and medium-sized business insurance market; and

(D) two individuals shall be members of the general public.

(2) SMALL AND MEDIUM-SIZED BUSINESS REPRESENTATIVES.—Individuals appointed under paragraph (1)(A) shall—

(A) be selected from geographically diverse regions of the country;

(B) include at least one representative of small or medium-sized businesses that are located in rural areas and one representative of small or medium-sized businesses located in urban areas;

(C) include at least one individual who represents the concerns of minority businesses; and

(D) represent a diversity of businesses.

(3) CHAIRPERSON.—The members of the committee shall elect an individual to serve as chairperson.

(4) COMPENSATION AND REIMBURSEMENT OF EXPENSES.—Members of the committee appointed under paragraph (1) shall receive compensation for each day (including travel time) engaged in carrying out the duties of the committee. Such compensation may not be in an amount in excess of the maximum rate of basic pay payable for GS-18 of the General Schedule.

(5) STAFF.—The Secretary shall provide to the committee such staff, information, and other assistance as may be necessary to carry out the duties of the committee.

(6) REGULATIONS.—The Secretary shall promulgate regulations that prescribe the terms to be served by the members of the committee, the procedure for filling vacancies on the committee, and the procedure for holding and administering meetings.

(c) DUTIES.—The committee shall—

(1) perform the advisory functions as described in subsection (a);

(2) analyze the impact of the implementation of this Act and the amendments made by this Act on small and medium-sized businesses and make recommendations to the Secretary and the appropriate committees of Congress concerning appropriate modifications to such Act;

(3) review and provide comments concerning the regulations promulgated pursuant to this Act that impact on small and medium-sized businesses;

(4) monitor the effectiveness of the small insurer reform program established under subtitle A, and make recommendations to the Secretary and the appropriate committees of Congress concerning appropriate modifications in such program;

(5) serve as a channel of communication between the Secretary and the small and medium-sized business communities; and

(6) perform such other functions as the Secretary considers appropriate.

(d) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated such sums as may be necessary to carry out this section.

TITLE IV—REDUCING HEALTH CARE COST INFLATION

Subtitle A—Outcomes Research and Practice Guideline Development and Dissemination

SEC. 401. INITIAL GUIDELINES AND STANDARDS.

Subsection (d) of section 912 of the Public Health Service Act (as added by section 6103(a) of Public Law 101-239) is amended to read as follows:

"(d) INITIAL GUIDELINES AND STANDARDS.—

"(1) IN GENERAL.—Not later than January 1, 1992, the Administrator shall assure the development of an initial set of guidelines as described in subsection (a)(1) that shall include not less than three clinical treatments or conditions that—

"(A) account for a significant portion of national health expenditures;

"(B) have a significant variation in the frequency or the type of treatment provided; or

"(C) otherwise meet the needs and priorities described in this section.

"(2) MENTAL HEALTH SERVICES.—The Administrator, in consultation with the National Institute of Mental Health and mental health providers, shall develop outcomes research and practice parameters for mental health services, including at least the diagnosis and treatment of childhood attention deficit disorders and manic depression.".

SEC. 402. AMENDMENTS TO THE SOCIAL SECURITY ACT.

Section 1142(l) of the Social Security Act (as added by section 6103(b) of Public Law 101-239) is amended—

(1) in paragraph (1), to read as follows:

"(1) IN GENERAL.—There are authorized to be appropriated to carry out this section—

"(A) $125,000,000 for fiscal year 1991;

"(B) $175,000,000 for fiscal year 1992;

"(C) $225,000,000 for fiscal year 1993; and

"(D) $275,000,000 for fiscal year 1994."; and

(2) in paragraph (2), by striking out "75 percent" and inserting in lieu thereof "50 percent".

Subtitle B—Federal Health Expenditure Board

SEC. 411. FEDERAL HEALTH EXPENDITURE BOARD.

(a) PUBLIC HEALTH SERVICE ACT.—Title XXVII of the Public Health Service Act (as added under section 101 and amended by section 201 and 311) is further amended by adding at the end thereof the following new part:

"PART D—FEDERAL HEALTH EXPENDITURE BOARD

"SEC. 2761. ESTABLISHMENT AND MEMBERSHIP.

"(a) ESTABLISHMENT.—There is established as an independent agency in the executive branch a Federal Health Expenditure Board (hereafter referred to in this part as the 'Board').

"(b) MEMBERSHIP.—

"(1) IN GENERAL.—

"(A) APPOINTMENT.—The Board shall be composed of 11 members to be appointed by the President, by and with the advice and consent of the Senate.

"(B) EX OFFICIO MEMBERS.—The Secretary, the Chairman of the Prospective Payment Assessment Commission and the Chairman of the Physician Payment Review Commission shall serve as ex officio members of the Board.

"(2) REPRESENTATION.—In appointing members to the Board under paragraph (1)(A), the President shall ensure that—

"(A) the interests of health care providers and purchasers are fairly represented; and

"(B) a majority of the members of the Board are experts in health care issues and fairly represent the interests of the general public in having access to quality and affordable health care.

"(3) CHAIRPERSON.—The President shall appoint a member appointed under paragraph (1)(A) to serve as the Chairperson of the Board.

"(4) TERMS.—

"(A) IN GENERAL.—Except as provided in subparagraph (B), the members of the Board appointed under paragraph (1)(A) shall serve for terms of 7 years. Such members may be reappointed.

"(B) INITIAL MEMBERS.—Of the initial members of the Board appointed under paragraph (1)(A)—

"(i) three shall be appointed for a term of 2 years;

"(ii) three shall be appointed for a term of 4 years;

"(iii) three shall be appointed for a term of 6 years; and

"(iv) two shall be appointed for a term of 7 years;

as designated by the President at the time of appointment.

"(5) VACANCIES.—Any vacancy in the membership of the Board shall be filled in the same manner in which the original appointment was made. Any member appointed to fill a vacancy occurring before the expiration of the term of office for which such member's predecessor was appointed shall be appointed only for the remainder of such term.

"(6) QUORUM.—Six members of the Board appointed under paragraph (1)(A) shall constitute a quorum for purposes of conducting the business of the Board, but a lesser number may meet to hold hearings.

"(7) MEETINGS.—The Board shall meet at the call of the Chairperson, or upon motion by not less than six of the members of the Board appointed under paragraph (1)(A), to conduct the business of the Board.

"SEC. 2762. FUNCTIONS AND DUTIES OF THE BOARD.

"(a) IN GENERAL.—The Board shall—

"(1) develop national health care expenditure, access and quality goals;

"(2) convene and oversee negotiations between health care providers and purchasers to develop payment rates and perform other activities necessary to achieve expenditure goals developed under paragraph (1);

"(3) establish recommended payment levels and other recommended measures that may include increased utilization of managed care, increased utilization of alternatives to institutionalization, and procedures for the allocation and limitation of capital investment necessary to achieve health care expenditure, quality and access targets subsequent to the conclusion of required negotiations;

"(4) develop goals for States and regions that are consistent with national goals established under paragraph (1);

"(5) prepare and submit, to the President, the appropriate committees of Congress and to the general public, an annual report concerning the success in achieving the goals established under paragraph (1), together with such recommendations as the Board considers appropriate to further the objectives of providing access to affordable, quality health care;

"(6) establish uniform billing and claim forms and mandatory reporting requirements to—

"(A) measure the success in meeting the goals established under paragraph (1);

"(B) permit the Board, to the extent practicable, to analyze data acquired under such reporting requirements for individual providers to assist purchasers and consumers in evaluating the quality and cost of care offered by different providers; and

"(C) reduce the administrative cost of the health care system;

"(7) recommend rates, budgets and such other measures as may be appropriate and consistent with expenditure goals developed by negotiators or the Board under this part to assure access to quality affordable health care under Federal health insurance programs and programs under which the Federal Government enters into contracts for the delivery of health care;

"(8) conduct studies, issue reports, and gather and disseminate data to the Congress, the President and the general public, to contribute to the objective of providing access to high-quality affordable health care;

"(9) cooperate with State-based consortium established under section 2781; and

"(10) carry out any other activities determined by the Board to be necessary to further the goal of making available affordable, accessible, high quality health care in the United States.

"(b) PERSONNEL, SERVICES, REGULATIONS.—The Board may, for the purpose of performing its duties and carrying out its functions under this part—

"(1) employ such personnel as it considers necessary to perform administrative, clerical, technical and other duties;

"(2) procure the temporary and intermittent services of experts and consultants to the extent authorized by section 3109(b) of title 5, United States Code, at rates the Board determines to be reasonable; and

"(3) prescribe regulations necessary to carry out the functions and duties of the Board under this part.

"SEC. 2763. DEVELOPMENT OF NATIONAL HEALTH CARE EXPENDITURE, ACCESS, AND QUALITY GOALS.

"(a) EXPENDITURE GOALS.—

"(1) IN GENERAL.—The Board shall, to the extent practicable, develop national expenditure goals under section 2762(a)(1) applicable to the total amount to be expended in the United States for health care. To the extent practicable, such goals shall contain a separate expenditure breakdown for—

"(A) hospital services;

"(B) physician services;

"(C) laboratory services;

"(D) pharmaceutical products;

"(E) durable medical equipment; and

"(F) such other health services or sectors, including subdivisions of the sectors described in this paragraph, other than long-term care services, as the Board determines appropriate.

"(2) CONSIDERATIONS.—In developing expenditure goals under paragraph (1), the Board shall take into consideration—

"(A) the aging of the population and such other factors as may affect the demand for health care in the future;

"(B) general inflation factors and the costs related to inflation in labor and other inputs used to produce health services;

"(C) technological advances that may increase or decrease health care costs;

"(D) appropriate improvements in health care productivity;

"(E) feasible reductions in unnecessary health care;

"(F) the need to assure that all sectors of the population have adequate access to health care services;

"(G) the impact and availability of such goals on the quality of health care; and

"(H) such other factors as the Board determines appropriate.

"(b) QUALITY GOALS.—

"(1) DEVELOPMENT.—The Board shall, to the extent practicable, develop national goals under section 2762(a)(1) for improving the quality of the health care system of the United States. Such goals shall include recommendations for improving the quality of health care provided in the United States and establish a system of measuring the progress made in achieving such goals.

"(2) DATA AND STUDIES.—The Board shall collect such data and conduct such studies as may be necessary to carry out paragraph (1).

"(c) ACCESS GOALS.—

"(1) DEVELOPMENT.—The Board shall, to the extent practicable, develop national goals under section 2762(a)(1) for improving access to the health care system for all Americans. Such goals shall include recommendations for achieving such goals and establish a system of measuring progress made in achieving such goals.

"(2) DATA AND STUDIES.—The Board shall collect such data and conduct such studies as may be necessary to carry out paragraph (1).

"(d) STATE AND REGIONAL GOALS.—In carrying out its functions under this section, the Board shall develop separate goals for each State and region, based on an adjustment of the national goals, to reflect the demographic characteristics and other relevant characteristics of such States and regions.

"(e) TIMING.—The Board shall, not later than June 30 of each year, develop preliminary goals under this section and, not later than December 1 of each year, develop final goals and the recommended payment rates and other measures necessary to achieve such goals.

"SEC. 2764. HEALTH CARE PROVIDER AND PURCHASER NEGOTIATIONS.

"(a) REQUIREMENT OF NEGOTIATIONS TO ACHIEVE GOALS.—The Board shall convene appropriate representatives of health care providers and purchasers recognized or appointed as negotiators under section 2765 to negotiate concerning terms and conditions related to the provision of health care to achieve the expenditure goals developed under section 2763(a). The Board shall adopt a negotiating process that shall be followed by such negotiators.

"(b) OBLIGATION TO BARGAIN IN GOOD FAITH.—It shall be the obligation of negotiators participating in negotiations under subsection (a) to bargain in good faith and consistent with the processes established by the Board.

"(c) TIME FOR NEGOTIATIONS.—The negotiations required under subsection (a) shall be commenced not later than July 1, and shall be completed not later than September 31, of each year unless such time period is extended by the Board.

"(d) SECTORS FOR NEGOTIATIONS.—The Board shall require negotiations under subsection (a) for the achievement of the expenditure goals for physician and hospital care. The Board may require that negotiations also be convened under such subsection concerning other health care sectors of the type referred to in section 2763(a)(1), including subdivisions of sectors, to the extent determined to be appropriate and feasible by the Board.

"(e) CONTENT OF NEGOTIATIONS.—

"(1) IN GENERAL.—Negotiators participating in negotiations under subsection (a) shall attempt to agree on recommendations to be submitted to the Board concerning a health care payment system and uniform payment rates, together with other appropriate recommendations for achieving the expenditure goals developed under section 2763(a).

"(2) ACHIEVEMENT OF GOALS.—In developing recommendations under paragraph (1), the negotiators shall attempt to ensure that such recommended payment system, payment rates, and other recommended measures will, if implemented, will result in the achievement of the expenditure goals developed under section 2763(a).

"SEC. 2765. NEGOTIATION REQUIREMENTS.

"(a) NEGOTIATION BY SECTOR.—In each sector selected by the Board under section 2764(d) as a sector in which negotiations shall be conducted, negotiators representing providers of health care and purchasers of health care shall be selected in accordance with this section. The Board shall determine which individuals, organizations, and institutions are eligible for representation as providers or purchasers in each sector.

"(b) HEALTH CARE PROVIDERS.—

"(1) IN GENERAL.—

"(A) PETITION.—An organization (through a representative of such organization) or an individual that desires to be a negotiator on behalf of health care providers under this section shall submit a petition requesting such to the Board. Such petition shall include any authorizations of representation that such organization or individual has received on behalf of health care providers, in such form and meeting such requirements as the Board may require.

"(B) GENERAL APPROVAL.—An organization or individual submitting a petition under subparagraph (A) that contains authorizations of representation from not less than 25 percent of the health care providers in a sector, as determined by the Board, shall be approved by the Board as a negotiator for providers with respect to that sector.

"(C) EXCLUSIVE NEGOTIATOR.—An organization or individual submitting a petition under subparagraph (A) that contains authorizations of representation from not less than 50 percent of the health care providers in a sector, as determined by the Board, shall be approved by the Board as the exclusive negotiator for providers with respect to that sector.

"(D) APPOINTMENT.—If no organization or individual submits a petition under subparagraph (A) that contains authorizations of representation from 25 percent or more of the health care providers in a sector, as determined by the Board, the Board shall—

"(i) appoint a negotiator or negotiators to represent such providers; or

"(ii) establish an election procedure for the election of a negotiator or negotiators for such providers.

"(2) INSTITUTIONAL SECTORS.—In the case of a health care sector in which health care services are delivered primarily through institutions or organizations, the Board shall establish a procedure to select negotiators to represent such institutions and organizations that is based on a weighted designation of all such institutions and organizations after consideration of the revenues or number of patients served by such institutions or organizations or based on such other measure as the Board determines appropriate.

"(c) PURCHASERS.—

"(1) IN GENERAL.—

"(A) PETITION.—An organization (through a representative of such organization) or an individual that desires to be a negotiator on behalf of health care purchasers under this section shall submit a petition requesting such to the Board. Such petition shall include any authorizations of representation that such organization or individual has received on behalf of health care purchasers.

"(B) GENERAL APPROVAL.—An organization or individual submitting a petition under subparagraph (A) that contains authorizations of representation from not less than 25 percent of the health care purchasers in a sector, as determined by the Board, shall be approved by the Board as a negotiator for purchasers with respect to that sector.

"(C) EXCLUSIVE NEGOTIATOR.—An organization or individual submitting a petition under subparagraph (A) that contains au-

thorizations of representation from not less than 50 percent of the health care purchasers in a sector, as determined by the Board, shall be approved by the Board as the exclusive negotiator for purchasers with respect to that sector.

"(D) APPOINTMENT.—If no organization or individual submits a petition under subparagraph (A) that contains authorizations of representation from 25 percent or more of the health care purchasers in a sector, as determined by the Board, the Board shall—

"(i) appoint a negotiator or negotiators to represent such purchasers; or

"(ii) establish an election procedure for the election of a negotiator or negotiators for such purchasers.

"(2) DETERMINATIONS.—If the Board designates employment-based health benefit plans as all or some of the purchasers entitled to be represented in negotiations for a sector, the Board shall establish a procedure for determining whether the 25 percent or 50 percent requirements are met for purposes of subparagraphs (B) and (C) of paragraph (1), based on a weighted designation that considers the number of individuals covered by the health benefits plan of the purchaser, the total expenditures under such plans, or such other measure as the Boards determines appropriate. In the case of health benefit plans provided pursuant to a collective bargaining agreement, for purposes of the weighted designation, 50 percent of the costs of or individuals covered under such plan shall be assigned to the union and 50 percent to the appropriate employer or employers. If the Board designates other categories of purchasers, a similar procedure shall be utilized.

"(d) CONTINUED APPROVAL AS NEGOTIATORS, LIMITATION.—

"(1) ESTABLISHMENT OF PROCEDURES.—The Board shall establish procedures for the withdrawal of approvals granted to organizations or individuals under subsections (b)(1) or (c)(1).

"(2) EXCLUSIVE NEGOTIATORS.—

"(A) PETITION FOR INITIATION OF PROCEDURES.—The Board may initiate procedures under paragraph (1) to withdraw the approval of an exclusive negotiator under subsection (b)(1)(C) or (c)(1)(C), if not less than 30 percent of the health care providers or purchasers in the appropriate sector file a petition with the Board for such withdrawal.

"(B) VOTE ON WITHDRAWAL.—If the Board determines that a petition received under subparagraph (A) is valid, the Board shall arrange for a vote to take place among the appropriate purchasers or providers to determine whether to withdraw the approval that is the subject of such petition. If in excess of 50 percent of such providers or purchasers vote to withdraw such approval, the Board shall certify that such approval is withdrawn and initiate procedures to select a new negotiator or negotiators.

"(3) LIMITATION AND ELECTION.—

"(A) LIMITATION.—With respect to a sector in which no exclusive negotiator has been approved under subsection (b)(1)(C) or (c)(1)(C), the Board may not grant approvals to organizations and individuals under paragraph (1)(B) of each such subsection, as applicable, in a manner that would result in the approval of individuals and organizations representing in excess of 100 percent of the purchasers or providers.

"(B) ELECTION.—In the event that petitions are received (whether or not approvals have previously been granted) under subsection (b)(1)(B) or (c)(1)(C), from organizations or individuals cumulatively representing in excess of 100 percent of the purchasers or providers in a sector the Board shall conduct an election among such qualified organizations or individuals to determine which such organizations and individuals will be approved or have their approval continued.

"(4) PERIOD OF DESIGNATION.—No organization or individual shall be a negotiator or an exclusive negotiator for more than a 5-year period without being recertified as a negotiator or exclusive negotiator in the same manner as the original designation was made under this section.

"(5) TIMING.—Any vote or election held under this subsection to determine the negotiators for a particular year, shall be completed prior to June 30 of that year. Votes or elections completed after such date shall apply to the negotiations for the following year.

"SEC. 2766. REQUIREMENTS FOR RECOMMENDED PAYMENT SYSTEMS AND RATES.

"(a) HOSPITALS.—

"(1) NEGOTIATED AGREEMENT.—A payment system for hospitals that is recommended in an agreement negotiated pursuant to section 2767 shall be based on the hospital payment system established under title XVIII of the Social Security Act, except that the Board may approve or adopt an alternative payment system.

"(2) ALTERNATIVE PAYMENT SYSTEM.—An alternative payment system approved or adopted under paragraph (1) shall provide for the adjustment of payment rates to reflect the differences in costs between different types of hospitals to the extent that such costs represent appropriate differences in the costs of delivering care efficiently and effectively in different types of hospitals or are necessary to achieve other public policy objectives, as determined by the Board. Such a payment system shall reflect geographic differences in labor and to the extent feasible, other input costs, capital and other needs to maintain adequate access to care and quality of care. To the extent desirable and feasible, the negotiators shall recommend, and the Board shall approve, special treatment for managed care programs.

"(b) PHYSICIANS.—

"(1) NEGOTIATED AGREEMENT.—A payment system for physicians that is recommended in an agreement negotiated pursuant to section 2767 shall be based on the physician payment system established under title XVIII of the Social Security Act, except that the Board may approve or adopt an alternative payment system.

"(2) ALTERNATIVE PAYMENT SYSTEM.—An alternative payment system approved or adopted under paragraph (1) shall reflect geographic differences in practice costs insofar as those differences reflect the cost of economical and efficient provision of quality care, and shall promote an appropriate distribution of primary and specialty care. To the extent desirable and feasible, the negotiators shall recommend, and the Board shall approve, special treatment for managed care programs.

"SEC. 2767. OUTCOME OF NEGOTIATIONS, AGREEMENTS.

"(a) AGREEMENT.—If a majority of the negotiators (in the case of multiple negotiators) for the providers and a majority of the negotiators (in the case of multiple negotiators) for the purchasers, for a particular sector, agree to recommend a proposal under this part to the Board, such proposal shall be considered to have been agreed to by the negotiators.

"(b) BINDING NATURE OF AGREEMENTS.—If a negotiated agreement is reached, pursuant to subsection (a), concerning a health services rate structure, or concerning any other matter that would lead to the achievement of the goals developed by the Board under section 2763, or an alternative goal accepted by the Board under subsection (c), and such agreement, in the judgment of the Board, will lead to the achievement of such goals, the Board shall promulgate regulations implementing such rates and other matters and such rates and other matters shall be binding on providers and purchasers in the sector to which such agreement applies.

"(c) AGREEMENT ON DIFFERENT GOAL.—If the negotiators reach an agreement, pursuant to subsection (a), concerning a goal that is different than a goal that has been developed by the Board under section 2763, the Board shall adopt such agreed upon goal if the Board determines that it would be in the best interest of the general public to adopt such goal. The Board, on a rejection of such alternative agreed upon goal, may request that the negotiators attempt to reach a negotiated agreement concerning the original goal under section 2763, and such other measures to achieve such original goal, and may promulgate regulations recommending rates and other matters to achieve the original goal.

"(d) EFFECT OF NO AGREEMENT.—

"(1) IN GENERAL.—If the negotiators for a particular sector fail to reach a negotiated agreement, pursuant to subsection (a), concerning a goal established under section 2763, the Board shall promulgate regulations recommending advisory rates and other matters necessary to achieve such goals. Such advisory rates and other matters shall not be binding on health care providers and purchasers.

"(2) CONSTRUCTION.—Notwithstanding any other provision of law, health care purchasers may combine for the purpose of agreeing to pay health care providers for services at rates recommended pursuant to paragraph (1). Notwithstanding any other provision of law, health care providers may combine for the purpose of agreeing to charge for services at rates recommended pursuant to paragraph (1).

"(e) TECHNICAL ASSISTANCE.—The Board shall provide technical assistance to negotiators, including estimates of the effect on expenditure goals of alternative proposals and estimates of utilization changes that can be expected under different proposals. The Board may recommend a proposal to achieve expenditure goals for the consideration of the negotiators. The Board may make available professional mediation and conciliation services to the negotiators.

"SEC. 2768. ENFORCEMENT.

"(a) IN GENERAL.—A health care provider assessing rates other than those required under regulations promulgated by the Board under this part, or failing to comply in any other manner with such regulations, or a health care purchaser paying rates other than those required under such regulations, except in the case of an alternative rate or method established under subsections (a)(2) and (b)(2) of section 2766, shall—

"(1) be ineligible for any assistance under this Act; and

"(2) be liable to the United States for a civil penalty for such failure in an amount not to exceed $50,000 in the case of an individual and $500,000 in the case of an organization, as provided for in subsection (b).

"(b) CIVIL ACTIONS.—

"(1) IN GENERAL.—A civil penalty under subsection (a)(2) shall be assessed by the Board on a health care provider or purchaser by an order made on the record after an opportunity for a hearing on any disputed issues of material fact and the amount of the penalty. In the course of any investigation or hearing under this paragraph, the Board or its designees may administer oaths

and affirmations, examine witnesses, receive evidence, and issue subpoenas requiring the attendance and testimony of witnesses and the production of evidence that relates to the matter under investigation.

"(2) AMOUNT.—In determining the amount of a civil penalty under paragraph (1), the Board shall take into account the nature, circumstances, extent, and gravity of the act subject to penalty, the ability to pay, the effect on the ability to continue to do business, any history of prior, similar acts, and such other matters as the Board determines appropriate.

"(3) LIMITATION ON ACTIONS.—The Board may not initiate an action under this subsection with respect to any noncompliance described in subsection (a) that occurred before the date of the enactment of this section.

"(c) INJUNCTIVE RELIEF.—The Board shall have the power, upon the initiation of an action regarding noncompliance with a provision of this part, to petition any United States district court, within any district wherein such noncompliance is alleged to have occurred, for appropriate temporary injunctive relief. Upon the filing of any such petition, the court shall cause notice thereof to be served upon such person, and thereupon shall have jurisdiction to grant the Board such temporary injunctive relief as the court determines to be appropriate.

"(d) JUDICIAL REVIEW.—Any health care provider or purchaser that is the subject of an adverse decision under subsection (b)(1) or subsection (c) may obtain a review of such decision by the United States Court of Appeals for the District of Columbia or for the circuit in which the provider or purchaser resides, by filing in such court within 60 days following the date the purchaser or provider is notified of the decision of the Board) a petition requesting that the decision be modified or set aside.

"SEC. 2769. OTHER GOVERNMENT PROGRAMS.

"The Board shall promulgate regulations recommending advisory rates and other matters necessary to achieve the goals established under section 1172 for all Federal programs (other than the program under titles XVIII, XIX and XXI of the Social Security Act) that reimburse providers on a fee, charge, or cost basis or charge third-party providers on such basis. Such nonbinding rates shall be consistent with the rates promulgated by the Board under sections 1176 and 1178, except that Federal payments resulting from such rates shall be no greater than such payments would have been if determined without regard to this section through the fifth full fiscal year after the date of enactment of this section.

"SEC. 2770. ROLE OF STATES.

"(a) ALTERNATIVE SYSTEMS, ETC.—A State consortia established under section 2781 may, with the approval of the Board, establish an alternative payment system, rates, and methods for achieving goals developed by the Board under section 2763.

"(b) APPROVAL.—The Board shall approve alternative payment systems, rates, and methods under subsection (a) if Board determines that such alternative systems, rates, or methods would result in a level of health care expenditures in the State that achieves the national goals developed under section 2763, adjusted to the State level. If the Board determines that such national goals would not be achieved through the proposed alternative systems, rates or methods, the rates or other matters that apply to the State under regulations promulgated by the Board shall remain binding in the State. Such Board approval is only necessary where binding payment systems, rates and methods are not promulgated under a negotiated agreement.

"(c) STANDARD FOR DETERMINATION.—In making a determination under subsection (b), the Board shall consider the effect of the alternative systems, rates or methods, with respect to the goals established under section 2763, on the State as a whole rather than on particular health care sectors in the State.

"SEC. 2771. UNIFORM BILLING AND MANDATORY REPORTING.

"(a) IN GENERAL.—The Board shall establish a system of uniform billing and reporting, as required under subsection (c), that will enable the Board to determine the progress made in meeting the goals established under section 2763, to provide information for health care providers and purchasers to assist such providers and purchasers in providing and obtaining efficiently provided quality health care, and to reduce administrative costs of the health care system.

"(b) GENERAL REPORTING AND DATA REQUIREMENTS.—The Board shall—

"(1) develop a computerized system for the collection, analysis, and dissemination of data required to be collected under this part;

"(2) establish one or more uniform claims and billing form as required in subsection (c)(2) to be utilized by all data sources and providers;

"(3) audit information provided by health care providers on a sample basis or in situations where there exists reasonable cause for such an audit; and

"(4) issue public reports concerning health care costs and the effectiveness of the health care provided by health care providers.

"(c) DATA COLLECTION.—

"(1) IN GENERAL.—Data sources shall submit to the Board, on the request of the Board, all data required to be submitted under this part in accordance with the uniform submission formats, coding systems, and other technical specifications established by the Board to assure that such incoming data is substantially valid, consistent, compatible and manageable.

"(2) UNIFORM CLAIMS AND BILLING FORMS.—Data shall be collected by the Board through the use of one or more Federal Uniform Claims and Billing Forms developed by the Board and utilized by providers and purchasers of health care that shall, at a minimum, include—

"(A) a uniform patient identifier;

"(B) the date of birth of the patient;

"(C) the gender of the patient;

"(D) the ZIP Code of the patient;

"(E) the date of admission of the patient for inpatient hospital services;

"(F) the date of discharge of the patient referred to in subparagraph (E);

"(G) the principal and secondary diagnoses of the patient;

"(H) the principal and secondary procedures to be followed in treating the patient;

"(I) a uniform health care facility identifier;

"(J) uniform identifiers of physicians and treating the patient;

"(K) for services provided in an inpatient setting, the total charges of the health care facility treating the patient, segregated into major categories determined appropriate by the Board;

"(L) the amounts of actual payments made to the treating health care facility;

"(M) the amounts of the charges of each physician or professional rendering service to the patient;

"(N) the services provided in an inpatient setting;

"(O) the amounts of actual payments made to each physician or professional rendering service to the patient;

"(P) a uniform identifier of the primary payor;

"(Q) the ZIP Code of the facility where service is rendered to the patient;

"(R) the patient discharge status; and

"(S) such other material as the Board determines necessary or useful to carry out the duties of the Board or to provide adequate information to purchasers of health care to assist such purchasers in appropriately paying for services.

"(3) MEASURE OF SERVICE EFFECTIVENESS.—

"(A) DEVELOPMENT OF METHODOLOGY.—To the extent practical and as rapidly as feasible, the Secretary shall develop and implement a methodology or methodologies that will measure the effectiveness of the health care service provided by health care providers.

"(B) INCLUSION IN UNIFORM BILLING FORM.—To the extent practical and as rapidly as feasible, the Secretary shall include in the uniform claims and billing forms or in other data collection instruments established under subsection (b) data necessary to provide the Secretary with information concerning each service provided by health care providers that is sufficient to enable the Secretary to analyze the quality, cost, and service effectiveness of the provider.

"(4) ADDITIONAL DATA.—The Board may collect additional data, including audited annual financial reports of all hospitals and ambulatory service facilities, medicare cost reports, information on capital expenditures, and any other data that the Board determines necessary to carry out its responsibilities under this part.

"(5) RECOMMENDATIONS.—The Board shall make recommendations to the committees of Congress, the President, and the insurance industry concerning methods to reduce the cost and burden of duplication or excessive reporting requirements imposed on health care providers.

"(d) REPORTS.—

"(1) IN GENERAL.—The Board, not less than once each calendar year, shall for every health care provider for which sufficient data is available, prepare and make available reports that shall, to the extent practicable and scientifically valid, contain data in a form that will provide the most useful information to purchasers of health care services regarding such providers to enable such purchasers to compare providers on the basis of cost and quality.

"(2) AVAILABILITY.—The Secretary shall advertise and make available all reports prepared under paragraph (1) to the general public, including any dissents submitted by health care providers.

"(3) RECOMMENDATIONS.—The Board shall make recommendations to the appropriate committees of Congress, the President, and the insurance industry concerning methods to reduce the cost and burden of duplicative or excessive reporting requirements imposed on health care providers.

"(e) DEFINITION.—As used in this section, the term 'data sources' means classes of entities and individuals that the Board designates as data sources.

"SEC. 2772. ANNUAL REPORTS.

"Not later than June 30 of each year, the Board shall prepare and submit to the President, the appropriate committees of Congress and the general public, a report concerning the success in attaining expenditure, access, and quality goals developed under section 2763, and containing recommendations for additional measures, if any, that the Board determines are necessary to achieve such goals.

"SEC. 2773. DEFINITIONS.

"As used in this part:

"(1) PROVIDER.—The term 'provider' means a physician, hospital, health maintenance organization, pharmacy, laboratory, or other provider of health care services or supplies, that has entered into an agreement with a managed care entity to provide such services or supplies to a patient enrolled in a managed care plan.

"(2) PURCHASER.—The term 'purchaser' means an entity that pays for the services of providers, including in the case of a health benefit plan provided pursuant to a collective bargaining agreement, the labor union that has negotiated for such plan on behalf of employees shall be considered to be a purchaser.

"SEC. 2774. EFFECTIVE DATES.

"The Board shall develop the goals under section 2763 for each calendar year beginning not later than the second full calendar year after the date of enactment of this part. The Board shall establish the negotiating procedures required under section 2714(a) for each calendar year beginning not later than the third calendar year after the date of enactment of this part.".

(b) SOCIAL SECURITY ACT.—Title XI of the Social Security Act (42 U.S.C. 1301 et seq.) is amended by adding at the end thereof the following new part:

"PART C—FEDERAL HEALTH EXPENDITURE BOARD

"FUNCTIONS AND DUTIES OF THE FEDERAL HEALTH EXPENDITURE BOARD

"SEC. 1171. (a) IN GENERAL.—The Federal Health Expenditure Board (hereafter in this part referred to as the 'Board') shall—

"(1) develop national health care expenditure, access and quality goals;

"(2) convene and oversee negotiations between health care providers and purchasers to develop payment rates and perform other activities necessary to achieve expenditure goals developed under paragraph (1);

"(3) establish recommended payment levels and other recommended measures that may include increased utilization of managed care, increased utilization of alternatives to institutionalization, and procedures for the allocation and limitation of capital investment necessary to achieve health care expenditure, quality, and access targets subsequent to the conclusion of required negotiations;

"(4) develop goals for States and regions that are consistent with national goals established under paragraph (1);

"(5) prepare and submit, to the President, the appropriate committees of Congress and to the general public, an annual report concerning the success in achieving the goals established under paragraph (1), together with such recommendations as the Board considers appropriate to further the objectives of providing access to affordable, quality health care;

"(6) establish uniform billing and claims forms and mandatory reporting requirements to—

"(A) measure the success in meeting the goals established under paragraph (1);

"(B) permit the Board, to the extent practicable, to analyze data acquired under such reporting requirements for individual providers to assist purchasers and consumers in evaluating the quality and cost of care offered by different providers; and

"(C) reduce the administrative cost of the health care system;

"(7) recommend rates, budgets, and such other measures as may be appropriate and consistent with expenditure goals developed by negotiators or the Board under this part to assure access to quality affordable health care under Federal health insurance programs and programs under which the Federal Government enters into contracts for the delivery of health care;

"(8) conduct studies, issue reports, and gather and disseminate data to the Congress, the President, and the general public, to contribute to the objective of providing access to high-quality affordable health care;

"(9) cooperate with State-based consortium described under part D of this title; and

"(10) carry out any other activities determined by the Board to be necessary to further the goal of making available affordable, accessible, high quality health care in the United States.

"(b) PERSONNEL, SERVICES, REGULATIONS.—The Board may, for the purpose of performing its duties and carrying out its functions under this part—

"(1) employ such personnel as it considers necessary to perform administrative, clerical, technical and other duties;

"(2) procure the temporary and intermittent services of experts and consultants to the extent authorized by section 3109(b) of title 5, United States Code, at rates the Board determines to be reasonable; and

"(3) prescribe regulations necessary to carry out the functions and duties of the Board under this part.

"DEVELOPMENT OF NATIONAL HEALTH CARE EXPENDITURE, ACCESS, AND QUALITY GOALS

"SEC. 1172. (a) EXPENDITURE GOALS.—

"(1) IN GENERAL.—The Board shall, to the extent practicable, develop national expenditure goals under section 1171(a)(1) applicable to the total amount to be expended in the United States for health care. To the extent practicable, such goals shall contain a separate expenditure breakdown for—

"(A) hospital services;

"(B) physician services;

"(C) laboratory services;

"(D) pharmaceutical products;

"(E) durable medical equipment; and

"(F) such other health services or sectors, including subdivisions of the sectors described in this paragraph, other than long-term care services, as the Board determines appropriate.

"(2) CONSIDERATIONS.—In developing expenditure goals under paragraph (1), the Board shall take into consideration—

"(A) the aging of the population and such other factors as may affect the demand for health care in the future;

"(B) general inflation factors and the costs related to inflation in labor and other inputs used to produce health services;

"(C) technological advances that may increase or decrease health care costs;

"(D) appropriate improvements in health care productivity;

"(E) feasible reductions in unnecessary health care;

"(F) the need to assure that all sectors of the population have adequate access to health care services;

"(G) the impact of such goals on the quality and availability of health care; and

"(E) such other factors as the Board determines appropriate.

"(b) QUALITY GOALS.—

"(1) DEVELOPMENT.—The Board shall, to the extent practicable, develop national goals under section 1171(a)(1) for improving the quality of the health care system of the United States. Such goals shall include recommendations for improving the quality of health care provided in the United States and establish a system of measuring the progress made in achieving such goals.

"(2) DATA AND STUDIES.—The Board shall collect such data and conduct such studies as may be necessary to carry out paragraph (1).

"(c) ACCESS GOALS.—

"(1) DEVELOPMENT.—The Board shall, to the extent practicable, develop national goals under section 1171(a)(1) for improving access to the health care system for all Americans. Such goals shall include recommendations for achieving such goals and establish a system of measuring progress made in achieving such goals.

"(2) DATA AND STUDIES.—The Board shall collect such data and conduct such studies as may be necessary to carry out paragraph (1).

"(d) STATE AND REGIONAL GOALS.—In carrying out its functions under this section, the Board shall develop separate goals for each State and region, based on an adjustment of the national goals, to reflect the demographic characteristics and other relevant characteristics of such States and regions.

"(e) TIMING.—The Board shall, no later than June 30 of each year, develop preliminary goals under this section and, not later than December 1 of each year, develop final goals and the recommended payment rates and other measures necessary to achieve such goals.

"HEALTH CARE PROVIDER AND PURCHASER NEGOTIATIONS

"SEC. 1173. (a) REQUIREMENT OF NEGOTIATIONS TO ACHIEVE GOALS.—The Board shall convene appropriate representatives of health care providers and purchasers recognized or appointed as negotiators under section 1174 to negotiate concerning terms and conditions related to the provision of health care to achieve the expenditure goals developed under section 1172(a). The Board shall adopt a negotiating process that shall be followed by such negotiators.

"(b) OBLIGATION TO BARGAIN IN GOOD FAITH.—It shall be the obligation of negotiators participating in negotiations under subsection (a) to bargain in good faith and consistent with the processes established by the Board.

"(c) TIME FOR NEGOTIATIONS.—The negotiations required under subsection (a) shall be commenced not later than July 1, and shall be completed not later than September 31, of each year unless such time period is extended by the Board.

"(d) SECTORS FOR NEGOTIATIONS.—The Board shall require negotiations under subsection (a) for the achievement of the expenditure goals for physician and hospital care. The Board may require that negotiations also be convened under such subsection concerning other health care sectors of the type referred to in section 1172(a)(1), including subdivisions of sectors, to the extent determined to be appropriate and feasible by the Board.

"(e) CONTENT OF NEGOTIATIONS.—

"(1) IN GENERAL.—Negotiators participating in negotiations under subsection (a) shall attempt to agree on recommendations to be submitted to the Board concerning a health care payment system and uniform payment rates, together with other appropriate recommendations for achieving the expenditure goals developed under section 1172(a).

"(2) ACHIEVEMENT OF GOALS.—In developing recommendations under paragraph (1), the negotiators shall attempt to ensure that such recommended payment system, payment rates, and other recommended measures will, if implemented, will result in the achievement of the expenditure goals developed under section 1172(a).

"NEGOTIATION REQUIREMENTS

"SEC. 1174. (a) NEGOTIATION BY SECTOR.—In each sector selected by the Board under section 1173(d) as a sector in which negotiations shall be conducted, negotiators repre-

senting providers of health care and purchasers of health care shall be selected in accordance with this section. The Board shall determine which individuals, organizations, and institutions are eligible for representation as providers or purchasers in each sector.

"(b) HEALTH CARE PROVIDERS.—

"(1) IN GENERAL.—

"(A) PETITION.—An organization (through a representative of such organization) or an individual that desires to be a negotiator on behalf of health care providers under this section shall submit a petition requesting such to the Board. Such petition shall include any authorizations of representation that such organization or individual has received on behalf of health care providers, in such form and meeting such requirements as the Board may require.

"(B) GENERAL APPROVAL.—An organization or individual submitting a petition under subparagraph (A) that contains authorizations of representation from not less than 25 percent of the health care providers in a sector, as determined by the Board, shall be approved by the Board as a negotiator for providers with respect to that sector.

"(C) EXCLUSIVE NEGOTIATOR.—An organization or individual submitting a petition under subparagraph (A) that contains authorizations of representation from not less than 50 percent of the health care providers in a sector, as determined by the Board, shall be approved by the Board as the exclusive negotiator for providers with respect to that sector.

"(D) APPOINTMENT.—If no organization or individual submits a petition under subparagraph (A) that contains authorizations of representation from 25 percent or more of the health care providers in a sector, as determined by the Board, the Board shall—

"(i) appoint a negotiator or negotiators to represent such providers; or

"(ii) establish an election procedure for the election of a negotiator or negotiators for such providers.

"(2) INSTITUTIONAL SECTORS.—In the case of a health care sector in which health care services are delivered primarily through institutions or organizations, the Board shall establish a procedure to select negotiators to represent such institutions and organizations that is based on a weighted designation of all such institutions and organizations after consideration of the revenues or number of patients served by such institutions or organizations or based on such other measure as the Board determines appropriate.

"(c) PURCHASERS.—

"(1) IN GENERAL.—

"(A) PETITION.—An organization (through a representative of such organization) or an individual that desires to be a negotiator on behalf of health care purchasers under this section shall submit a petition requesting such to the Board. Such petition shall include any authorizations of representation that such organization or individual has received on behalf of health care purchasers.

"(B) GENERAL APPROVAL.—An organization or individual submitting a petition under subparagraph (A) that contains authorizations of representation from not less than 25 percent of the health care purchasers in a sector, as determined by the Board, shall be approved by the Board as a negotiator for purchasers with respect to that sector.

"(C) EXCLUSIVE NEGOTIATOR.—An organization or individual submitting a petition under subparagraph (A) that contains authorizations of representation from not less than 50 percent of the health care purchasers in a sector, as determined by the Board, shall be approved by the Board as the exclusive negotiator for purchasers with respect to that sector.

"(D) APPOINTMENT.—If no organization or individual submits a petition under subparagraph (A) that contains authorizations of representation from 25 percent or more of the health care purchasers in a sector, as determined by the Board, the Board shall—

"(i) appoint a negotiator or negotiators to represent such purchasers; or

"(ii) establish an election procedure for the election of a negotiator or negotiators for such purchasers.

"(2) DETERMINATIONS.—If the Board designates employment-based health benefit plans as all or some of the purchasers entitled to be represented in negotiations for a sector, the Board shall establish a procedure for determining whether the 25 percent or 50 percent requirements are met for purposes of subparagraphs (B) and (C) of paragraph (1), based on a weighted designation that considers the number of individuals covered by the health benefits plan of the purchaser, the total expenditures under such plans, or such other measure as the Boards determines appropriate. In the case of health benefit plans provided pursuant to a collective bargaining agreement, for purposes of the weighted designation, 50 percent of the costs of or individuals covered under such plan shall be assigned to the union and 50 percent to the appropriate employer or employers. If the Board designates other categories of purchasers, a similar procedure shall be utilized.

"(d) CONTINUED APPROVAL AS NEGOTIATORS, LIMITATION.—

"(1) ESTABLISHMENT OF PROCEDURES.—The Board shall establish procedures for the withdrawal of approvals granted to organizations or individuals under subsections (b)(1) or (c)(1).

"(2) EXCLUSIVE NEGOTIATORS.—

"(A) PETITION FOR INITIATION OF PROCEDURES.—The Board may initiate procedures under paragraph (1) to withdraw the approval of an exclusive negotiator under subsection (b)(1)(C) or (c)(1)(C), if not less than 30 percent of the health care providers or purchasers in the appropriate sector file a petition with the Board for such withdrawal.

"(B) VOTE ON WITHDRAWAL.—If the Board determines that a petition received under subparagraph (A) is valid, the Board shall arrange for a vote to take place among the appropriate purchasers or providers to determine whether to withdraw the approval that is the subject of such petition. If in excess of 50 percent of such providers or purchasers vote to withdraw such approval, the Board shall certify that such approval is withdrawn and initiate procedures to select a new negotiator or negotiators.

"(3) LIMITATION AND ELECTION.—

"(A) LIMITATION.—With respect to a sector in which no exclusive negotiator has been approved under subsection (b)(1)(C) or (c)(1)(C), the Board may not grant approvals to organizations and individuals under paragraph (1)(B) of each such subsection, as applicable, in a manner that would result in the approval of individuals and organizations representing in excess of 100 percent of the purchasers or providers.

"(B) ELECTION.—In the event that petitions are received (whether or not approvals have previously been granted) under subsection (b)(1)(B) or (c)(1)(C), from organizations or individuals cumulatively representing in excess of 100 percent of the purchasers or providers in a sector the Board shall conduct an election among such qualified organizations or individuals to determine which such organizations and individuals will be approved or have their approval continued.

"(4) PERIOD OF DESIGNATION.—No organization or individual shall be a negotiator or an exclusive negotiator for more than a 5-year period without being recertified as a negotiator or exclusive negotiator in the same manner as the original designation was made under this section.

"(5) TIMING.—Any vote or election held under this subsection to determine the negotiators for a particular year, shall be completed prior to June 30 of that year. Votes or elections completed after such date shall apply to the negotiations for the following year.

"REQUIREMENTS FOR RECOMMENDED PAYMENT SYSTEMS AND RATES

"SEC. 1175. (a) HOSPITALS.—

"(1) NEGOTIATED AGREEMENT.—A payment system for hospitals that is recommended in an agreement negotiated pursuant to section 1176 shall be based on the hospital payment system established under title XVIII of this Act, except that the Board may approve or adopt an alternative payment system.

"(2) ALTERNATIVE PAYMENT SYSTEM.—An alternative payment system approved or adopted under paragraph (1) shall provide for the adjustment of payment rates to reflect the differences in costs between different types of hospitals to the extent that such costs represent appropriate differences in the costs of delivering care efficiently and effectively in different types of hospitals or are necessary to achieve other public policy objectives, as determined by the Board. Such a payment system shall reflect geographic differences in labor and to the extent feasible, other input costs, capital and other needs to maintain adequate access to care and quality of care. To the extent desirable and feasible, the negotiators shall recommend, and the Board shall approve; special treatment for managed care programs.

"(b) PHYSICIANS.—

"(1) NEGOTIATED AGREEMENT.—A payment system for physicians that is recommended in an agreement negotiated pursuant to section 1176 shall be based on the physician payment system established under title XVIII of this Act, except that the Board may approve or adopt an alternative payment system.

"(2) ALTERNATIVE PAYMENT SYSTEM.—An alternative payment system approved or adopted under paragraph (1) shall reflect geographic differences in practice costs insofar as those differences reflect the cost of economical and efficient provision of quality care, and shall promote an appropriate distribution of primary and specialty care. To the extent desirable and feasible, the negotiators shall recommend, and the the Board shall approve, special treatment for managed care programs.

"OUTCOME OF NEGOTIATIONS, AGREEMENTS

"SEC. 1176. (a) AGREEMENT.—If a majority of the negotiators (in the case of multiple negotiators) for the providers and a majority of the negotiators (in the case of multiple negotiators) for the purchasers, for a particular sector, agree to recommend a proposal under this part to the Board, such proposal shall be considered to have been agreed to by the negotiators.

"(b) BINDING NATURE OF AGREEMENTS.—If a negotiated agreement is reached, pursuant to subsection (a), concerning a health services rate structure, or concerning any other matter that would lead to the achievement of the goals developed by the Board under section 1172, or an alternative goal accepted by the Board under subsection (c), and such agreement, in the judgment of the Board, will lead to the achievement of such goals,

the Board shall promulgate regulations implementing such rates and other matters and such rates and other matters shall be binding on providers and purchasers in the sector to which such agreement applies.

"(c) AGREEMENT ON DIFFERENT GOAL.—If the negotiators reach an agreement, pursuant to subsection (a), concerning a goal that is different than a goal that has been developed by the Board under section 1172, the Board shall adopt such agreed upon goal if the Board determines that it would be in the best interest of the general public to adopt such goal. The Board, on a rejection of such alternative agreed upon goal, may request that the negotiators attempt to reach a negotiated agreement concerning the original goal under section 1172, and such other measures to achieve such original goal, and may promulgate regulations recommending rates and other matters to achieve the original goal.

"(d) EFFECT OF NO AGREEMENT.—

"(1) IN GENERAL.—If the negotiators for a particular sector fail to reach a negotiated agreement, pursuant to subsection (a), concerning a goal established under section 1172, the Board shall promulgate regulations recommending advisory rates and other matters necessary to achieve such goals. Such advisory rates and other matters shall not be binding on health care providers and purchasers.

"(2) CONSTRUCTION.—Notwithstanding any other provision of law, health care purchasers may combine for the purpose of agreeing to pay health care providers for services at rates recommended pursuant to paragraph (1).

"(e) TECHNICAL ASSISTANCE.—The Board shall provide technical assistance to negotiators, including estimates of the effect on expenditure goals of alternative proposals and estimates of utilization changes that can be expected under different proposals. The Board may recommend a proposal to achieve expenditure goals for the consideration of the negotiators. The Board may make available professional mediation and concillation services to the negotiators.

"ENFORCEMENT

"SEC. 1177. (a) IN GENERAL.—A health care provider assessing rates other than those required under regulations promulgated by the Board under this part, or failing to comply in any other manner with such regulations, or a health care purchaser paying rates other than those required under such regulations, except in the case of an alternative rate or method established under subsections (a)(2) and (b)(2) of section 1175, shall—

"(1) be ineligible for any assistance under this Act; and

"(2) be liable to the United States for a civil penalty for such failure in an amount not to exceed $50,000 in the case of an individual and $500,000 in the case of an organization, as provided for in subsection (b).

"(b) CIVIL ACTIONS.—

"(1) IN GENERAL.—A civil penalty under subsection (a)(2) shall be assessed by the Board on a health care provider or purchaser by an order made on the record after an opportunity for a Board hearing on any disputed issues of material fact and the amount of the penalty. In the course of any investigation or hearing under this paragraph, the Board or its designees may administer oaths and affirmations, examine witnesses, receive evidence, and issue subpoenas requiring the attendance and testimony of witnesses and the production of evidence that relates to the matter under investigation.

"(2) AMOUNT.—In determining the amount of a civil penalty under paragraph (1), the Board shall take into account the nature, circumstances, extent, and gravity of the act subject to penalty, the ability to pay, the effect on the ability to continue to do business, any history of prior, similar acts, and such other matters as the Board determines appropriate.

"(3) LIMITATION ON ACTIONS.—The Board may not initiate an action under this subsection with respect to any noncompliance described in subsection (a) that occurred before the date of the enactment of this section.

"(c) INJUNCTIVE RELIEF.—The Board shall have the power, upon the initiation of an action regarding noncompliance with a provision of this part, to petition any United States district court, within any district wherein such noncompliance is alleged to have occurred, for appropriate temporary injunctive relief. Upon the filing of any such petition, the court shall cause notice thereof to be served upon such person, and thereupon shall have jurisdiction to grant the Board such temporary injunctive relief as the court determines to be appropriate.

"(d) JUDICIAL REVIEW.—Any health care provider or purchaser that is the subject of an adverse decision under subsection (b)(1) or subsection (c) may obtain a review of such decision by the United States Court of Appeals for the District of Columbia or for the circuit in which the provider or purchaser resides, by filing in such court (within 60 days following the date the purchaser or provider is notified of the decision of the Board) a petition requesting that the decision be modified or set aside.

"ROLE OF STATES

"SEC. 1178. (a) ALTERNATIVE SYSTEMS, ETC.—A State consortia described in part D of this title may, with the approval of the Board, establish an alternative payment system, rates, and methods for achieving goals developed by the Board under section 1172.

"(b) APPROVAL.—The Board shall approve alternative payment systems, rates, and methods under subsection (a) if Board determines that such alternative systems, rates, or methods would result in a level of health care expenditures in the State that achieves the national goals developed under section 1172, adjusted to the State level. If the Board determines that such national goals would not be achieved through the proposed alternative systems, rates or methods, the rates or other matters that apply to the State under regulations promulgated by the Board shall remain binding in the State. Such Board approval is only necessary where binding payment systems, rates and methods are not promulgated under a negotiated agreement.

"(c) STANDARD FOR DETERMINATION.—In making a determination under subsection (b), the Board shall consider the effect of the alternative systems, rates or methods, with respect to the goals established under section 1172, on the State as a whole rather than on particular health care sectors in the State.

"OTHER GOVERNMENT PROGRAMS

"SEC. 1179. The Board shall promulgate regulations recommending advisory rates and other matters necessary to achieve the goals established under section 1172 for all Federal programs (other than the program under title XVIII of this Act) that reimburse providers on a fee, charge, or cost basis or charge third-party providers on such basis. Such nonbinding rates shall be consistent with the rates promulgated by the Board under sections 1176 and 1178, except that Federal payments resulting from such rates shall be no greater than such payments would have been if determined without regard to this section through the fifth full fiscal year after the date of enactment of this section.

"UNIFORM BILLING AND MANDATORY REPORTING

"SEC. 1180. (a) IN GENERAL.—The Board shall establish a system of uniform billing and reporting, as required under subsection (c), that will enable the Board to determine the progress made in meeting the goals established under section 1172, to provide information for health care providers and purchasers to assist such providers and purchasers in providing and obtaining efficiently provided quality health care, and to reduce administrative costs of the health care system.

"(b) GENERAL REPORTING AND DATA REQUIREMENTS.—The Board shall—

"(1) develop a computerized system for the collection, analysis, and dissemination of data required to be collected under this part;

"(2) establish one or more uniform claims and billing form as required in subsection (c)(2) to be utilized by all data sources and providers;

"(3) audit information provided by health care providers on a sample basis or in situations where there exists reasonable cause for such an audit; and

"(4) issue public reports concerning health care costs and the effectiveness of the health care provided by health care providers.

"(c) DATA COLLECTION.—

"(1) IN GENERAL.—Data sources shall submit to the Board, on the request of the Board, all data required to be submitted under this part in accordance with the uniform submission formats, coding systems, and other technical specifications established by the Board to assure that such incoming data is substantially valid, consistent, compatible and manageable.

"(2) UNIFORM CLAIMS AND BILLING FORMS.—Data shall be collected by the Board through the use of one or more Federal Uniform Claims and Billing Forms developed by the Board and utilized by providers and purchasers of health care that shall, at a minimum, include—

"(A) a uniform patient identifier;

"(B) the date of birth of the patient;

"(C) the gender of the patient;

"(D) the ZIP Code of the patient;

"(E) the date of admission of the patient for inpatient hospital services;

"(F) the date of discharge of the patient referred to in subparagraph (E);

"(G) the principal and secondary diagnoses of the patient;

"(H) the principal and secondary procedures to be followed in treating the patient;

"(I) a uniform health care facility identifier;

"(J) uniform identifiers of physicians treating the patient;

"(K) for services provided in an inpatient setting, the total charges of the health care facility treating the patient, segregated into major categories determined appropriate by the Board;

"(L) the amounts of actual payments made to the treating health care facility;

"(M) the amounts of the charges of each physician or professional rendering service to the patient;

"(N) the services provided in an inpatient setting;

"(O) the amounts of actual payments made to each physician or professional rendering service to the patient;

"(P) a uniform identifier of the primary payor;

"(Q) the ZIP Code of the facility where service is rendered to the patient;

"(R) the patient discharge status; and

"(S) such other material as the Board determines necessary or useful to carry out the duties of the Board or to provide adequate information to purchasers of health care to assist such purchasers in appropriately paying for services.

"(3) MEASURE OF SERVICE EFFECTIVENESS.—

"(A) DEVELOPMENT OF METHODOLOGY.—To the extent practical and as rapidly as feasible, the Secretary shall develop and implement a methodology or methodologies that will measure the effectiveness of the health care service provided by health care providers.

"(B) INCLUSION IN UNIFORM BILLING FORM.—To the extent practical and as rapidly as feasible, the Secretary shall include in the uniform claims and billing forms or in other data collection instruments established under subsection (b) data necessary to provide the Secretary with information concerning each service provided by health care providers that is sufficient to enable the Secretary to analyze the quality, cost, and service effectiveness of the provider.

"(4) ADDITIONAL DATA.—The Board may collect additional data, including audited annual financial reports of all hospitals and ambulatory service facilities, medicare cost reports, information on capital expenditures, and any other data that the Board determines necessary to carry out its responsibilities under this part.

"(5) RECOMMENDATIONS.—The Board shall make recommendations to the committees of Congress, the President, and the insurance industry concerning methods to reduce the cost and burden of duplication or excessive reporting requirements imposed on health care providers.

"(d) REPORTS.—

"(1) IN GENERAL.—The Board, not less than once each calendar year, shall for every health care provider for which sufficient data is available, prepare and make available reports that shall, to the extent practicable and scientifically valid, contain data in a form that will provide the most useful information to purchasers of health care services regarding such providers to enable such purchasers to compare providers on the basis of cost and quality.

"(2) AVAILABILITY.—The Secretary shall advertise and make available all reports prepared under paragraph (1) to the general public, including any dissents submitted by health care providers.

"(3) RECOMMENDATIONS.—The Board shall make recommendations to the appropriate committees of Congress, the President, and the insurance industry concerning methods to reduce the cost and burden of duplicative or excessive reporting requirements imposed on health care providers.

"(e) DEFINITION.—As used in this section, the term 'data sources' means classes of entities and individuals that the Board designates as data sources.

"ANNUAL REPORTS

"SEC. 1181. Not later than June 30 of each year, the Board shall prepare and submit to the President, the appropriate committees of Congress and the general public, a report concerning the success in attaining expenditure, access, and quality goals developed under section 1172, and containing recommendations for additional measures, if any, that the Board determines are necessary to achieve such goals.

"DEFINITIONS

"SEC. 1182. As used in this part:

"(1) HEALTH BENEFIT PLAN.—The term 'health benefit plan' means an employee welfare benefit plan (as defined in section 3(1) of the Employee Retirement Income Security Act of 19 (29 U.S.C. 1002(1)) that—

"(A) provides medical care to participants or beneficiaries directly or through insurance, reimbursement, or otherwise; and

"(B) meets the requirements of section 2721 of the Public Health Service Act.

Such term shall include a small business health benefits plan, as defined in section 2713(11) of such Act.

"(2) MANAGED CARE PLAN.—The term 'managed care plan' has the meaning given such term by section 2108(a)(6).

"(3) PROVIDER.—The term 'provider' means a physician, hospital, health maintenance organization, pharmacy, laboratory, or other appropriately licensed provider of health care services or supplies, that has entered into an agreement with a managed care entity to provide such services or supplies to a patient enrolled in a managed care plan.

"(4) PURCHASER.—The term 'purchaser' means an entity that pays for services of providers, including in the case of a health benefit plan provided pursuant to a collective bargaining agreement, the labor union that has negotiated for such plan on behalf of employees shall be considered to be a purchaser.

"EFFECTIVE DATES

"SEC. 1183. The Board shall develop the goals under section 1172 for each calendar year beginning not later than the second full calendar year after the date of the enactment of this part. The Board shall establish the negotiating procedures required under section 1173(a) for each calendar year beginning not later than the third calendar year after the date of the enactment of this part.".

(c) CONFORMING AMENDMENTS.—

(1) COMPENSATION, LEVEL III.—Section 5314 of title 5, United States Code, is amended by adding at the end thereof the following:

"Members, Federal Health Expenditure Board.".

(2) COMPENSATION, LEVEL IV.—Section 5315 of title 5, United States Code, is amended by adding at the end thereof the following:

"Members, Federal Health Expenditure Board.".

(d) MEDICARE.—Title XVIII of the Social Security Act (42 U.S.C. 1395 et seq.) is amended by adding at the end the following new section:

"FEDERAL HEALTH EXPENDITURE BOARD

"SEC. 1893. (a) HOSPITAL SERVICES.—Notwithstanding any other provision of this title, in the second full fiscal year after the date of enactment of this section and annually thereafter, the Federal Health Expenditure Board (hereafter in this section referred to as the 'Board') shall, with due regard to the recommendations of the Prospective Payment Assessment Commission, recommend—

"(1) the update factor for the DRG prospective payment rates provided in section 1886(d);

"(2) the DRG recalibration;

"(3) the update factor for excluded hospitals; and

"(4) such other matters relating to reimbursement under this title as the Board shall elect.

In making such recommendations to the Congress, the Board shall also make recommendations for modifications of the prospective payment system under this title. In recommending the update factor for DRG prospective payment rates and for excluded hospitals, the Board shall seek to maintain parity in increases in payment rates with other purchasers of health care services, and, shall over time, seek to achieve comparability in such rates. Such recommendations shall not result in Federal payments greater than such payments would have been if determined without regard to this section through the fifth full fiscal year after the date of enactment of this section.

"(b) PHYSICIAN SERVICES.—Notwithstanding any other provision of this title, in the second full fiscal year after the date of enactment of this section and annually thereafter, the Board shall, with due regard to the recommendations of the Physician Payment Review Commission, recommend—

"(1) appropriate modifications of the resource based relative value schedule provided for in section 1848;

"(2) volume performance standards provided for in section 1848(f);

"(3) updates in the conversion factor, consistent with the volume performance standards, provided in section 1848(d);

"(4) revisions of the geographical adjustment factors provided in section 1848(e); and

"(5) such other matters relating to reimbursement under this title as the Board shall elect.

In making such recommendations to the Congress, the Board shall also make recommendations for modifications of the physician payment system under this title. In making the recommendations described in paragraphs (1), (2), (3), and (4), the Board shall seek to maintain parity in increases in payment rates with other purchasers of health care services, and shall, over time, seek to achieve comparability in such rates. Such recommendations shall not result in Federal payments greater than such payments would have been if determined without regard to this section through the fifth full fiscal year after the date of enactment of this section.".

Subtitle C—State Purchasing Consortia

SEC. 421. STATE PURCHASING CONSORTIA

(a) PUBLIC HEALTH SERVICE ACT.—Title XXVII of the Public Health Service Act (as added by section 101 and amended by sections 201, 311 and 411) is further amended by adding at the end thereof the following new part:

"PART E—STATE PURCHASING CONSORTIA

"SEC. 2781. STATE PURCHASING CONSORTIA.

"(a) REQUIREMENT.—

"(1) ESTABLISHMENT BY STATE.—Not later than 1 year after the date of enactment of this part, or the first day of the first calendar year beginning after the close of the first regular session of the State legislature that begins after the date of enactment of this part, whichever is later, the State shall establish a State Consortium (hereafter referred to in this section as the 'consortium') which may be a public or nonprofit private entity, or be a member of a Regional Consortium in accordance with subsection (f), that shall carry out the activities described in subsection (d).

"(2) ESTABLISHMENT BY SECRETARY.—If a State fails to establish a State consortium as required under paragraph (1), the Secretary shall develop and implement a State consortium for such State.

"(b) BOARD OF DIRECTORS AND MEMBERSHIP.—

"(1) BOARD OF DIRECTORS.—

"(A) IN GENERAL.—A consortium shall be managed by a board of directors who shall be appointed and serve in accordance with guidelines and regulations developed by the State.

"(B) MANDATORY FUNCTIONS.—The guidelines and regulations developed under subparagraph (A) shall ensure that, for purposes of carrying out the mandatory functions under subsection (d)(1), the board of

directors will be composed of insurers, providers and consumers.

"(C) OPTIONAL FUNCTIONS.—The guidelines and regulations developed under subparagraph (A) shall ensure that, for purposes of carrying out the optional functions under subsection (d)(2), the board of directors will be composed of individuals who represent the balanced interests of all interested parties.

"(2) MEMBERSHIP IN CONSORTIUM.—All providers and purchasers of health insurance and health care in the State, including business, labor, and consumer organizations, shall be eligible to become members of the consortium in such State.

"(c) APPLICATION AND PLAN, GRANTS AND TECHNICAL ASSISTANCE.—

"(1) APPLICATION AND PLAN.—

"(A) REQUIREMENT.—Prior to the establishment of the State consortium, the State shall prepare and submit to the Secretary for approval, an application in such form and containing such information as the Secretary may require, including the plan described in subparagraph (B).

"(B) PLAN.—As part of the application submitted under subparagraph (A), the State shall prepare a plan that shall outline the form of the State consortium and that shall include a description—

"(i) of the guidelines applicable to the appointment and service of the board of directors of the consortium;

"(ii) of the manner in which the State will solicit membership for the consortium;

"(iii) of the manner in which the consortium will perform the mandatory functions under subsection (d)(1);

"(iv) of the optional functions that the consortium will perform under subsection (d)(2); and

"(v) of any other information that the Secretary determines appropriate.

"(2) GRANTS.—

"(A) IN GENERAL.—The Secretary shall award a grant to each State to assist the State in paying the costs associated with the establishment and initial operation of the State consortium.

"(B) AMOUNTS.—Not less than $150,000 shall be provided to each State under a grant awarded under this subparagraph (A), except that additional amounts may be provided to a State if the Secretary determines, based on an application that is submitted by the State for such amounts, that such amounts are needed to help defray the costs associated with optional functions provided by the consortium under the State plan submitted under paragraph (1)(B).

"(C) PLANNING FUNCTIONS.—Except as provided in subparagraph (B), amounts provided under grants awarded under this paragraph shall be utilized for planning functions only.

"(3) TECHNICAL ASSISTANCE.—The Secretary shall provide technical assistance to States in setting up the State consortia.

"(d) FUNCTIONS OF CONSORTIUM.—

"(1) MANDATORY FUNCTIONS.—The State consortium shall—

"(A) enroll all small share health insurance companies in the State as members of the consortium for insurers, purchasers and providers;

"(B) establish a claim payment fund and procedures for the payment, by the consortium on behalf of its enrollees, of valid claims submitted by providers or enrollees to the consortium, such fund to be capitalized through public and private contributions and assessments made by the consortium on such enrollees to reflect amounts paid from such fund on behalf of each such enrollee;

"(C) develop, in consultation and with the assistance of the Secretary and consistent with the program established under part D, and employ uniform billing and claim form and procedures for providers of health services covered by enrollees, and for individuals submitting claims directly to the consortium;

"(D) further attempt to reduce administrative costs and burdens on enrollees and providers of health services, through—

"(i) the maintenance of a staff to explain claims procedures (that shall be consistent with claims procedures adopted under title XVIII of the Social Security Act) to providers and enrollees and to provide such other services as may assist providers in receiving reimbursement promptly and at the lowest possible cost;

"(ii) establish, to the maximum extent practicable, a paperless processing system to permit providers to submit claims electronically to the consortium;

"(iii) establish, to the maximum extent practicable, the use of 'smart cards' or other electronic methods for immediate verification by providers of an individuals's health insurance coverage;

"(iv) encouraging providers to submit claims directly to the consortium on behalf of enrollees; and

"(v) the conduct of appropriate utilization reviews;

"(E) carry out any other activities determined appropriate by the Secretary; and

"(F) cooperate with the Federal Health Expenditure Board established under part D.

"(2) OPTIONAL FUNCTIONS.—The State consortium may—

"(A) permit insurers with a large share of the market in a State to participate in the consortium;

"(B) convene negotiations with health care providers and purchasers and others, as appropriate, concerning the availability of health care services, coverage and reimbursement levels for such services, and claim submission and payment procedures (activities undertaken as a result of such negotiations shall be exempt from Federal anti-trust laws if such activities are authorized by the State);

"(C) develop procedures for—

"(i) the allocation of capital among health care providers to encourage an adequate and efficient level and distribution of health care resources;

"(ii) encouraging a rational distribution of health care providers; and

"(iii) encouraging the development of managed care;

"(D) the collection and dissemination of data through a Statewide data organization that is accessible to all interested parties in the State in order to facilitate appropriate decisions by consumers and to encourage efficient behavior by providers;

"(E) coordinate with entities responsible for assuring the quality of health care provided within the State; and

"(F) carry out any other activities that are contained within the State plan and approved by the Secretary and that are designed to improve the quality of health care, access to such care, and to control the costs of such care.

"(3) APPLICABILITY OF CONSUMER PROTECTION LAWS.—Notwithstanding any other provision of law, the provisions of the Consumer Product Safety Act and other Federal consumer protection laws shall apply to the functions carried out under paragraph (1).

"(4) MANAGED CARE.—This subsection shall not be construed as limiting the ability of a managed care plan to select providers eligible to perform services under the plan, or to establish reasonable procedures to be followed by providers participating in the plan, to assure the provision of cost-effective, quality services.

"(5) SMALL SHARE HEALTH INSURANCE COMPANIES.—As used in this subsection, the term 'small share health insurance companies' shall include entities determined appropriate by the Secretary. In making such determination, the Secretary shall seek to minimize the number of sources reimbursing providers directly in the State but shall permit insurers with a market share that is large enough to sufficiently achieve the economies of scale sought through the consortium, to remain independent of the consortium, to the extent that permitting such separate payment sources would not dilute the purpose of the consortium.

"(e) DATA AND INFORMATION.—A State consortium shall collect or provide for the collection of data and information concerning the operations of the consortium and shall provide such data and information to the Secretary on an annual basis.

"(f) REGIONAL CONSORTIUM.—States may enter into an agreement for the establishment of a regional consortium that shall have jurisdiction over all States that are parties to such agreement and that shall be subject to the provisions of this section as if such consortium were established by a single State.

"(g) ENFORCEMENT.—A State that fails to comply with the requirements of this section shall be ineligible to receive assistance made available under this Act.

"(h) STUDY.—Not later than 3 years after the date of enactment of this part, the Secretary shall prepare and submit to the appropriate committees of Congress, a report that shall contain the results of a study conducted by the Secretary concerning the State consortia system established under this section, and whether such consortia are effective in containing health care costs, in expanding the availability of access to such care, and in protecting and enhancing the quality of such care.

"(i) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated such sums as may be necessary to carry out this section.".

(b) SOCIAL SECURITY ACT.—Title XI of the Social Security Act (as amended by section 411) is further amended by adding at the end thereof the following new part:

"PART D—STATE PURCHASING CONSORTIA

"STATE PURCHASING CONSORTIA

"SEC. 1191. (a) MEMBERSHIP IN CONSORTIUM.—

"(1) IN GENERAL.—A State may, with the approval of the Secretary, require that the providers operating under the programs conducted under titles XVIII, XIX, and XXI of this Act in the State, participate in the State consortium for purposes of claims processing and for such other purposes as the Secretary may approve, in the least restrictive manner practicable.

"(2) WAIVERS.—With respect to a State requirement under paragraph (1) that providers under titles XVIII, XIX, and XXI of this Act participate in the consortium, the Secretary may waive such requirement on the request of such a provider, if the Secretary determines, on a budget neutral basis, that such waiver is necessary to protect the access of the beneficiaries of such provider to care provided by such provider, and that such waiver will promote the cost effective delivery of services.

"(b) FUNCTIONS OF CONSORTIUM.—

"(1) MANDATORY FUNCTIONS.—The State consortium shall—

"(A) enroll all small share health insurance companies in the State as members of

the consortium for insurers, purchasers and providers;

"(B) establish a claim payment fund and procedures for the payment, by the consortium on behalf of it's enrollees, of valid claims submitted by providers or enrollees to the consortium, such fund to be capitalized through public and private contributions and assessments made by the consortium on such enrollees to reflect amounts paid from such fund on behalf of each such enrollee;

"(C) develop, in consultation and with the assistance of the Secretary and consistent with the program established under part C, and employ uniform billing claim forms and procedures for providers of health services covered by enrollees, and for individuals submitting claims directly to the consortium;

"(D) further attempt to reduce administrative costs and burdens on enrollees and providers of health services, through—

"(i) the maintenance of a staff to explain claims procedures (that shall be consistent with claims procedures adopted under title XVIII of this Act) to providers and enrollees and to provide such other services as may assist providers in receiving reimbursement promptly and at the lowest possible cost;

"(ii) establish, to the maximum extent practicable, a paperless processing system to permit providers to submit claims electronically to the consortium;

"(iii) establish, to the maximum extent practicable, the use of 'smart cards' or other electronic methods for immediate verification by providers of an individual's health insurance coverage;

"(iv) encouraging providers to submit claims directly to the consortium on behalf of enrollees; and

"(v) the conduct of appropriate utilization reviews;

"(E) carry out any other activities determined appropriate by the Secretary; and

"(F) cooperate with the Federal Health Expenditure Board.

"(2) OPTIONAL FUNCTIONS.—The State consortium may—

"(A) permit insurers with a large share of the market in a State to participate in the consortium;

"(B) convene negotiations with health care providers and purchasers and others, as appropriate, concerning the availability of health care services, coverage and reimbursement levels for such services, and claim submission and payment procedures (activities undertaken as a result of such negotiations shall be exempt from Federal anti-trust laws if such activities are authorized by the State);

"(C) develop procedures for—

"(i) the allocation of capital among health care providers to encourage an adequate and efficient level and distribution of health care resources;

"(ii) encouraging a rational distribution of health care providers; and

"(iii) encouraging the development of managed care;

"(D) the collection and dissemination of data through a Statewide data organization that is accessible to all interested parties in the State in order to facilitate appropriate decisions by consumers and to encourage efficient behavior by providers;

"(E) coordinate with entities responsible for assuring the quality of health care provided within the State; and

"(F) carry out any other activities that are contained within the State plan and approved by the Secretary and that are designed to improve the quality of health care, access to such care, and to control the costs of such care.

"(3) APPLICABILITY OF CONSUMER PROTECTION LAWS.—Notwithstanding any other provision of law, the provisions of the Consumer Product Safety Act and other Federal consumer protection laws shall apply to the functions carried out under paragraph (1).

"(4) MANAGED CARE.—This subsection shall not be construed as limiting the ability of a managed care plan to select providers eligible to perform services under the plan, or to establish reasonable procedures to be followed by providers participating in the plan, to assure the provision of cost-effective, quality services.

"(5) SMALL SHARE HEALTH INSURANCE COMPANIES.—As used in this subsection, the term 'small share health insurance companies' shall include entities determined appropriate by the Secretary. In making such determination, the Secretary shall seek to minimize the number of sources reimbursing providers directly in the State but shall permit insurers with a market share that is large enough to sufficiently achieve the economies of scale sought through the consortium, to remain independent of the consortium, to the extent that permitting such separate payment sources would not dilute the purpose of the consortium.

"(c) DATA AND INFORMATION.—A State consortium shall collect or provide for the collection of data and information concerning the operations of the consortium and shall provide such data and information to the Secretary on an annual basis.

"(d) REGIONAL CONSORTIUM.—States may enter into an agreement for the establishment of a regional consortium that shall have jurisdiction over all States that are parties to such agreement and that shall be subject to the provisions of this section as if such consortium were established by a single State.

"(e) ENFORCEMENT.—A State that fails to comply with the requirements of this section shall be ineligible to receive payments under section 2109 of this Act.".

Subtitle D—Cost Control Grant Program

SEC. 431. COST CONTROL GRANT PROGRAM.

Part A of title IX of the Public Health Service Act (42 U.S.C. 299 et seq.) is amended by adding at the end thereof the following new section:

"SEC. 905. COST CONTROL GRANT PROGRAM.

"(a) IN GENERAL.—The Administrator may award grants and enter into contracts with States, public entities, insurers, health plan administrators, businesses, labor unions, non-profit organizations, and researchers for the development, demonstration, and evaluation of innovative methods for reducing health care costs.

"(b) APPLICATION.—To be eligible for a grant or contract under subsection (a), an entity of the type described in such subsection shall prepare and submit, to the Administrator, an application at such time, in such form, and containing such information as the Administrator shall require.

"(c) PREFERENCES.—In awarding grants or entering into contracts under subsection (a), the Administrator shall give a preference to entities submitting applications under subsection (b) that propose to implement projects, with assistance provided under this section, with the potential to develop programs that could have a significant impact on overall national health care costs.

"(d) CLEARINGHOUSE.—

"(1) ESTABLISHMENT.—The Administrator shall establish a clearinghouse, and undertake such other activities as may be necessary, to disseminate information concerning successful health care cost control methods and to provide technical assistance in the implementation of such methods.

"(2) OPERATION.—The Administrator may reserve not to exceed 10 percent of the amount appropriated under subsection (g) in each fiscal year for the operation of the clearinghouse, the dissemination of information, and the provision of technical assistance under paragraph (1).

"(e) CONSULTATION.—In developing the procedures for awarding grants under this section, the Secretary shall consult with the Federal Health Expenditure Board established under part D of title XXVII.

"(f) MATCHING REQUIREMENT.—In the case of a grant awarded for the conduct of a demonstration program that will provide a direct benefit to the grantee, the Administrator shall not award such grant unless the grantee agrees to provide additional amounts for such program equal to not less than 25 percent of the amount of the grant. Such additional amounts may be in cash or in kind.

"(g) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated to carry out this section, such sums as may be necessary in each of the fiscal years 1992 through 1994.".

Subtitle E—Malpractice Reform

SEC. 441. MALPRACTICE REFORM.

Part A of title IX of the Public Health Service Act (42 U.S.C. 299 et seq.) as amended by section 431 is further amended by adding at the end thereof the following new section:

"SEC. 906. MALPRACTICE REFORM.

"(a) IN GENERAL.—The Administrator may award grants to States for the development and implementation of programs for medical malpractice reforms. Programs receiving such grants shall include efforts to develop alternative methods to resolve liability disputes that fairly protect the interests of all parties involved and may include an appropriate role for the use of medical practice guidelines. No grant shall be awarded that is inconsistent with the goal of—

"(1) reducing excessive health care costs;

"(2) reducing unnecessary or ineffective medical care;

"(3) improving access to quality health care;

"(4) ensuring fair and adequate compensation for and review of injuries arising from medical negligence;

"(5) ensuring reasonable insurance rating and premium setting practices; and

"(6) improving patient protections, disciplinary standards for health care professionals, and the effectiveness of State medical boards.

"(b) TYPES OF GRANTS.—A grant awarded under subsection (a) shall be either—

"(1) a planning grant, to assist the grantee in the development of a program under this section that shall be for a period of not to exceed two years; or

"(2) an operational grant, to assist the grantee in operation and evaluation of the new program referred to in paragraph (1), that shall be for a period of not to exceed five years.

"(c) REQUIREMENT.—An operational grant under subsection (b)(2) shall include a requirement that an evaluation, approved by the Administrator as being adequate, is conducted to determine the effectiveness of the program for which the grant is utilized. A final report on the results of the evaluation shall be prepared and submitted to the Administrator.

"(d) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated such sums as may be necessary to carry out this section.".

SEC. 442. STUDY OF MEDICAL MALPRACTICE.

(a) CONTRACT.—The Secretary shall enter into a contract with the Institute of Medicine, or with a similar independent entity, for the collection and analysis of data and issues, by a group of representatives of interested parties and experts, related to—

(1) ineffective or unnecessary medical testing and practices;

(2) the occurrence of malpractice and malpractice awards (including the number of claims filed and the number of findings of negligence);

(3) the adequacy of existing health care provider licensing and disciplining procedures in preventing malpractice;

(4) the reasonableness of malpractice insurance premiums and rate-setting practices; and

(5) any other issues relevant to the adequacy of current medical practices, of compensation for injuries resulting from medical malpractice, and the impact of legal liability on medical practices.

(b) RECOMMENDATIONS.—Not later than 1 year after the date of enactment of this Act, the Institute or entity referred to in subsection (a) shall make available to the Secretary, the appropriate committees of Congress, the appropriate State officials, and to the general public, a report containing the recommendations of the Institute or entity for any desirable medical malpractice reforms.

(c) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated such sums as may be necessary to carry out this section.

Subtitle F—Reducing the Administrative Cost of Assuring Appropriate Utilization of Health Care Services and Improving the Quality of Health Care Services

SEC. 451. ESTABLISHMENT OF A QUALITY IMPROVEMENT BOARD.

(a) PUBLIC HEALTH SERVICE ACT.—Title XXVII of the Public Health Service Act (as added by section 101 and amended by sections 201, 311, 411, and 421) is further amended by adding at the end thereof the following new part:

"PART F—ESTABLISHMENT OF A QUALITY IMPROVEMENT BOARD

"SEC. 2785. ESTABLISHMENT OF A QUALITY IMPROVEMENT BOARD.

"(a) CONTRACT.—The Secretary shall enter into a contract with an entity in each State (such entity shall hereafter be referred to in this section as the 'quality improvement board') to review the quality of health care provided by health care professionals and institutions in each such State and to establish mechanisms to encourage continuous quality improvement.

"(b) BOARD OF DIRECTORS.—

"(1) REQUIREMENT.—The quality improvement board shall, in accordance with Federal guidelines and regulations and in accordance with the requirements of the contract entered into under subsection (a), be managed by a board of directors.

"(2) MEMBERSHIP.—The board of directors required under paragraph (1) shall consist of 15 members, of whom—

"(A) seven members shall be representatives of health care providers, including individuals of recognized excellence in the development, application, and evaluation of health care services, procedures, and technologies;

"(B) four members shall be representatives of insurers and purchasers of health care services; and

"(C) four members shall be health care service researchers and consumers.

"(3) DUTIES.—The board of directors shall adopt policies for the quality improvement board, approve the budget of the quality improvement board, appoint the executive director of the quality improvement board, and shall assume such other duties as the Secretary may prescribe or the board of directors shall determine to be necessary to the proper functioning of the quality improvement board.

"(c) DUTIES OF THE QUALITY IMPROVEMENT BOARD.—

"(1) GUIDELINES.—

"(A) REQUIREMENT.—The quality improvement board shall adopt guidelines for appropriate medical practice and for recommended measures to be taken by providers to improve the quality of care.

"(B) CONTENTS.—Guidelines adopted under subparagraph (A) shall include those of the type developed under the authority of section 912 and such guidelines as the Secretary may specify, and may include additional guidelines developed by professional societies or other appropriately qualified bodies or individuals.

"(2) RECOMMENDED MEASURES.—In cooperation with appropriate professional bodies, associations, and the Joint Commission on Accreditation of Hospitals, the quality improvement board shall recommend measures for continuous quality improvement to be adopted by health care professionals and institutions. Such measures shall include measures specified by the Secretary, appropriate continuing medical education and, for health care institutions, internal quality improvement procedures.

"(3) CERTIFICATION OF PROVIDERS.—The quality improvement board shall periodically review the performance of health care service providers and, based on—

"(A) the conformity of the practice of the provider with the guidelines developed by the board;

"(B) such measures of health care outcomes as may be scientifically valid and adopted by the board;

"(C) adoption by the provider of the measures for continuous quality improvement recommended by the board; and

"(D) such other factors as the board or the Secretary may prescribe; and

may certify a health care provider as an outstanding provider for the purpose of this section.

"(4) LIMITATION ON CERTIFICATION.—A certification under paragraph (3) shall be examined periodically by the quality improvement board to determine if continued certification is appropriate. The quality improvement board may suspend the certification of a provider at any time. At the request of a health plan, insurance company or State agency, the board must reconsider the certification of a provider.

"(5) DATA COLLECTION.—The quality improvement board shall collect and review such data and conduct such inspections and evaluations as are necessary to enable the board to carry out its duties. At the request of the board, insurers shall provide the board with any data collected in the normal course of business as the board determines necessary to perform its duties. The data collected by the Federal Health Expenditure Board under part D and the data collected by the State consortia under part E shall be made available to the board.

"(d) RESTRICTION ON LIMITATION OF PAYMENT FOR SERVICES PERFORMED BY OUTSTANDING PROVIDERS.—A health benefit plan may not deny payment for any service performed or ordered by a provider certified as outstanding under subsection (c)(3) during the period of such certification for any reason other than noncoverage of the provided service under the plan. The plan may not deny coverage on the basis that the service is not medically necessary. Nothing in this subsection shall be construed to prohibit a plan from paying for services performed or ordered by such provider at its normal reimbursement rates.

"(e) RECERTIFICATION AND SUSPENSION OF CERTIFICATION.—A provider certified as outstanding under subsection (c)(3) shall be recertified periodically by the quality improvement board unless the board acts to suspend such certification. Such suspensions, at the request of the provider shall be reconsidered.

"(f) EXCEPTION FOR MANAGED CARE PLANS.—Nothing in this section shall be construed to limit the ability of a managed care plan to choose providers eligible to perform services under the plan or to establish reasonable procedures to be followed by providers participating in the plan in order to assure cost-effective, quality services.

"(g) PLANNING GRANTS.—To facilitate the establishment of a quality improvement board in each State, the Secretary may award planning grants, in amounts that shall not exceed $200,000 for each State, to private, non-profit or public entities, for the planning, development and implementation of the board and the programs undertaken by the board.

"(h) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated, such sums as may be necessary to carry out this section.".

(b) SOCIAL SECURITY ACT.—Title XI of the Social Security Act (42 U.S.C. 1301 et seq.) as amended by sections 411 and 421, is further amended by adding at the end thereof the following new part:

"PART E—ESTABLISHMENT OF A QUALITY IMPROVEMENT BOARD

"ESTABLISHMENT OF A QUALITY IMPROVEMENT BOARD

"SEC. 1195. (a) DUTIES OF THE QUALITY IMPROVEMENT BOARD.—

"(1) GUIDELINES.—

"(A) REQUIREMENT.—The quality improvement board for a State established under section 451(a) of the HealthAmerica Act (hereafter referred to as the 'quality improvement board') shall adopt guidelines for appropriate medical practice and for recommended measures to be taken by providers to improve the quality of care.

"(B) CONTENTS.—Guidelines adopted under subparagraph (A) shall include such guidelines as the Secretary may specify, and may include additional guidelines developed by professional societies or other appropriately qualified bodies or individuals.

"(2) RECOMMENDED MEASURES.—In cooperation with appropriate professional bodies, associations, and the Joint Commission on Accreditation of Hospitals, the quality improvement board shall recommend measures for continuous quality improvement to be adopted by health care professionals and institutions. Such measures shall include measures specified by the Secretary, appropriate continuing medical education and, for health care institutions, internal quality improvement procedures.

"(3) CERTIFICATION OF PROVIDERS.—The quality improvement board shall periodically review the performance of health care service providers and, based on—

"(A) the conformity of the practice of the provider with the guidelines developed by the board;

"(B) such measures of health care outcomes as may be scientifically valid and adopted by the board;

"(C) adoption by the provider of the measures for continuous quality improvement recommended by the board; and

"(D) such other factors as the board or the Secretary may prescribe; and

may certify a health care provider as an outstanding provider for the purpose of this section.

"(4) LIMITATION ON CERTIFICATION.—A certification under paragraph (3) shall be examined periodically by the quality improvement board to determine if continued certification is appropriate. The quality improvement board may suspend the certification of a provider at any time. At the request of a health plan, insurance company or State agency, the board must reconsider the certification of a provider.

"(5) DATA COLLECTION.—The quality improvement board shall collect and review such data and conduct such inspections and evaluations as are necessary to enable the board to carry out its duties. At the request of the board, insurers shall provide the board with any data collected in the normal course of business as the board determines necessary to perform its duties. The data collected by the Federal Health Expenditure Board under part C and the data collected by the State consortium under part D of title XI shall be made available to the board.

"(b) RESTRICTION ON LIMITATION OF PAYMENT FOR SERVICES PERFORMED BY OUTSTANDING PROVIDERS.—A health benefit plan may not deny payment for any service performed or ordered by a provider certified as outstanding under subsection (a)(3) during the period of such certification for any reason other than noncoverage of the provided service under the plan. The plan may not deny coverage on the basis that the service is not medically necessary. Nothing in this subsection shall be construed to prohibit a plan from paying for services performed or ordered by such provider at its normal reimbursement rates.

"(c) RECERTIFICATION AND SUSPENSION OF CERTIFICATION.—A provider certified as outstanding under subsection (a)(3) shall be recertified periodically by the quality improvement board unless the board acts to suspend such certification. Such suspensions, at the request of a provider, shall be reconsidered.

"(d) EXCEPTION FOR MANAGED CARE PLANS.—Nothing in this section shall be construed to limit the ability of a managed care plan to choose providers eligible to perform services under the plan or to establish reasonable procedures to be followed by providers participating in the plan in order to assure cost-effective, quality services.

"(e) PLANNING GRANTS.—To facilitate the establishment of a quality improvement board in each State, the Secretary may award planning grants, in amounts that shall not exceed $200,000 for each State, to private, non-profit or public entities, for the planning, development and implementation of the board and the programs undertaken by the board.

"(f) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated, such sums as may be necessary to carry out this section.".

Subtitle G—Use of Practice Guidelines in Federal Health Insurance and Service Programs

SEC. 461. USE OF PRACTICE GUIDELINES IN FEDERAL HEALTH INSURANCE AND SERVICE PROGRAMS.

Guidelines developed under the authority of section 912 of the Public Health Service Act (42 U.S.C. 299b-1) shall, to the extent practical and effective, be utilized in Federal health insurance programs as utilization review screens and as practice guidelines in Federal programs providing health care services either directly or through grantees.

Subtitle H—National Standards for the Promotion of Managed Care

SEC. 471. NATIONAL STANDARDS FOR THE PROMOTION OF MANAGED CARE.

Title XXVII of the Public Health Service Act (as added by section 101 and amended by sections 201, 311, 411, 421 and 451) is further amended by adding at the end thereof the following new part:

"PART G—NATIONAL STANDARDS FOR THE PROMOTION OF MANAGED CARE

"SEC. 2791. NATIONAL STANDARDS.

"(a) PROHIBITIONS.—No requirement of any State insurance, health care or any other law or regulation shall—

"(1) prohibit a managed care plan from freely selecting the health care providers, or the type of health care providers in a locale, as the participating providers; or

"(2) limit the ability of a managed care entity to negotiate, enter into contracts or establish alternative rates or forms of payment for participating providers, or to require or provide incentives that promote the use of participating providers.

"(b) UTILIZATION REVIEW SERVICES.—Notwithstanding any State law, an insurer or other person or entity may offer utilization review services in any State if such insurer, person or entity has established—

"(1) a procedure that adequately evaluates the necessity and appropriateness of the proposed or delivered health care services;

"(2) a procedure that permits patients and providers to appeal any adverse decisions by the person or entity performing the utilization review services, as provided for in section 2725;

"(3) a procedure that ensures that the person or entity providing the utilization review services is reasonably accessible (five days each week during normal business hours and, where necessary, at other appropriate times) to patients and providers; and

"(4) a procedure that ensures that all applicable Federal and State laws that are designed to protect the confidentiality of individual medical records are followed.

"SEC. 2792. FAVORABLE TREATMENT OF MANAGED CARE PLANS.

"(a) MANAGED CARE PLAN DEFINED.—

"(1) DEFINED.—As used in this part, the term 'managed care plan' has the same meaning given such term in section 2713(7).

"(2) DETERMINATION OF MANAGED CARE PLANS.—In the case of a health benefit plan that is offered by an entity, that is not a self-insured entity, that is subject to regulation by an applicable regulatory authority (as defined in section 2744(c)), consistent with procedures established by the Secretary in consultation with such authorities, such authorities shall be responsible for certifying for purposes of this part and the Social Security Act whether the health benefit plan is a managed care plan. In the case of self-insured entities, the Secretary shall be responsible for providing such certification.

"(b) CONDITION OF STATE FUNDING.—

"(1) IN GENERAL.—No amounts shall be made available under this Act to a State in any fiscal year (beginning with the first fiscal year beginning after the date of the enactment of this section) unless the State is in compliance with subsection (a).

"(2) DEEMED ELECTION; IMPLIED PREEMPTION.—

"(A) IN GENERAL.—A State is deemed to have elected subsection (a) to be in effect in the State as of the beginning of a fiscal year, unless the chief executive officer of a State indicates in writing that the State will not comply with this section. Such an election shall have the effect of preempting the establishment or enforcement of any State law that is in violation of subsection (a).

"(B) CHANGES.—A State is deemed not to have such an election in effect as of the date the Secretary determines that the State is enforcing any law or regulation in violation of subsection (a).

"(c) LIMITATION ON RESTRICTIONS ON MANAGED CARE PLANS.—In order to comply with the requirements of this subsection, a State may not by law or regulation prohibit or unreasonably limit any of the following:

"(1) A State may not prohibit or limit a managed care plan from including incentives for enrollees to use the services of participating providers.

"(2) A State may not prohibit or limit a managed care plan from limiting coverage of services to those provided by a participating provider.

"(3)(A) Subject to subparagraph (B), a State may not prohibit or limit the negotiation of rates and forms of payments for providers under a managed care plan.

"(B) Subparagraph (A) shall not apply where the amount of payments with respect to a block of services or providers is established under a Statewide system applicable to all non-Federal payors with respect to such services or providers.

"(4) A State may not prohibit or limit a managed care plan from limiting the number of participating providers.

"(5) A State may not prohibit or limit a managed care plan from requiring that services be provided (or authorized) by a primary care physician selected by the enrollee from a list of available participating providers.

"(d) ADDITIONAL DEFINITIONS.—In this part, the definitions contained in sections 2713 shall also apply.

"SEC. 2793. FAVORABLE TREATMENT OF UTILIZATION REVIEW PROGRAMS.

"(a) PREEMPTION OF STATE LAWS RESTRICTING UTILIZATION REVIEW PROGRAMS THAT MEET FEDERAL STANDARDS.—In the case of a health benefit plan that includes a utilization review program, no State law or regulation shall prohibit or regulate activities under such program, except insofar as such law or regulation is consistent with the standards established under subsection (b).

"(b) ESTABLISHMENT OF STANDARDS FOR UTILIZATION REVIEW PROGRAMS.—

"(1) IN GENERAL.—The Secretary shall provide, by regulation, for the establishment of Federal standards for utilization review programs of health benefit plans. Such standards shall be designed to assure, within a plan, the cost-effective and medically appropriate use of services.

"(2) CONTENTS OF STANDARDS.—Such standards shall be established with respect to at least each of the following aspects of utilization review programs:

"(A) The qualification of those who may perform utilization review activities.

"(B) The standards to be applied in performing utilization review.

"(C) The timeliness in which utilization review determinations are to be made.

"(D) An appeals process which provides a fair opportunity for individuals adversely affected by a utilization review determination to have such a determination reviewed.

"(E) Protection for the confidentiality of individually-identifiable information used in the process.

"(3) USE OF GUIDELINES.—Such standards shall, to the maximum extent feasible, be consistent with practice guidelines developed by the Agency for Health Care Policy and Research.

"(4) DEADLINE.—Standards shall first be established under this subsection by not later than 2 years after the date of the enactment of this part. The Secretary may revise the standards from time to time as re-

quired to assure, within health benefit plans, the cost-effective and medically appropriate use of services.

"(c) UTILIZATION REVIEW PROGRAM DEFINED.—In this section, the term 'utilization review program' means a system of reviewing the medical necessity and appropriateness of patient services (which may include inpatient and outpatient services) using specified guidelines. Such a system may include preadmission certification, the application of practice guidelines, continued stay review, discharge planning, preauthorization of ambulatory procedures, and retrospective review.".

Subtitle I—Expansion of Technology Assessment

SEC. 481. EXPANSION OF TECHNOLOGY ASSESSMENT.

Section 904 of the Public Health Service Act (42 U.S.C. 299a-2) is amended by adding at the end thereof the following new subsections:

"(e) EXPANSION OF EFFORTS.—In carrying out section 901(b) through subsection (a), the Administrator shall focus on expanding and applying appropriate assessments of existing health care technologies. Such expansion shall be achieved in part, through an evaluation of health services provided to individuals through publicly and privately funded sources.

"(f) PUBLIC-PRIVATE PARTNERSHIPS.—

"(1) ESTABLISHMENT OF PROGRAM.—The Administrator shall establish a program under which the Administrator shall enter into contracts or cooperative agreements with eligible entities for the establishment of public-private partnerships to undertake technology assessment and related activities in the private sector.

"(2) ELIGIBLE ENTITIES.—Entities eligible to receive a contract or agreement under paragraph (1), shall include academic medical centers, research institutions, or a consortia of appropriate entities established for the purposes of conducting technology assessment.

"(3) APPLICATION.—To be eligible to receive a contract or agreement under paragraph (1), an entity shall prepare and submit to the Administrator an application, at such time, in such form, and containing such information as the Administrator may require.".

TITLE V—CONTRIBUTION BY EMPLOYERS NOT PROVIDING PRIVATE HEALTH COVERAGE

SEC. 501. CONTRIBUTION BY EMPLOYERS NOT PROVIDING PRIVATE HEALTH BENEFIT PLANS.

(a) IN GENERAL.—Subtitle C of the Internal Revenue Code of 1986 is amended by adding at the end thereof the following new chapter:

"CHAPTER 26—CONTRIBUTION BY EMPLOYERS NOT PROVIDING PRIVATE HEALTH BENEFIT PLANS

"Sec. 3601. Contribution by employers not providing private health benefit plans.

"SEC. 3601. CONTRIBUTION BY EMPLOYERS NOT PROVIDING PRIVATE HEALTH BENEFIT PLANS.

"(a) CONTRIBUTION.—If an employer to whom part B of title XXVII or section 2701(a) of the Public Health Service Act applies elects to have this chapter apply, there is hereby imposed on such employer for each payroll period a contribution requirement in the amount determined under subsection (b).

"(b) AMOUNT OF CONTRIBUTION.—

"(1) IN GENERAL.—The amount of the contribution required by subsection (a) for any payroll period shall be equal to the applicable percentage of wages (50 percent of wages in the case of an employer described in section 352 of the HealthAmerica Act) paid during such period to employees with respect to whom the employer is required (without regard to the election under this section) to provide health insurance coverage under part B of title XXVII of the Public Health Service Act.

"(2) APPLICABLE PERCENTAGE.—For purposes of paragraph (1)—

"(A) IN GENERAL.—The applicable percentage for any calendar year shall be the percentage established under this paragraph for such calendar year by the Secretary of Health and Human Services at the lowest level consistent with maintaining a fair balance between public and private health insurance coverage for employees employed by employers not currently offering health insurance coverage.

"(B) FAIR BALANCE.—For purposes of subparagraph (A), the term 'fair balance' means, with respect to a year, a balance calculated based on the estimated cost of a fully implemented health insurance plan in that year, and would, if such plan were fully implemented and in effect, result in a ratio between coverage of such employees under the public health insurance plan under title XXI of the Social Security Act and under a health benefit plan under part B of title II of the Public Health Service Act that is not disproportionate.

"(C) NOT DISPROPORTIONATE.—For purposes of subparagraph (B), the term 'not disproportionate' means a ratio of not greater than 65 percent to 35 percent in comparing coverage under such public health insurance plan to such health benefit plans for a year.

"(3) WAGES.—For purposes of this subsection, the term 'wages' has the meaning given such term by section 3121(a), without regard to any limitation by reference to the contribution and benefit base under section 230 of the Social Security Act.

"(c) PAYROLL PERIOD.—For purposes of this section, the term 'payroll period' has the meaning given such term by section 3401(b).

"(d) ADMINISTRATION.—For purposes of this title, the contribution required by subsection (a) shall be treated in the same manner as the tax imposed by section 3111(a).".

(b) CONFORMING AMENDMENTS.—The table of chapters for subtitle C of the Internal Revenue Code of 1986 is amended by adding at the end thereof the following new item:

"Chapter 26. Contribution in lieu of employer coverage.".

(c) EFFECTIVE DATE.—The amendments made by this section shall apply to payroll periods beginning on or after the effective date of this Act.

TITLE VI—ASSURING PROVISION OF HEALTH BENEFITS TO ALL AMERICANS

SEC. 601. ESTABLISHMENT OF AMERICARE.

(a) IN GENERAL.—The Social Security Act (42 U.S.C. 301 et seq.) is amended by adding at the end thereof the following new title:

"TITLE XXI—AMERICARE

"TABLE OF CONTENTS OF TITLE

"Sec. 2101. State requirements for participation in AmeriCare.
"Sec. 2102. Basic health benefits.
"Sec. 2103. Cost-sharing provisions.
"Sec. 2104. Supplemental payments.
"Sec. 2105. Health care providers.
"Sec. 2106. Quality and cost-effective care measures.
"Sec. 2107. Administration.
"Sec. 2108. Definitions and special rules.
"Sec. 2109. Payments to States.
"Sec. 2110. AmeriCare trust fund.

"STATE REQUIREMENTS FOR PARTICIPATION IN AMERICARE

"SEC. 2101. (a) IN GENERAL.—A State must—

"(1) provide either for the establishment or designation of a single State agency (other than the agency established or designated under section 1902 of this Act) to administer or supervise the administration of AmeriCare;

"(2) provide basic health benefits described in section 2102, subject to cost-sharing provisions under section 2103—

"(A) to any child or pregnant woman who is not otherwise covered under a nongovernmental health insurance policy, plan, or program beginning on the first day of the second full calendar year after the date of the enactment of this title;

"(B) to any employee or family member with respect to whom an employer makes a contribution under title V of the Health America Act beginning on the first day of the second full calendar year after the date of the enactment of this title; and

"(C) to any individual not covered under a health benefit plan under title II of such Act, beginning on the first day of the fifth full calendar year after the effective date described in subparagraph (A);

"(3) provide at least monthly supplemental payments for premiums, deductibles, and other cost-sharing charged to individuals and families as provided under section 2104;

"(4) provide a clear, simple explanation of the basic health benefits and supplemental payments available under AmeriCare through public announcements, mailings, and any other suitable means;

"(5) provide enrollment in AmeriCare as described in subsection (b);

"(6) to the extent required by the Seeretary, provide basic health benefits or supplemental payments under AmeriCare to individuals who are—

"(A) residents of the State but are absent therefrom,

"(B) temporarily located in the State but are not permanent residents of any State; or

"(C) formerly residents of the State but are currently United States citizens permanently residing in a country which has reciprocity agreements with the United States;

"(7) provide to any individual covered under a health benefit plan under title II of the HealthAmerica Act, or any employer of such individual, the opportunity to purchase (or have purchased for such individual by the individual's employer) AmeriCare benefits described in section 2102(a)(7) at a separate actuarial premium rate determined by the State and subject to such other cost-sharing provisions as the plan under such title II provides for other benefits under such plan;

"(8) provide for granting an opportunity for a fair hearing before the State agency to any individual whose claim for coverage under AmeriCare is denied or is not acted upon with reasonable promptness, under rules described in section 2107(b);

"(9) meet the requirements of—

"(A) paragraphs (4), (6), (7), (11), (19), (27), (45), (46), (48), and (49) of section 1902(a),

"(B) subsections (b) and (g) of section 1902, and

"(C) section 1907,

in the same manner as they apply to title XIX of this Act;

"(10) meet the requirements of section 2105 and 2108(c);

"(11) provide that AmeriCare shall be in effect in all political subdivisions of the State, and if administered by such subdivisions, be mandatory upon such subdivisions;

"(12) provide for financial participation by the State equal to the non-Federal share of the expenditures under AmeriCare with respect to which payments under section 2109 are authorized by this title;

"(13) meet any other requirements of this title; and

"(14) in order to insure compliance with this title and to receive the Federal share under section 2109, submit to the Secretary a plan that meets the requirements of this subsection and is subject to rules similar to the rules of section 1904.

"(b) ELIGIBILITY FOR BASIC HEALTH BENEFITS.—

"(1) IN GENERAL.—Subject to the provisions of paragraphs (2) and (6) of subsection (a), each individual not otherwise covered under a health benefit plan under title II of the HealthAmerica Act is entitled to basic health benefits under AmeriCare.

"(2) PERIOD OF COVERAGE.—

"(A) GENERAL RULE.—Upon notification of the approval of an application submitted by any individual (or a guardian or representative of such individual), AmeriCare coverage of the applicant begins on the date of such application.

"(B) FAILURE TO MAKE TIMELY NOTIFICATION.—If the State fails to notify the applicant of the applicant's ineligibility within 1 month of the date of the application, AmeriCare coverage shall apply during the period beginning on the date the individual submitted the application and ending on the date the State notifies such individual of such ineligibility.

"(C) EMPLOYER'S CONTINUATION COVERAGE.—Coverage under AmeriCare shall not apply for services provided during a period of hospitalization that begins prior to the date specified in subparagraph (A) or (B) with respect to an individual whose enrollment in an employer-based health plan terminated during such period of hospitalization.

"(D) GUARANTEED MINIMUM ELIGIBILITY.—An individual who is determined in a month to be eligible for benefits under AmeriCare shall remain eligible for coverage for a period of not less than 1 year, unless otherwise covered under a health benefit plan under title II of the Health America Act.

"(3) APPLICATION FORMS.—Each State plan shall use a standard Federal application which shall be as simple in form as possible and understandable to the average individual and require attachment of such documentation as deemed necessary by the Secretary in order to insure eligibility.

"(4) ENROLLMENT PROCESS.—

"(A) IN GENERAL.—Each State shall provide for the receipt of AmeriCare applications—

"(i) by mail; and

"(ii) at locations broadly available to the general public, including locations that serve large numbers of indigent individuals (as defined and determined by the Secretary).

"(B) EMPLOYER ASSISTANCE.—

"(i) IN GENERAL.—Any employer who contributes under title V of the HealthAmerica Act in lieu of providing a health benefit plan under title II of such Act shall notify the State of the identities of all employees of that State and shall provide such employees with AmeriCare applications.

"(ii) CHANGE IN STATUS NOTIFICATION.—Any employer shall notify the State of—

"(I) the identities of any employees of that State who become eligible for AmeriCare as the result of changes in employment status; and

"(II) the identities of any individuals (including members of the families of such individuals) who become covered under a health benefit plan under title II of the HealthAmerica Act and who were covered under AmeriCare in such State.

Each employer shall provide employees described in subclause (I) with AmeriCare applications.

"(iii) COLLECTION OF PREMIUMS.—

"(I) IN GENERAL.—Each State may require that employers collect AmeriCare premiums on behalf of the employees of such employer.

"(II) FAILURE TO PAY PREMIUMS.—If a State plan includes the requirement described in subclause (I), the State shall notify the employee and the Secretary of the failure of the employer to make timely premium payments on behalf of the employee and the employee's family members as required under such plan. Such notification shall be provided not less that 30 days prior to any termination of coverage by the State as the result of such nonpayment of premiums.

"(5) ENROLLMENT PERIODS.—

"(A) IN GENERAL.—Except as provided in this paragraph, any individual may enroll in AmeriCare—

"(i) during an annual open enrollment period (of not less than 1 month) established by the Secretary; and

"(ii) during such other periods (including upon loss of coverage under a health benefit plan under title II of the HealthAmerica Act) as the Secretary shall require in regulations.

"(B) FOR UNDER-POVERTY FAMILIES.—In the case of an individual who is determined to be a member of an under-poverty family, the individual may enroll in AmeriCare at any time.

"(C) PHASE-IN PERIODS.—In the case of any individual who first becomes eligible for benefits under AmeriCare in a calendar year described in subsection (a)(2), the period of enrollment shall continue for the entire calendar year.

"(6) AMERICARE CARD.—The State shall issue an AmeriCare card which may be used for purposes of identification and processing of claims under AmeriCare. AmeriCare cards shall identify (as appropriate) if the individual is eligible for special eligibility benefits.

"BASIC HEALTH BENEFITS

"SEC. 2102. (a) GENERAL BENEFITS.—Benefits under this section with respect to all individuals shall include—

"(1) inpatient and outpatient hospital care, except that treatment for a mental disorder is subject to the special limitations described in paragraph (6)(A);

"(2) inpatient and outpatient physician services, except that psychotherapy or counseling for a mental disorder is subject to the special limitations described in paragraph (6)(B);

"(3) diagnostic tests;

"(4) prenatal care and well-baby care provided to children who are 1 year of age or younger;

"(5) preventive services, limited to—

"(A) well child care;

"(B) pap smears; and

"(C) mammograms; and

"(6)(A) inpatient hospital care for a mental disorder for not less than 45 days per year, except that days of partial hospitalization or residential care may be substituted for days of inpatient care according to a ratio established by the Secretary; and

"(B) outpatient psychotherapy and counseling for a mental disorder for not less than 20 visits per year provided by a provider who is acting within the scope of State law and who—

"(i) is a physician; or

"(ii) meets the standards of subsection (e)(2) and is a duly licensed or certified clinical psychologist or a duly licensed or certified clinical social worker, a duly licensed or certified equivalent mental health professional, or a clinic or center providing duly licensed or certified mental health services; and

"(7) items and services described in section 1905(a)(4)(B) (relating to early and periodic screening, diagnosis, and treatment for children under the age of 21).

(b) EXCEPTIONS.—Subsection (a) shall not be construed as requiring a plan for AmeriCare to include payment for—

(1) items and services that are not medically necessary as determined under rules similar to rules under title XVIII of this Act;

(2) routine physical examinations or preventive care (other than care and services described in paragraphs (4), (5), and (7) of subsection (a); or

(3) experimental services and procedures as determined under rules similar to rules under title XVIII of this Act.

(c) AMOUNT, SCOPE, AND DURATION OF CERTAIN BENEFITS.—Except as provided in subsection (b), AmeriCare shall place no limits on the amount, scope, or duration of benefits described in paragraphs (1) through (3) of subsection (a).

(d) AMOUNT, SCOPE, AND DURATION OF PREVENTIVE SERVICES.—AmeriCare may limit the preventive services described in subsection (a)(5) pursuant to regulations of the Secretary specifying the content and periodicity of such care. The Secretary shall develop such regulations after consultation with appropriate medical experts.

(e) MENTAL HEALTH CARE.—

(1) INPATIENT CARE.—Inpatient hospital care described in subsection (a)(6)(A) shall include reimbursement for professional care provided to the individual while the individual is receiving such inpatient care, by a physician or duly licensed or certified clinical psychologist operating within the scope of practice of the physician or psychologist, as determined appropriate under State law. Nothing in this subsection shall be construed to modify hospital practices with regard to scope of practice, admitting privileges, or billing arrangements.

(2) STANDARDS FOR CERTAIN PROVIDERS OF OUTPATIENT CARE.—The Secretary shall establish standards that providers referred to in subsection (a)(6)(B)(ii) must meet to be eligible for payment under AmeriCare.

"(f) ENHANCED BENEFITS.—Basic health benefits under this section with respect to special eligibility individuals shall include medical assistance, not otherwise described in subsection (a), in the State's plan under title XIX of this Act, other than medical assistance described in paragraphs (4)(A), (7), (14), and (18) of section 1905(a).

"(g) ADDITIONAL BENEFITS.—As part of AmeriCare, a State may provide for the coverage of health benefits in addition to the basic health benefits described in the preceding subsections of this section, on the condition that the State shall not receive any Federal payment for such additional coverage.

"COST-SHARING PROVISIONS

"SEC. 2103. (a) IN GENERAL.—Except as provided in subsection (b), each State that provides AmeriCare shall provide for cost-sharing as follows:

"(1) UNDER-POVERTY FAMILIES.—With respect to an individual who is a member of an under-poverty family, AmeriCare may not impose any premiums, deductibles or other cost-sharing on such individual.

"(2) NEAR-POVERTY FAMILIES.—

"(A) IN GENERAL.—Subject to subparagraph (C), with respect to an individual who is a member of a near-poverty family that

receives benefits under AmeriCare, the amount of the monthly AmeriCare premium for such individual shall be the applicable percentage of the monthly actuarial rate of such State.

"(B) APPLICABLE PERCENTAGE.—For the purposes of this paragraph, the term 'applicable percentage' means 2 percentage points for each 10 percentage point bracket (or any portion thereof) such family's income equals or exceeds the income official poverty line (as defined by the Office of Management and Budget, and revised annually in accordance with section 673(2) of the Omnibus Budget Reconciliation Act of 1981) applicable to a family of the size involved.

"(C) LIMITATION.—The aggregate amount of any AmeriCare premiums imposed on the family of the individual under this paragraph for any calendar year shall not exceed an amount equal to 3 percent of the family income .

"(D) ADDITIONAL COST SHARING LIMITATION.—

"(i) IN GENERAL.—With respect to any individual who is a member of a near-poverty family that receives benefits under AmeriCare, such individual shall, in addition to the AmeriCare premium described in this paragraph, pay the applicable percentage of any AmeriCare deductible or other cost-sharing.

"(ii) APPLICABLE PERCENTAGE.—For purposes of this subparagraph, the term 'applicable percentage' means 10 percentage points for each 10 percentage point bracket (or any portion thereof) such family's income equals or exceeds 110 percent of such income official poverty line.

"(3) OTHER FAMILIES.—

"(A) IN GENERAL.—Subject to subparagraph (C), with respect to an individual who is a member of a family that receives benefits under AmeriCare and whose income equals or exceeds an income level that is 200 percent of the income official poverty line (as described in paragraph (2)(B)), the amount of the monthly AmeriCare premium for such individual shall be the monthly actuarial rate of such State.

"(B) LIMITATION.—The aggregate amount of any AmeriCare premiums imposed on the family of the individual under this paragraph for any calendar year shall not exceed an amount equal to—

"(i) in the case of a family whose income equals or exceeds 200 percent of such income official poverty line but is less than 250 percent of such income official poverty line, 3.5 percent of the family income,

"(ii) in the case of a family whose income equals or exceeds 250 percent of such income official poverty line but is less than 325 percent of such income official poverty line, 4 percent of the family income, and

"(ii) in the case of a family whose income equals or exceeds 325 percent of such income official poverty line but is less than 400 percent of such income official poverty line, 5 percent of the family income.

"(C) With respect to any individual who is a member of a family described in this paragraph that receives benefits under AmeriCare, such individual shall, in addition to the AmeriCare premium described in this paragraph, pay 100 percent of any AmeriCare deductible or other cost-sharing.

"(4) PHASE-IN COVERAGE FOR CHILDREN.—With respect to any family described in this subsection, the children of which are the only individuals eligible for coverage under AmeriCare, the percentages described in paragraphs (2)(C) and (3)(B) shall be reduced by two-thirds.

"(b) MONTHLY AMERICARE PREMIUM FOR EMPLOYED INDIVIDUALS.—

"(1) IN GENERAL.—Except as provided in paragraph (2), a State plan for AmeriCare shall require an individual whose employer makes a contribution under title V of the HealthAmerica Act in lieu of providing a health benefit plan under title II of such Act to pay an AmeriCare premium equal to the lesser of—

"(A) coverage under AmeriCare for such individual for a period of one month; or

"(B) 20 percent of the monthly actuarial rate of such State.

"(2) With respect to any part-time employee who is a member of a family that receives benefits under AmeriCare and whose income equals or exceeds an income level that is 200 percent of the income official poverty line (as described in subsection (a)(2)(B)) and whose employer makes a contribution under title V of the HealthAmerica Act, the amount of any AmeriCare premium imposed on such employee shall be 50 percent of the amount determined under paragraph (1).

"(c) DEFINITIONS AND SPECIAL RULES.—

"(1) MONTHLY ACTUARIAL RATE DEFINED.—

"(A) IN GENERAL.—For purposes of this section, the term 'monthly actuarial rate' means, with respect to AmeriCare in a plan year, the average monthly per enrollee amount that the State estimates, based on actuarial calculations conducted in conformity with requirements established by the Secretary, for enrollees under AmeriCare during the year, would be necessary to pay for the total benefits required under the State plan for AmeriCare (including administrative costs for the provision of such benefits and an appropriate amount for a contingency margin) during the year.

"(B) SPECIAL RULE.—With respect to any State plan for AmeriCare, for any period ending before the date described in section 2101(a)(2)(C), the monthly actuarial rate shall be calculated as if all eligible children in such State participate in such plan.

"(2) APPLICATION ON BASIS OF FAMILY STATUS.—For purposes of this section, a State plan for AmeriCare may provide for the AmeriCare premium to be applied, and the monthly actuarial rate to be computed—

"(A) separately for individuals who have family members covered under AmeriCare and for individuals who do not have family members covered under the AmeriCare; and

"(B) with respect to individuals with such covered family members, separately—

"(i) for individuals who have a covered spouse and one or more covered children;

"(ii) for individuals who have a covered spouse but no covered children; and

"(iii) for individuals who do not have a covered spouse but have one or more covered children.

"(3) ADJUSTMENT FOR COVERED SPOUSE WITH OTHER COVERAGE.—For purposes of this section, if a State plan for AmeriCare charges an individual for a share of the AmeriCare premium, the plan shall establish a separate AmeriCare premium category (or categories) for family coverage in the case of a covered spouse who is receiving primary health insurance coverage from another health benefit plan. The AmeriCare premium for such categories shall be established based on actual or projected plan experience or according to a formula established by the Secretary, and shall take into account the reduction in health insurance costs resulting from such coverage.

"(d) AMERICARE DEDUCTIBLE OR OTHER COST-SHARING.—

"(1) IN GENERAL.—For purposes of this title, the term 'AmeriCare deductible or other cost-sharing' means any deductible, copayment, or coinsurance established by the State plan for AmeriCare as determined under paragraphs (2) and (3) of this subsection.

"(2) LIMITATION ON DEDUCTIBLES.—A State plan for AmeriCare shall not provide, for benefits provided in any plan year, for a deductible amount that exceeds—

"(A) with respect to benefits payable for items and services furnished to any individual with no family member enrolled under AmeriCare, for a plan year beginning in—

"(i) the first calendar year that begins more than 1 year after the effective date of this title, $250; or

"(ii) for a subsequent calendar year, the limitation of deductions specified in clause (i) for the previous calendar year increased by the percentage increase in the consumer price index for all urban consumers (United States city average, as published by the Bureau of Labor Statistics) for the 12-month period ending on September 30 of the preceding calendar year; and

"(B) with respect to benefits payable for items and services furnished to any individual with a family member enrolled under AmeriCare, for a plan year beginning in—

"(i) the first calendar year that begins more than 1 year after the effective date of this title, $250 per family member and $500 per family; or

"(ii) for a subsequent calendar year, the limitation of deductions specified in clause (i) for the previous calendar year increased by the percentage increase in the consumer price index for all urban consumers (United States city average, as published by the Bureau of Labor Statistics) for the 12-month period ending on September 30 of the preceding calendar year.

If the limitation of deductions computed under subparagraph (A)(ii) or (B)(ii) is not a multiple of $10, it shall be rounded to the next highest multiple of $10.

"(3) LIMITATION ON COPAYMENTS AND COINSURANCE.—

"(A) IN GENERAL.—Subject to subparagraphs (B) through (D), a State plan for AmeriCare shall not—

"(i) require the payment of any copayment or coinsurance for an item or service for which coverage is provided under section 2102(g) in an amount that exceeds 20 percent of the cost of the item or service; or

"(ii) require the payment of any copayment or coinsurance for items and services required under section 2102 (other than subsection (g)) to be furnished in a plan year for an individual after the individual has incurred out-of-pocket expenses under the plan that are equal to the out-of-pocket limit (as defined in subparagraph (E)(ii)).

"(B) EXCEPTION FOR PREFERRED PROVIDERS.—If a State plan for AmeriCare establishes reasonable classifications of participating and nonparticipating providers of items and services, the plan may require payments in excess of the amount permitted under subparagraph (A) in the case of items and services furnished by nonparticipating providers.

"(C) EXCEPTION FOR IMPROPER UTILIZATION.—A State plan for AmeriCare may provide for copayment or coinsurance in excess of the amount permitted under subparagraph (A) for any item or service that an individual obtains without complying with any reasonable procedures established by the plan to ensure the efficient and appropriate utilization of covered services.

"(D) MENTAL HEALTH CARE.—In the case of care provided under section 2102(a)(6)(B), a State plan for AmeriCare shall not require payment of any copayment or coinsurance for an item or service for which coverage is required by this title in an amount that exceeds 50 percent of the cost of the item or service.

"(E) LIMIT ON OUT-OF-POCKET EXPENSES.—

"(i) OUT-OF-POCKET EXPENSES DEFINED.—For purposes of this paragraph, the term 'out-of-pocket expenses' means, with respect to an individual in a plan year, amounts payable under AmeriCare as deductibles and co-insurance with respect to items and services provided under AmeriCare and furnished in a plan year on behalf of the individual or family covered under AmeriCare.

"(ii) OUT-OF-POCKET LIMIT DEFINED.—For purposes of this paragraph, the term 'out-of-pocket limit' means for a plan year beginning in—

"(I) the first calendar year that begins more than 1 year after the effective date of this title, $3,000; or

"(II) for a subsequent calendar year, the out-of-pocket limit specified in subclause (I) for the previous calendar year increased by the percentage increase in the consumer price index for all urban consumers (United States city average, as published by the Bureau of Labor Statistics) for the 12-month period ending on September 30 of the preceding calendar year.

If the out-of-pocket limit computed under subclause (II) is not a multiple of $10, it shall be rounded to the next highest multiple of $10.

"SUPPLEMENTAL PAYMENTS

"SEC. 2104. (a) IN GENERAL.—Except as provided in this section, an individual who is enrolled in a health benefit plan under title II of the HealthAmerica Act is not entitled to benefits under AmeriCare.

"(b) ASSISTANCE FOR UNDER-POVERTY FAMILIES.—In the case of an individual described in subsection (a) or an individual whose employer makes a contribution under title V of the HealthAmerica Act in lieu of providing a health benefit plan under title II of such Act, who is a member of an under-poverty family, AmeriCare shall provide for payment of—

"(1) any premiums charged the individual for the applicable category of coverage under the employer's health benefit plan or AmeriCare in which the individual is enrolled, except that AmeriCare is not required to pay for such amount of a premium as exceeds the lowest premium which would be charged the individual for the applicable category of coverage under any health benefit plan offered the individual under title II of the HealthAmerica Act or AmeriCare, as the case may be; and

"(2) deductibles and other cost-sharing imposed on the individual under the employer's health benefit plan or AmeriCare, but only with respect to the basic benefits required under such a plan under such title II or AmeriCare, as the case may be.

"(c) ASSISTANCE FOR NEAR-POVERTY FAMILIES.—

"(1) IN GENERAL.—In the case of an individual described in subsection (a) or an individual whose employer makes a contribution under title V of the HealthAmerica Act in lieu of providing a health benefit plan under title II of such Act, who is a member of a near-poverty family, AmeriCare shall provide for payment of the applicable premium percentage of any premiums charged the individual for the applicable category of coverage under the employer's health benefit plan or AmeriCare in which the individual is enrolled, except that AmeriCare is not required to pay for such amount of a premium as exceeds the lowest premium which would be charged the individual for the applicable category of coverage under any health benefit plan offered the individual under title II of the HealthAmerica Act or AmeriCare, as the case may be.

"(2) APPLICABLE PREMIUM PERCENTAGE.—For purposes of paragraph (1)(A), the term 'applicable premium percentage' means 20 percent reduced (but not below 2 percent) by 2 percentage points for each 10 percentage point bracket (or portion thereof) such family's income equals or exceeds 110 percent of the income official poverty line (as defined by the Office of Management and Budget, and revised annually in accordance with section 673(2) of the Omnibus Budget Reconciliation Act of 1981) applicable to a family of the size involved.

"(d) APPLICATION FOR ASSISTANCE.—The State plan for AmeriCare shall use a standard Federal application which shall be as simple in form as possible and understandable to the average individual and require attachment of such documentation as deemed necessary by the Secretary in order to insure eligibility. Such application shall be available to any employee as provided in section 2107(b), may be filed at any time, and shall initiate coverage under the rules similar to the rules of subparagraphs (A) and (B) of section 2101(b)(2).

"(e) PAYMENT OF PREMIUMS.—

"(1) IN GENERAL.—The State plan shall provide that upon the initiation of coverage under this section, an individual shall receive advanced payment of supplemental premium payments for the calendar year from AmeriCare, or in the case of an individual enrolled in AmeriCare, a reduction in the annual AmeriCare premium.

"(2) REQUIREMENT FOR FILING OF INCOME STATEMENT.—In the case of a family which is receiving supplemental premium payments (or a reduction in AmeriCare premiums) under this section for any month in a year, a member of the family shall file with the State, by not later than April 15 of the following year, a statement that verifies the family's total family income for the taxable year ending during the previous year. Such a statement shall provide information necessary to determine the family income during the year and the number of family members in the family as of the last day of the year.

"(3) RECONCILIATION OF PREMIUM ASSISTANCE BASED ON ACTUAL INCOME.—Based on and using the income reported in the statement filed under paragraph (2) with respect to a family or individual, the State shall compute the amount of assistance that should have been provided under this section with respect to premiums for the family in the year involved. If the amount of such assistance computed is—

"(A) greater than the amount of premium assistance provided, the State shall provide for payment (directly or through a credit against future premiums owed) to the family or individual involved of an amount equal to the amount of the deficit, or

"(B) less than the amount of assistance provided, the State shall require the family or individual to pay (directly or through an increase in future premiums owed) to the State (to the credit of the program under this title) an amount equal to the amount of the excess payment.

"(4) DISQUALIFICATION FOR FAILURE TO FILE.—In the case of any family that is required to file an information statement under paragraph (2) in a year and that fails to file such a statement by the deadline specified in such paragraph, no member of the family shall be eligible for assistance under this section after May 1 of such year. The State shall waive the application of this paragraph if the family establishes, to the satisfaction of the State, good cause for the failure to file the statement on a timely basis.

"(5) PENALTIES FOR FALSE INFORMATION.—Any individual that provides false information in a statement under paragraph (2) is subject to a criminal penalty to the same extent as a criminal penalty may be imposed under section 1128B(a) with respect to a person described in clause (ii) of such section.

"(6) NOTICE OF REQUIREMENT.—The State shall provide for written notice, in March of each year, of the requirement of paragraph (2) to each family which received assistance under this section in any month during the preceding year and to which such requirement applies.

"(7) TRANSMITTAL OF INFORMATION.—The Secretary of the Treasury shall transmit annually to the State such information relating to the total income of individuals for the taxable year ending in the previous year as may be necessary to verify the reconciliation of assistance under this subsection.

"(f) PAYMENT OF OTHER COST-SHARING CLAIMS.—The State plan shall provide that each individual subject to coverage under this section or the health care provider rendering the service shall file claims for the supplemental payment of deductibles and other cost-sharing imposed on such individual under the employer's health benefit plan or AmeriCare, and the State shall make such payments at the option of the individual, to such individual or the health care provider.

"HEALTH CARE PROVIDERS

"SEC. 2105. (a) USE OF MEDICARE PAYMENT RULES.—

"(1) IN GENERAL.—Except as provided in subsections (b) and (c)—

"(A) payment of benefits under the State plan for AmeriCare shall be made in the same amounts and on the same basis as payment may be made with respect to such benefits under title XVIII of this Act, and

"(B) the provisions of sections 1814, 1815, 1833, 1834(c) (other than paragraphs (1)(A)(2)), 1835, 1842, 1848, 1886, 1887 shall apply to payment of benefits (and provision of services and charges thereon) under this title in the same manner as such provisions apply to benefits, services, and charges under title XVIII of this Act.

"(2) IDENTIFICATION OF COMPARABLE PAYMENT METHODS FOR NEW SERVICES.—In the case of services for which there is not a payment basis established under title XVIII of this Act, the Secretary shall establish payment rules that are similar to the payment rules for similar services under such title.

"(3) ADJUSTMENT OF MEDICARE PAYMENT RATES.—

"(A) IN GENERAL.—For purposes of payment for inpatient hospital services, physicians' services, and other services under this title for which payment rates are established under title XVIII of this Act, the Secretary shall adjust the payment rates otherwise established under such title XVIII to take into account differences between the population served under that title and the population served by the State plan or enrolled under health benefit plans under title II of the HealthAmerica Act and such other appropriate factors (such as the special circumstances of hospitals the inpatients of which are predominantly children) as the Secretary deems appropriate.

"(B) CONSULTATION.—In making adjustments under subparagraph (A), the Secretary shall consult with the Prospective Payment Assessment Commission with respect to inpatient hospital services and with the Physician Payment Review Commission with respect to physicians' services.

"(b) ALTERNATIVE METHODS.—In issuing regulations to establish national reimbursement levels under this section, a State may provide for alternative payment systems that apply rates and methodologies that are not employed in the Federal guidelines described in subsection (a) if such State meets in the aggregate for all health care provid-

ers in such State the requirements for national reimbursement levels described in this section.

"(c) PHASE-IN OF MEDICARE RATES.—In lieu of the rates established under the rules described in subsection (a) or (b), the payment of benefits under the State plan for AmeriCare shall be made in the same amounts and on the same basis as payment may be made with respect to comparable medical assistance under title XIX of this Act, and the provisions of such title shall apply to payment of benefits (and provision of services and charges thereon) under this title in the same manner as such provisions apply to payment of comparable medical assistance under title XIX of this Act, except as follows:

"(1) With respect to prenatal and child delivery benefits and infant care benefits—

"(A) 50 percent of the rate differential beginning on the first day of the third full calendar year after the date of the enactment of this title

"(B) 100 percent of the rate differential beginning on the first day of the fourth full calendar year after the date of the enactment of this title.

"(2) With respect to benefits described in section 2102(a)(7) and children outpatient and pediatric hospitalization benefits—

"(A) 50 percent of the rate differential beginning on the first day of the fifth full calendar year after the date of the enactment of this title

"(B) 100 percent of the rate differential beginning on the first day of the sixth full calendar year after the date of the enactment of this title.

"(3) With respect to all other benefits described in section 2102—

"(A) 50 percent of the rate differential beginning on the first day of the seventh full calendar year after the date of the enactment of this title

"(B) 100 percent of the rate differential beginning on the first day of the eighth full calendar year after the date of the enactment of this title.

For purposes of this subsection, the term 'rate differential' means with respect to each benefit the difference between the reimbursement rate as determined under subsection (a) or (b) and the reimbursement rate for comparable medical assistance determined under subsection (c).

"(d) NO JUDICIAL OR ADMINISTRATION REVIEW.—There shall be no administrative or judicial review of the payment rates or rules under this section (including adjustments made under this section).

"(e) UNIFORM CLAIMS AND BILLING FORM.—Each State plan shall require the use of any Federal Uniform Claims and Billing Form developed by the Federal Health Expenditure Board under section 1180(b). Additional information may be required by the State plan if approved by the Secretary.

"(f) UNIFORM IDENTIFICATION SYSTEM.—Each State plan shall require each health care provider to use the identification number (if any) such provider uses in furnishing services for which payment is made under title XVIII of this Act or such other identification number specified by the Secretary.

"(g) MULTI-STATE PROVIDERS.—Each State plan shall allow health care providers participating in AmeriCare to participate under any other State plan for AmeriCare.

"QUALITY AND COST-EFFECTIVE CARE MEASURES

"SEC. 2106. (a) APPLICATION OF PEER REVIEW ORGANIZATIONS.—

"(1) IN GENERAL.—The Secretary shall ensure that that the quality control and peer review activities described in section 1165 are conducted in the manner prescribed in such section.

"(2) ADDITIONAL CRITERIA.—The Administrator of the Agency for Health Care Policy and Research shall, on an annual basis, and as otherwise determined by the Secretary, advise the Secretary concerning the incorporation of patient outcome measures and practice parameters with respect to care and services furnished under this title in conjunction with the quality control and peer review activities described in paragraph (1) of this subsection.

"(b) ALTERNATIVE DELIVERY AND ADMINISTRATIVE SYSTEMS.—A State may enter into a contract with a private entity or insurer or a State consortium (described under part D of title XI of this Act) to design and implement innovative systems of health care delivery and administrative systems that meet the standards of this title.

"(c) MANAGED CARE.—

"(1) IN GENERAL.—Each State plan shall, as part of AmeriCare, provide for managed care plans in accordance with the requirements of this subsection.

"(2) REQUIREMENTS.—In providing for managed care plans under this subsection, a State shall ensure that—

"(A) managed care plans are, to the extent practicable, selected through a competitive selection process;

"(B) an eligible individual under this title has an option to enroll in any of the managed care plans selected by the State offered by any qualified health care provider (as defined and determined by the Secretary);

"(C) an eligible individual who is receiving benefits under a managed care plan, may, not less often than annually, and without cause, exercise the option to discontinue receiving benefits under the managed care plan and receive coverage under an alternative plan under AmeriCare;

"(D) any arrangements for incentive payments for physicians under a managed care plan must comply with requirements for the provision of quality care that the Secretary shall prescribe by regulation, taking into account, at a minimum, quality care guidelines under title XVIII of this Act; and

"(E) a managed care plan shall provide for a system of rate assessment and adjustment that minimizes risk selection and segmentation (as defined and determined by the Secretary).

"(3) REGULATIONS.—The Secretary shall, not more than 180 days after the date of the enactment of this title, develop and establish by regulation, standards to ensure the quality of care under managed care plans under AmeriCare.

"(e) COST CONTAINMENT DEMONSTRATION PROJECTS.—

"(1) IN GENERAL.—The Secretary shall establish various demonstration projects to enable the States that submit an approved application, to implement cost management initiatives that promote the effective furnishing of care under this title. Such cost management initiatives shall include:

"(A) Programs for contracting with community-based providers (as defined by the Secretary).

"(B) Financial incentives to encourage the delivery of high quality, cost effective managed care under subsection (d) of this section, including enhanced payment rates to States with a high percentage of individuals enrolled in managed care plans, to the degree such enrollment results in reduced Federal expenditures.

"(C) Case management, including case-finding and the coordination of social and support services.

"(D) Financial incentives to encourage outreach programs.

"(E) Financial incentives to encourage the use of cost-effective services.

"(F) Measures to encourage an awareness of the costs associated with medical care, including nominal copayments (as determined by the Secretary) and the advantages of preventive care and other cost-effective types of care.

The Secretary shall require each State that submits an approved application to develop plans for conducting a demonstration project under this paragraph, in accordance with requirements that the Secretary shall establish by regulation.

"(2) ENHANCED COVERAGE DEMONSTRATION PROJECTS.—The Secretary may by waiver provide that a State plan for AmeriCare may include as benefits under such plan payment for all or part of the cost of services described in section 1915(c) (other than paragraph (3) thereof).

"ADMINISTRATION

"SEC. 2107. (a) ADMINISTRATION.—

"(1) IN GENERAL.—Subject to paragraph (3), each State shall provide for administration of this title in the same manner as it provides for administration of the plan established under section 1902(a) of this Act. In the administration of this title, the State agency designated under section 2101(a)(1) may delegate or contract with other public or private entities for the administration of the plan for AmeriCare.

"(2) NOTIFICATION OF AMERICARE; APPLICATION PROCESSING.—Any State that submits an application approved by the Secretary may contract with private entities or a State agency other than the agency designated under section 2101(a)(1) to provide notification of AmeriCare to the residents of the State and process and review applications as required under section 2101(a)(6), and sections 2101(b) and 2104(d), respectively.

"(3) ELECTION.—A State, with such notice to the Secretary as the Secretary may require, may elect to have this title (insofar as it provides benefits with respect to individuals under section 2101(a)(2)) administered with respect to that State by the Secretary (or by such agent as the Secretary may designate). The Secretary may not accept such an election unless the State provides assurances satisfactory to the Secretary that the State will make payments to the Secretary toward the cost of implementing this title in the same amounts and at the same time as the State would make payments under this title but for the fact of such an election.

"(4) MULTI-STATE PROGRAMS.—Subject to the approval of the Secretary, any State may submit a joint plan for AmeriCare along with 1 or more other States to implement a regional administration of 1 plan for AmeriCare.

"(5) DATA COLLECTION.—Each State shall submit to the Secretary (in such form and manner as the Secretary determines) for collection and analysis—

"(A) aggregate and per enrollee expenditures for each benefit covered under AmeriCare, including categorization by age, race, sex, and income level; and

"(B) uniform claims collection (by computer) that provide data to assist in the assessment of the amount, type, quality, and location of health care furnished through AmeriCare.

"(b) RIGHT TO REVIEW DENIED CLAIMS.—

"(1) NOTICE.—Each State plan for AmeriCare shall require that the State agency shall provide an individual with written notice concerning the denial of a claim submitted by such individual. Such notice shall include the reasons for such denial.

"(2) PROCESS FOR REVIEW.—Each State plan for AmeriCare shall utilize a fair proc-

ess for the timely review of claims denied under such plan.

"(3) CLAIM FOR CARE NEEDED FOR LIFE-THREATENING ILLNESS.—In cases in which the failure to provide health care promptly would be life-threatening or result in a risk of permanent disability, the AmeriCare beneficiary shall be entitled to a decision as to whether care will be provided under AmeriCare not later than 1 day after supplying the State with all requested information. In the event of a denial of coverage for such care, the beneficiary shall be entitled to an expedited review of an appeal of such denial within 5 days.

"(4) APPEALS.—Individuals shall be entitled to appeal the denial of a claim submitted by such individual to the State agency. The Secretary shall promulgate regulations establishing procedures to be utilized for appealing denials of claims under AmeriCare that are similar to the procedures established under title XVIII of this Act for appealing denials of claims under such title XVIII, including the right to a trial de novo.

"(c) ADMINISTRATIVE REGULATIONS.—

"(1) INCOME DETERMINATION.—The Secretary and the States shall develop and promulgate by regulation a system for the certifying of income and the reporting of changes of income by individuals within an appropriate period of time for the purposes of determining the amount of any premiums and copayments under section 2103 and the eligibility for supplemental payments of deductibles and other cost-sharing under section 2104, including the use of the social security identification number in tracking such changes and verifying the information at least biannually. Such system shall include rules similar to the rules described in paragraphs (2) through (7) of section 2[illegible] including a method for making adjustments for any overpayments or underpayments of such premiums, copayments, and supplemental payments.

"(2) NOTICE OF SUPPLEMENTAL PAYMENTS.—

"(A) IN GENERAL.—The Secretary, in consultation with the Secretary of the Treasury, shall, by regulation, require that each employer—

"(i) provide written notification forms to each employee outlining the availability of supplemental payments under AmeriCare in the State in which such employee resides as described in section 2104;

"(ii) coordinate the distribution of standard Federal application forms described in section 2104(d) in conjunction with the provision of written notification under paragraph (1);

"(iii) carry out the requirements of clauses (i) and (ii) without regard to the level of income of any employee.

"(B) CONTENTS OF NOTICE.—In promulgating the regulations described in subparagraph (A), the Secretary shall require the following information to be supplied in the written notification:

"(i) Information relating to the availability of supplemental payments on the basis of family income and size (prepared to coordinate with tax filing units or census information).

"(ii) Information concerning the amount of monthly supplemental payments.

"(c) FAILURE TO PRESCRIBE REGULATIONS.—The failure of the Secretary to prescribe any regulations under this title shall not relieve a State of any responsibility for complying with this title.

"DEFINITIONS AND SPECIAL RULES

"SEC. 2108. (a) DEFINITIONS.—As used in this title:

"(1) CHILD.—The term 'child' means an individual who—

"(A) is under 19 years of age;

"(B) is under 23 years of age and a full-time student; or

"(C) is, regardless of age, unmarried, dependent, and incapable of self-support as a result of a mental or physical disability that existed prior to the individual reaching 22 years of age.

"(2) EMPLOYEE.—The term 'employee' has the meaning given such term under section 2713(a)(2) of the Public Health Service Act.

"(3) EMPLOYER.—The term 'employer' has the meaning given such term under section 2713(a)(3) of the Public Health Service Act.

"(4) FAMILY.—The term 'family' means an individual, and any spouse or child of an individual. In determining if any individual is a child of another individual, rules similar to the rules of section 152(b)(2) of the Internal Revenue Code of 1986 shall apply.

"(5) HEALTH CARE PROVIDER.—The term 'health care provider' means any entity or person eligible to receive payments under titles XVIII and XIX of this Act.

"(6) MANAGED CARE PLAN.—

"(A) MANAGED CARE PLAN.—The term 'managed care plan' means a health benefit plan (as defined in section 1132(1)—

"(i) in which the insurer—

"(I) utilizes explicit standards for the selection and recertification of participating providers;

"(II) has organizational arrangements, established in accordance with regulations of the Secretary, for an ongoing quality assurance program for its health services, which program (aa) stresses health outcomes, and (bb) provides review by physicians and other health professionals of the process followed in the provision of health services; and

"(III) contains significant incentives to use the participating providers and procedures provided for by the plan; and

"(ii) which, if it limits coverage of services to those provided by participating providers or permits deductibles and coinsurance with respect to basic health services provided by persons who are not participating providers which are in excess of those permitted under health benefit plans—

"(I) has a sufficient number and distribution of participating providers to assure that all covered items and services are (aa) available and accessible to each enrollee, within the area served by the plan, with reasonable promptness and in a manner which assures continuity, and (bb) when medically necessary, available and accessible twenty-four hours a day and seven days a week; and

"(II) provides benefits for covered items and services not furnished by participating providers if the items and services are medically necessary and immediately required because of an unforeseen illness, injury, or condition.

"(B) MANAGED CARE ENTITY.—The term 'managed care entity' means an insurer, health maintenance organization, preferred provider organization, dental plan organization, or other entity licensed to do business in a State, that markets managed care plans to groups or individuals or an employer, labor union, or other State licensed entity that provides managed care plans for its employees or members.

"(C) PARTICIPATING PROVIDER.—The term 'participating provider' means a physician, hospital, health maintenance organization, pharmacy, laboratory, or other appropriately licensed provider of health care services or supplies, that has entered into an agreement with a managed care entity to provide such services or supplies to a patient enrolled in a managed care plan.

"(D) UTILIZATION REVIEW.—The term 'utilization review' means a program for reviewing the necessity and appropriateness of health care services provided or proposed to be provided to a patient.

"(7) MENTAL DISORDER.—The term 'mental disorder' has the same meaning given such term in the International Classification of Diseases, 9th Revision, Clinical Modification.

"(8) NEAR-POVERTY FAMILY.—The term 'near-poverty family' means a family whose income equals or exceeds 100 percent of the income official poverty line (as described in paragraph (1)), but is less than 200 percent of such income official poverty line.

"(9) PART-TIME EMPLOYEE.—The term 'part-time employee' has the meaning given such term under section 2713(a)(2)(G) of the Public Health Service Act.

"(10) SPECIAL ELIGIBILITY INDIVIDUALS.—The term 'special eligibility individual' means an individual who on the date of application for benefits under AmeriCare is—

"(A) a member of an under-poverty family; or

"(B) would have qualified for assistance under title IV of this Act or for medical assistance in the State of the individual's residence under title XIX of this Act (as in effect on the date of the enactment of this title);

"(C) or both.

"(11) STATE.—The term 'State' means the 50 States and the District of Columbia.

"(12) UNDER-POVERTY FAMILY.—The term 'under-poverty family' means a family whose income is less than 100 percent of the income official poverty line (as defined by the Office of Management and Budget, and revised annually in accordance with section 673(2) of the Omnibus Budget Reconciliation Act of 1981) applicable to a family of the size involved.

"(b) DETERMINATIONS OF INCOME.—For the purposes of this title—

"(1) In general.—The term 'income' means—

"(A) adjusted gross income (as defined in section 62(a) of the Internal Revenue Code of 1986), determined without the application of paragraphs (6) and (7) of such section and without the application of section 162(l) of such Code, plus

"(B) the amount of social security benefits (described in section 86(d) of such Code) which is not includable in gross income under section 86 of such Code.

"(2) FAMILY INCOME.—The term 'family income' means, with respect to an individual, the sum of the income for the individual and all the other family members.

"(3) FAMILY SIZE.—The family size to be applied under this title, with respect to family income, is the number of individuals included in the family for purposes of coverage of basic health benefits under AmeriCare or under a health benefit plan (as the case may be).

"(4) TIMING OF DETERMINATION.—Income shall be determined in accordance with one of the following methods, at the option of the applicant, for coverage under this title:

"(A) Multiplying by a factor of 4 the family income of the applicant for the 3-month period immediately preceding the month in which the application for coverage under this title is made.

"(B) Determining the family income of the applicant for the month in which the application for such coverage is made.

"PAYMENT TO STATES

"SEC. 2109. (a) IN GENERAL.—The Secretary shall pay to each State which has a plan approved under this title, for each quarter, beginning with the quarter commencing January 1, 1992—

"(1) an amount equal to the Federal insurance assistance percentage of the total

amount expended during such quarter for benefits and supplemental payments under the State plan; plus

"(2) an amount equal to the administrative percentage of so much of the sums expended during such quarter as found necessary by the Secretary for the proper and efficient administration of the State plan.

"(b) FEDERAL INSURANCE ASSISTANCE PERCENTAGE.—

"(1) IN GENERAL.—For purposes of subsection (a)(1), the Federal insurance assistance percentage for any State shall be 100 percent less the State percentage.

"(2) STATE PERCENTAGE.—The State percentage for any State shall be equal to—

"(A) the State percentage determined under section 1905(b), minus

"(B) the applicable percentage of such State percentage.

"(c) ADMINISTRATIVE PERCENTAGE.—For purposes of subsection (a)(2), the administrative percentage for any State shall be—

"(1) 50 percent, plus

"(2) the applicable percentage of 50 percent.

"(d) APPLICABLE PERCENTAGE.—For purposes of this section, the term 'applicable percentage' means in the case of each quarter in the following full calendar years beginning after the date of the enactment of this title, the following percentage:

"Calendar year:	Applicable Percentage:
2nd	20
3rd	20
4th	15
5th	10
6th	5.

"AMERICARE TRUST FUND

"SEC. 2110. (a) CREATION OF TRUST FUND.—There is established in the Treasury of the United States a trust fund to be known as the 'AmeriCare Trust Fund' (hereafter in this section referred to as the 'Fund'), consisting of such gifts and bequests as may be made and such amounts as may be credited to the Fund under this section.

"(b) TRANSFERS TO FUND.—

"(1) IN GENERAL.—There are hereby appropriated to the Fund amounts equivalent to the net revenues received in the Treasury from—

"(A) contributions required by section 3601 of the Internal Revenue Code of 1986,

"(B) contributions made under section 2723(c)(2) of the Public Health Service Act,

"(C) AmeriCare premiums (as defined in section 2104(6)) collected by employers on behalf of employees, and

"(D) penalties collected under section 2732 of the Public Health Service Act.

"(2) TRANSFERS BASED ON ESTIMATES.—The amounts appropriated by subparagraphs (A), (B), and (C) shall be transferred from time to time (not less frequently than monthly) from the general fund in the Treasury to the Fund, such amounts to be determined on the basis of estimates by the Secretary of the Treasury of the amounts, specified in such subparagraphs, paid to or deposited into the Treasury; and proper adjustments shall be made in amounts subsequently transferred to the extent prior estimates were in excess of or were less than the amounts specified in such subparagraphs.

"(c) APPROPRIATION OF ADDITIONAL SUMS.—There are hereby authorized to be appropriated to the Fund such additional sums as may be required to make expenditures referred to in subsection (d).

"(d) EXPENDITURES FROM FUND.—

"(1) IN GENERAL.—For the purpose of establishing a public program to provide health insurance coverage to be known as 'AmeriCare', there are authorized and appropriated for each fiscal year from the Fund a sum sufficient to carry out the purpose of this title. The sums made available under this paragraph shall be used for making payments under section 2109 to States that have submitted, and had approved by the Secretary, a State plan for AmeriCare.

"(2) ALLOCATIONS.—Amounts described in subsection (b)(1) shall be allotted to each State under paragraph (1) on the basis of amounts received in the Fund with respect to employees residing in such State.

"(3) ADDITIONAL FUNDS FOR ADMINISTRATIVE EXPENSES.—Amounts in the Fund shall be available, as provided in appropriation Acts, for the expenses of the Health Care Financing Administration or any other Federal agency designated by the Secretary in administering the provisions of this title.

"(e) INCORPORATION OF TRUST FUND PROVISIONS.—The provisions of subsections (b) through (i) of section 1841, as in effect on the day before the date of the enactment of this title, shall apply to the Fund in the same manner as such provisions apply to the Federal Supplemental Medical Insurance Trust Fund, except that any reference to the Secretary of Health and Human Services or the Administrator of the Health Care Financing Administration shall be deemed a reference to the Secretary of Health and Human Services.".

(b) ADMINISTRATIVE AND JUDICIAL REVIEW OF CERTAIN ADMINISTRATIVE DETERMINATIONS.—Section 1116 of the Social Security Act (42 U.S.C. 1316) is amended—

(1) by striking "or XIX" each place it appears and inserting "XIX, or XXI", and

(2) by striking "or 1904" in subsection (a)(3) and inserting "1904, or 2101(a)(14)".

(c) UTILIZATION AND QUALITY CONTROL PEER REVIEW ORGANIZATIONS.—Title XI of the Social Security Act (42 U.S.C. 1301 et seq.) is amended by adding at the end the following new section:

"REVIEW OF AMERICARE UNDER TITLE XXI.

"SEC. 1165. (a) REVIEW OF AMERICARE UNDER TITLE XXI.—The Secretary shall provide, by regulation, for reviews of the programs under title XXI of this Act by utilization and quality control peer review organizations to be carried out in a similar manner as provided under this part for review of programs under title XVIII of this Act.".

"(b) CLINICAL PRACTICE GUIDELINES.—In providing for the review of programs under title XXI of this Act as described in subsection (a), the Secretary shall, in consultation with recognized experts in the field of utilization and quality control review, ensure that, to the extent practicable, the reviews conducted under this section take into consideration clinical practice guidelines, (including guidelines for clinical practice and other standards developed by the Advisory Council for Health Care Policy, Research, and Evaluation pursuant to section 921 of the Public Health Service Act (42 U.S.C. 299b-1)).".

(d) CALCULATION OF FEDERAL INSURANCE ASSISTANCE PERCENTAGE APPLICABLE TO TITLE XXI.—

(1) IN GENERAL.—The Secretary of Health and Human Services (hereafter in this subsection referred to as the "Secretary"), in consultation with the chief executives of the States, shall develop recommendations for the calculation of a specific Federal insurance assistance percentage applicable to coverage furnished under title XXI of the Social Security Act (as added by this Act). In a recommended formula for the determination of such Federal insurance assistance percentage, the Secretary shall consider factors related to the following:

(A) Levels of employment.

(B) The population of individuals covered under AmeriCare under such title XXI.

(C) Poverty levels.

(D) Economic conditions.

(E) The distribution of urban and rural populations.

(F) Health indicators, such as infant mortality.

(2) EMERGENCY FUND.—The Secretary shall develop recommendations for the creation of an emergency fund to fund certain benefits under title XXI of the Social Security Act (as added by this Act) in the event a State experiences changes in economic conditions or other conditions that the Secretary determines to necessitate emergency funding.

(3) REPORT.—Upon completion of the recommendations described in paragraphs (1) and (2), the Secretary shall submit a report to the appropriate committees of the Congress that includes such recommendations.

(e) REDUCTION IN PAYMENT FOR HOSPITALS RECEIVING A DISPROPORTIONATE SHARE ADJUSTMENT.—

(1) IN GENERAL.—Notwithstanding any other provision of law, the Secretary of Health and Human Services (hereafter in this subsection referred to as the "Secretary") shall for discharges occurring on or after the first day of the second full calendar year after the date of the enactment of this Act provide for a reduction in the payment of the disproportionate share adjustment percentage specified in section 1886(d)(5)(F) of the Social Security Act by ¼ (½, with respect to discharges occurring on or after the first day of the seventh such full calendar year) of what the payments to hospitals under such provision would have been but for the enactment of this subsection.

(2) APPLICATION FOR EXCEPTION.—

(A) IN GENERAL.—The Secretary shall, notwithstanding paragraph (1), provide for payment of the full disproportionate share adjustment percentage specified in section 1886(d)(5)(F) of the Social Security Act in any case in which a hospital applies to the Secretary for an exception from the reduction specified in paragraph (1) and it is determined by the Secretary that such hospital shall receive payments resulting from the enactment of title VI of this Act that are less than 200 percent of the amount of reduction of payments specified in paragraph (1) to such hospital.

(B) DETERMINATION CRITERIA.—In making a determination under subparagraph (A) the Secretary shall consider—

(i) the number of patients served by a hospital that are underinsured or uninsured and the costs to the hospital of providing services to such patients in the first full calendar year after the date of the enactment of this Act; and

(ii) such other relevant factors as the Secretary determines appropriate.

(C) CONSIDERATION OF APPLICATION.—In the case of a hospital that submits an application to the Secretary under this subsection at least 6 months before the first day of the second full calendar year after the date of the enactment of this Act, the Secretary shall make a determination with regard to such application prior to such first day. With respect to all other applications submitted to the Secretary under this subsection the Secretary shall make a determination with respect to such application no later than 6 months after the date of receipt of such application.

(D) APPEAL OF DETERMINATION.—A hospital submitting an application to the Secretary under this subsection may appeal a determination by the Secretary to the Provider Re-

imbursement Review Board established under section 1878 of the Social Security Act and the provisions of such section shall apply to any such appeal.

"COORDINATION WITH TITLE XIX.—Title XIX of the Social Security Act (42 U.S.C. 1396 et seq.) is amended by adding at the end the following new section:

"COORDINATION WITH TITLE XXI

"SEC. 1930. (a) The provision of medical assistance under this title shall not apply to any individual eligible for coverage under AmeriCare under title XXI of this Act.

"(b) The Secretary shall, by regulation, provide for appropriate coordination of this title with title XXI of this Act.".

(g) INCREASE IN TITLE XIX CAP FOR TERRITORIES.—Subsection (c) of section 1108 of the Social Security Act (42 U.S.C. 1308) is amended by adding at the end thereof the following new flush sentence:

"Notwithstanding the preceding sentence, for each fiscal year beginning after the date of the enactment of the HealthAmerica Act each amount under subclause (C) of each clause of such sentence shall be increased by the AmeriCare percentage increase for the preceding fiscal year. For purposes of the preceding sentence, the AmeriCare percentage increase equals the percentage increase (if any) in the total Federal program costs of title XXI of this Act over such costs of title XIX of this Act (as determined in the fiscal year preceding the effective date of the HealthAmerica Act) for all States.".

(h) EFFECTIVE DATE.—The amendments made by this title shall take effect on the first day of the second full calendar year beginning after the date of the enactment of this Act, without regard to whether regulations to implement such amendments are promulgated by such day.

TITLE VII—DEVELOPMENT OF HEALTH SERVICE CAPACITY

SEC. GRANTS FOR EXPANSION OF AVAILABILITY OF PRIMARY CARE SERVICES.

Part D of title III of the Public Health Service Act (42 U.S.C. 254b et seq.) is amended by adding at the end thereof the following new subpart:

"Subpart V—Emergency Health Care Grant Programs

"SEC. 340D. GRANTS FOR EXPANSION OF AVAILABILITY OF PRIMARY CARE SERVICES.

"(a) IN GENERAL.—The Secretary shall award grants to eligible entities to expand the availability of comprehensive primary health services (as defined in section 330(b)(1)) in medically underserved areas.

"(b) ELIGIBILITY.—To be eligible to receive a grant under this section an entity shall—

"(1) be—

"(A) a migrant or community health center that receives assistance under section 329 or 330;

"(B) be an entity that meets the requirements of section 329(a) of 330(a) for being a migrant or community health center, though not a recipient of a grant under either of such sections;

"(C) be an entity that does not meet the requirements of section 329(a) or 330(a) for being a migrant or community health center, but that provides assurances satisfactory to the Secretary, including subsequent demonstrable evidence, that such entity will meet the requirements of either such section not later than 2 years after receiving a grant under this section; or

"(D) be an entity that is eligible for a planning grant under sections 329(c) or 330(c); and

"(2) prepare and submit to the Secretary an application at such time, in such manner, and containing such information as the Secretary may require.

"(c) REVIEW OF APPLICATIONS; PRIORITY.—

"(1) REVIEW.—The Secretary shall develop a process and timetable for reviewing applications submitted under subsection (b)(2) to assure that, to the extent practicable, all amounts appropriated under this section are awarded not later than 180 days after the beginning of each fiscal year.

"(2) PRIORITY.—In awarding grants under this section, the Secretary shall give priority to—

"(A) applicants that will use amounts received under such grant to provide services in areas with the greatest need for such services and in which the demand for such services can be expected to increase after the implementation of the HealthAmerica Act;

"(B) applicants with a demonstrated ability to expand their operations in the most efficient manner;

"(C) applicants that are migrant or community health centers receiving assistance under section 329 or 330, that propose to use amounts received under such grants to expand their operations, including expansion to new sites, to serve high impact areas (as defined in section 329(a)(5)) or medically underserved populations (as defined in section 330(b)(3)), that are not currently being served;

"(D) applicants that do not receive assistance under section 329 or section 330, but that meet all requirements to receive funds under either of such sections, including, for the purpose of planning the establishment of new centers in areas of high need, entities eligible for planning grants under sections 329(c) and 330(c).

"(3) SECONDARY PRIORITY.—The Secretary shall give secondary priority in awarding grants under this section to applicants that—

"(A) propose to meet the requirements of section 329 or 330 within 2 years after the date on which the application is submitted; and

"(B) are serving or propose to serve such populations or areas that are not currently being served or have a proposal for such service pending.

"(d) USE OF AMOUNTS.—An entity receiving a grant under this section shall use amounts received under such grant to expand the availability of comprehensive primary health services (as defined in section 330(b)(1)) in medically underserved or high impact areas.

"(e) REIMBURSEMENT FROM OTHER SOURCES.—

"(1) IN GENERAL.—An entity receiving a grant under this section shall use any and all reimbursements received from other sources for services provided by such entity to—

"(A) compensate for the unreimbursed costs of providing services to patients;

"(B) expand the amounts and types of services furnished;

"(C) serve additional patients or areas; or

"(D) promote the recruitment, training, or retention of personnel.

"(2) RETURN OF UNUSED AMOUNTS.—Any amounts of the reimbursements referred to in paragraph (1) that are not used for the purposes described in such paragraph shall be returned to the Secretary, either directly or through adjustments in future grants, and shall be used by the Secretary to make additional or expanded grants under this section without regard to appropriations under subsection (h).

"(f) FAILURE TO COMPLY.—

"(1) TERMINATION OF PAYMENTS.—In the case of an entity that receives a grant under this section and fails to comply with the requirements of this section, the Secretary shall, after providing such entity with appropriate notice and an opportunity for a hearing, terminate the payment of amounts under such grant to such entity. The Secretary may terminate grants to entities that fail to demonstrate good faith efforts to meet the requirements of this section.

"(2) ADDITIONAL POWERS OF THE SECRETARY.—In addition to terminating payments under paragraph (1), the Secretary may—

"(A) sell any property acquired by the entity with amounts received under the grant, or transfer such property to another entity receiving such a grant; and

"(B) recoup (to the extent practicable) assistance previously provided to the entity under this section.

"(3) INELIGIBILITY FOR FUTURE GRANTS.—If an entity that is not in compliance with the requirements of this section may be granted a 2-year extension to meet such requirements. If at the end of such 2-year period the entity has failed to comply with such requirements, that entity shall be ineligible for further grants under this section.

"(g) ADMINISTRATION.—Not more than 10 percent of the amounts made available under this section may be used for administrative purposes. The costs of administration include—

"(1) the cost of providing, either directly or by grant or contract to nonprofit private entities that represent the recipients of grants under this section, for the identification of areas and populations eligible for assistance under this section; and

"(2) the provision of technical assistance to entities for the planning, development and operation of the service delivery systems supported under this section.

"(h) AUTHORIZATION OF APPROPRIATIONS.—

"(1) IN GENERAL.—There are authorized to be appropriated and there are appropriated to carry out this section—

"(A) $58,000,000 for fiscal year 1992;

"(B) $166,000,000 for fiscal year 1993;

"(C) $266,000,000 for fiscal year 1994;

"(D) $350,000,000 for fiscal year 1995; and

"(E) $426,000,000 for fiscal year 1996.

"(2) REPORT.—Not later than September 30, 1995, the Secretary shall prepare and submit to the appropriate committees of Congress a report concerning the need for further migrant and community health center primary care service capacity development and recommendations concerning the appropriate level of support needed for activities to address such capacity development.

"(3) ADDITIONAL AMOUNTS.—Amounts provided under this section shall be in addition to any amounts appropriated under sections 329 and 330.".

TITLE VIII—EFFECTIVE DATE

SEC. 801. EFFECTIVE DATE.

(a) GENERAL RULE.—Except as otherwise provided in this section, titles I and II of this Act shall take effect on January 1 of the second full year that begins after the date of the enactment of this Act.

(b) EXISTING PLANS.—In the case of an employer that, on the date of the enactment of this Act, has in effect a health insurance plan covering the employees of such employer, the amendments made by titles I and II shall not apply to such employer until the date described in subsection (a) or the first day of the second full year after the date of the enactment of this Act, whichever is later.

(c) STATE AND LOCAL GOVERNMENTS.—In the case of an employer whose revenue is raised by a taxing authority, a health insurance plan covering the employees of such employer shall not be required to meet the requirements of part B of title XXVII of the Public Health Service Act until the first day

of the third full year after the date of the enactment of this Act. During the period beginning on the effective date prescribed under subsections (a) and (b) and ending on the first day of such third full plan year, employee participation in such plan shall be voluntary unless otherwise required by the plan.

SEC. 802. POLICY RESPECTING ADDITIONAL BENEFITS.

(a) IN GENERAL.—After the date of the enactment of this Act, no employer shall be required under part B of title XXVII of the Public Health Service Act to provide any health benefit in addition to the benefits required to be provided under section 2721(a) of such Act (as in effect on the date of the enactment of this Act) unless—

(1) such additional health benefit is for a service that the AmeriCare plans (under title XXI of the Social Security Act) are required to cover; and

(2) before the enactment of such requirement, the benefits and costs of requiring the provision of such additional health benefit have been analyzed and considered by Congress.

(b) REPORTS.—

(1) IN GENERAL.—In carrying out subsection (a)(2) with respect to the consideration of a proposed additional health benefit, Congress shall request a report from the Institute of Medicine of the National Academy of Sciences or a public or nonprofit entity with expertise relating to health benefits. Any such report shall—

(A) analyze and summarize such proposed additional health benefit; and

(B) contain an estimate of the economic and health impacts of such proposed additional health benefit.

(2) CONSULTATION.—Any such report shall be prepared in consultation with interested members of the public and with individuals and entities having expertise with respect to such proposed additional health benefit.

SUMMARY OF HEALTHAMERICA: AFFORDABLE HEALTH CARE FOR ALL AMERICANS

OVERVIEW

The legislation will assure every American basic health insurance coverage, either through a plan provided by an employer or through a Federal-State public insurance program, called AmeriCare, that will replace Medicaid.[1] Universal health insurance coverage will be coupled with a comprehensive program to control health care costs and with provision to reflect the special needs and problems of small business.

EMPLOYMENT-BASED COVERAGE

Business responsibility.—Businesses will be offered a choice of providing coverage meeting minimum standards for employees and their families or making a contribution to the public plan. The contribution will be set at a percent of payroll. This contribution will encourage employers to provide health insurance while providing a substantial subsidy to employers, especially small employers, with a high percentage of low-wage or part-time workers. The contribution will be set at a level that will maximize private coverage for the working population without imposing an excessive burden on employers.

If an employer chooses to make a contribution, he or she will be required to facilitate the process of enrollment in the public program by providing his or her employees with enrollment forms and information about how to apply for coverage. States will be given the option to require those employers who elect to make a contribution to the public program to collect the employees' portion of the premium. In the absence of this requirement, employers will be allowed to voluntarily collect premiums on behalf of employees.

Individual responsibility.—Employees will be required to accept coverage for themselves and their families if offered by their employers and pay a share of the premium as well as co-payments and deductibles, if required under the employer plan. A similar obligation will be assumed by workers whose employers make a contribution to the public program. When the plan is fully phased-in, certification of health insurance coverage will be required for each individual claimed as a personal exemption. Certification of coverage will also be required when applying for government benefits such as government loans or food stamps as a condition of receiving benefits.

BASIC BENEFIT PACKAGE

Covered services. Plans must cover: hospital services; physician services; diagnostic tests; limited mental health benefits; 45 days of inpatient care; 20 outpatient visits; pre-natal and well-baby care; preventive health benefits: mammograms, pap smears, and well child care.

Cost-sharing. Maximum employee cost-sharing under basic plans is: 20 percent of the premium; deductibles of $250 per individual and $500 per family; co-payments of 20 percent (except for outpatient mental health services, for which 50 percent co-payments may be charged); out-of-pocket catastrophic cap on liability for covered services of $3,000; wage-related cost-sharing may be used for deductible and catastrophic cap; employee premium share and co-payments and deductibles will be subsidized by the public plan for low-income workers (as described in the public plan section below).

Actuarial equivalency. To assure employer flexibility to adapt the plan to the needs of the particular work force, employers may offer plans that do not meet minimum standards as long as the employer contribution to the plan offered is actuarially equivalent, pursuant to guidelines issued by the Secretary, to what would be provided under the basic plan. Under an actuarially equivalent plan, basic services must still be covered without limits on scope and duration, except as specified in the basic plan, but the level of cost-sharing could be adjusted. For example, an employer who offered a service that was not required to be covered could require his or her employees to pay a larger share of the premium or charge a higher deductible. An employer with a lower deductible could have a higher catastrophic cap.

EMPLOYEES TO BE COVERED

Full-time workers. If an employer provides private coverage rather than making a contribution to the public plan, all workers and their families working 17½ hours a week or more must be covered. An employer may choose to make a contribution to the public plan for workers employed less than 17½ hours per week even if direct coverage rather than the payment is chosen for other workers. For purposes of computing the wage base for contributions to the public plan, the employer may exclude workers for whom coverage is not mandatory, including employed children covered under a parent's plan and workers with two employers receiving coverage under another employer's plan.

Less than full-time workers. The required employer premium contribution for workers employed 17½ hours per week or more and less than 25 hours a week may be reduced based on the ratio of hours worked to 25. The required contribution for employees working less than 17½ hours per week is at least 50 percent. Employees who are charged premiums higher than 20 percent of the cost of a basic plan as the result of this provision may decline employer coverage and receive coverage through the public plan.

Two family members employed. Each employer is responsible for primary coverage of his or her employee. If a family member is covered under another plan, a worker may decline coverage for that family member. Parents may choose which employer plan will cover their children. A worker receiving primary coverage from an employer may also elect to participate in the plan of another working family member and receive secondary, wrap-around coverage from that plan. In the case of a two-worker family, the primary worker's premium payment, if any, to the primary employer shall be adjusted to reflect savings to that employer as the result of not bearing responsibility for primary coverage of the secondary worker. A similar adjustment shall be made for workers receiving retirement health benefits from a previous employer.

Employed child. Coverage may be waived for a working dependent child covered under a parent's plan.

ADDITIONAL FEATURES

Waiting period. The waiting period for coverage may not exceed 30 days. If the employer elects to impose a waiting period, the employee may elect to receive coverage from the employer during this period by paying 102 percent of the combined employer and employee share of the premium.

Pre-existing condition limitations on coverage. When fully phased-in, no limits on coverage may be imposed based on the existence of pre-existing conditions.

Consumer protection. A set of legal protections will be established for insured individuals, including the right to full information on plan provisions and the right to appeal coverage decisions.

PUBLIC PLAN

Medicaid will be replaced[2] by a new Federal-State program of public coverage called AmeriCare. The program would be administered by the states subject to national standards for eligibility, reimbursement, and coverage. All Americans not covered by employment-based coverage will receive coverage under AmeriCare.

Benefits under AmeriCare will be the same as for employment-based coverage, except that Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) will be available under the public program. Individuals below the poverty line will have access to optional Medicaid services that the State chooses to provide. Individuals below the poverty line covered by an employment-based plan will also be entitled to receive such services through the public plan.

Specific provisions include:

Premiums.—Individuals below 100 percentof poverty will pay no premium. Individuals between 100 and 200 percent of poverty will pay premiums on a sliding scale basis. Individuals above 200 percent of poverty will pay premiums equal to the average actuarial value of the coverage, capped by a percent of income reflecting ability to pay.

Workers receiving coverage through the public plan will pay 20 percent of the actuarial value of coverage, unless their incomes are below 200 percent of poverty.

Subsidy of low-income workers receiving private coverage through an employer.—The public plan will subsidize the premium share of workers with family income below 200 percent of poverty. Premiums will be

[1] Except for long-term care services.

[2] Except for long-term care services.

completely covered for below-poverty workers for basic plan benefits.

Consortia.—States will be encouraged to establish purchasing consortia to reduce the overall rate of health care cost inflation (see below). AmeriCare and Medicare can participate in these consortia.

Managed care.—States will be encouraged to set up and enroll beneficiaries in cost-effective managed care systems. Safeguards are included to assure that no enrollee will be forced to choose a managed care alternative.

Provider reimbursement.—Providers will be reimbursed at levels at least equivalent to the level that would be provided by the use of Medicare reimbursement rules. Reimbursement will be raised in phases.

Scope and duration.—No limits may be placed on scope and duration of coverage for required services.

Phase-in.—The public plan will be phased-in. All children and pregnant women will be assured coverage in the first phase.

Financing.—The public program would be financed by state and Federal contributions. States would receive an enhanced Federal match, phased out over time, for coverage of newly eligible persons and other new program costs in the public program. This enhanced match would be a specified percent increase over a state's current matching rate for the Medicaid program.

EXPANDING ACCESS THROUGH AN IMPROVED DELIVERY SYSTEM

Insurance coverage alone will not guarantee access to care for many individuals in rural and inner-city areas where there is an inadequate supply of health care providers. Over the next five years, approximately $1.2 billion in additional funding will be invested in the creation of community health centers to provide primary care services in such underserved areas. This additional funding will provide the capacity to serve an estimated 5.4 million people each year.

REDUCING THE BURDEN OF HEALTH CARE COSTS

Universal health insurance coverage itself significantly reduces the cost of health care to businesses and individuals currently purchasing insurance. Uncompensated care raises private health insurance premiums an estimated 10-15 percent.

In addition to the reduction in cost-shifting, the program includes a comprehensive program to lower health care cost inflation and total health care costs. The strategy is organized around steps to reduce unnecessary and ineffective care; to reduce the excessive administrative costs of the current pluralistic payment system, and to limit unrestrained price and volume increases by providers. Specific measures include:

REDUCING UNNECESSARY OR INEFFECTIVE CARE

Outcomes research/practice guidelines dissemination.—The Pepper Commission estimated that unnecessary or ineffective health care added as much as $18 billion annually to health care costs. The legislation will raise the authorization level for the Agency for Health Care Policy and Research by $50 million, to enable it to conduct additional outcomes research and develop practice guidelines for more procedures. The current emphasis on Medicare services will be supplemented by an equal emphasis on the services that are delivered in the private market. Government programs will be required to use practice guidelines in utilization review activities. Additional measures will be taken to assure dissemination of guidelines, once developed, to providers and payers (see below).

Technology Assessment.—The current public initiative through the Agency for Health Care Policy and Research to analyze the appropriate use of technology will be expanded. Cooperation between the public and private sector and coordination or private sector efforts will be encouraged. Federal matching grants will be available through the Agency for Health Care Policy and Research for private sector technology assessment initiatives.

Encouragement of managed cares.—Managed care works by encouraging use of the most efficient providers and minimizing unnecessary or ineffective care. Managed care will be encouraged by the following measures:

State legislative barriers to managed care will be preempted.

Small businesses (which employ 30 percent of all American workers) will be given guaranteed access to managed care through small business insurance reform (see below).

Through small business insurance reform (see below), insurers will be given additional incentives to develop cost-effective systems of managed care.

The public program will make managed care options available to those not covered by employment-based plans.

The data base necessary for effective managed care will be enhanced by the standardized data and evaluation of providers described below and by evaluation research and development of practice guidelines.

ELIMINATING UNNECESSARY ADMINISTRATIVE COSTS

Four programs will be established to reduce the excessive administrative costs of our pluralistic payment system.

Standardized claims forms.—The Federal Health Expenditure Board (see below) will be required to develop and implement standardized claims and data forms. This will reduce administrative costs for providers, who must now deal with a multiplicity of forms provided by different payers.

Insurance Consortia. (See Encourage State Consortia, below).—By requiring small insurance companies to combine for the purpose of paying providers, the legislation will dramatically reduce the number of payment entities with which providers must deal. This will make possible significant economies of scale in claims processing, facilitate electronic claims processing, and reduce administrative costs of providers.

Quality improvement agencies.—New agencies will be established in each state to work with providers on a program of continuous quality improvement and implementation of cost-effective methods of delivering care, including practice guidelines. Providers periodically certified by the agency as practicing efficient, quality care will be exempt from utilization review by insurers during the period of the certification, not to exceed one year. This step will focus utilization review where it is most likely to be cost-effective and enhance risk-management activities.

Small business insurance reform (see below).—By reducing the costs of the continuous enrollment and disenrollment endemic to the current system of insuring small businesses, by promoting more effective price competition, and eliminating or reducing the high costs associated with medical underwriting, this reform will reduce the average administrative costs associated with selling insurance to businesses of 25 employees or fewer from 25 percent of premium to 15 percent. For companies with ten or fewer workers, where administrative and sales costs are often as high as 40 percent, savings will be even greater.

ASSURE PROVIDER PRICE AND VOLUME RSTRAINT.

Federal Health Expenditure Board.—An independent agency with the stature and independence of the Federal Reserve Board will be established to set national expenditure goals, in total and by sectors of the health care industry. Advisory goals will also be established for states and regions. The Board will convene providers and purchasers to conduct negotiations on rates and other methods of achieving the expenditure goals. Negotiators may recommend adjustments of the goals to the Board. The Board will publish recommended rates and other measures to achieve the goals for the use of purchasers and providers. Recommended rates and other measures will be binding if the negotiations are successful unless State Consortia (see below) establish different payment methods, rates, or other measures that could be successful in achieving the goals.

Encourage State Consortia/Innovative cost control programs.—States will be required to establish insurance/purchasing consortia, which would, at a minimum, require insurance companies with small market shares to participate for the purpose of reducing administrative costs. These consortia would also be encouraged to take other cost-containment actions. To encourage states to use consortia, states will be given the flexibility to have both Medicare and AmeriCare participate. States will also be given grants to establish and evaluate these consortia.

Mandatory functions. The consortia will make all direct payments to providers on behalf of insurance companies with small market shares (most of the estimated 1200 insurance companies marketing health insurance) and will work with providers to establish paperless processing and "smart card" systems for reimbursement that will reduce administrative costs and burdens and take advantage of economies of scale. Larger insurers and the public programs will be allowed, and, at state option, required to join these insurance consortia.

Optional functions. Optional functions of the consortia may include: price negotiation; volume negotiation; capital allocation; rational distribution of providers; data collection; consumer protection; promotion of managed care/competition.

If state consortia establish effective methods of achieving overall state goals established by the Federal Expenditure Board, state rates or other methods may be used in lieu of Board published rates.

Develop and disseminate cost and quality data on individual providers.—The Federal Health Expenditure Board will collect, analyze, and disseminate data that will assist purchasers of care and consumers in evaluating the efficiency and quality of individual providers. This will assist in the development of managed care networks, in identifying quality providers for patients, and in encouraging providers to improve their performance.

ADDITIONAL COST CONTROL ACTIONS

Pre-empt state mandates.—The current ERISA pre-emption of state regulation of the content of employer health plans for self-insured plans will be extended to all employment-based health plans. Federal standards will replace state standards.

Malpractice.—A grant program will be established to provide states incentives to experiment with alternatives to the tort system for reimbursing and protecting the victims of malpractice and with the use of practice guidelines in malpractice cases. The Institute of Medicine or similar independent organization will conduct an evaluation of the current status of knowledge about the malpractice problem in all its facets and make recommendations to the Congress.

Health care cost control research and demonstration program.—A new program of health care cost control research grants and demonstrations will be established in the new Agency for Health Care Policy and Research. Grants will be made to develop effective methods of health care cost reduction. A similar program in the '70s led to the development of the DRG program.

SPECIAL PROGRAMS FOR SMALL BUSINESS

The legislation recognizes the special problems faced by small business in providing health insurance to their workers and addresses these problems in a number of ways.

Contribution to public coverage.—By offering businesses the opportunity to make a contribution based on a percentage of payroll instead of providing coverage directly, the legislation reduces the cost substantially to businesses, often small businesses, that employ predominantly low-wage or part-time workers. This alternative is far less costly to such businesses than providing coverage but will assist them in attracting a qualified work force.

Phase-in of Small Business Responsibility.—Small businesses with fewer than 100 workers will be allowed a phase-in period before they are required to provide or contribute to coverage for their workers. For businesses with 25 to 99 workers, the phase-in will be four years. For businesses with fewer than 25 workers, the phase-in will be five years. These transition periods will allow small business insurance reform time to take effect and give small businesses time to plan for the additional costs they will be expected to incur. Businesses with 25-99 workers will have 4 years to voluntarily provide coverage to workers. If at the end of 4 years 75 percent of the currently uncovered employees of these businesses have been covered, then employers in this group will not be required to provide coverage or pay a contribution to the public program. The same rule will apply for businesses with fewer than 25 employees, except that they will have 5 years to voluntarily provide coverage.

Small business insurance reform.—Federal standards for health insurance sold in the small group market will: remove barriers to access to group health insurance by eliminating pre-existing condition exclusions and denials of coverage on the basis of health status; promote equity in insurance premiums, by moving rate-setting toward a community-rated system; and improve the affordability of coverage for small employers, by preempting state benefit laws and ensuring access to managed care. States will be required to provide information and technical assistance to small employers and consumers seeking to choose a plan.

Special treatment of new small businesses.—Recognizing the fragility of small businesses in their early years, the legislation allows new, small businesses a reduced obligation with regard to providing or contributing toward health insurance coverage. Small businesses with fewer than 25 workers will have no obligation to provide or contribute to coverage during their first two years. In the third year, the contribution they will be required to make to the public plan will be one-half the normal level. In the fourth year, such businesses will be required to fulfill the same obligations as other businesses.

Special treatment of small businesses that have not previously provided coverage.—During the first five years after enactment, small businesses that have not provided coverage to their employees during the year prior to enactment of the legislation will be allowed to buy insurance paying providers under Medicare rules.

This program will allow these small businesses to provide coverage at lower costs and will encourage them to begin to provide coverage voluntarily during the transition period. The Secretary shall study this program and report to the Congress on its effectiveness.

Improved tax treatment for the self-employed.—Currently, the owner-operator of an unincorporated small business is only allowed to deduct 25 percent of the cost of his or her own health insurance premiums from income for tax purposes, and even this deduction is due to expire in December, 1991. By contrast, the cost of health insurance for the owner-operator of an incorporated business is fully deductible. This provision would allow the self-employed owner-operator to deduct 100 percent of the cost of his or her own health insurance premiums up to the value of the premium they paid on behalf of their employees. Owner-operators with no employees would be allowed to deduct 100 percent of the cost of the lowest cost small employer plan meeting the basic benefit requirements available in their area.

Tax credits for small business.—In addition to the improved deductibility of health insurance expenses for the self-employed, small businesses that are not profitable enough to be able to afford to provide health insurance coverage to their workers without difficulty will receive a tax credit to cover up to 25 percent of the cost. This credit will be provided to small businesses with fewer than 60 employees for each full-time employee with a salary of less than $20,000, except for high-profit firms in which the employer earns more than $53,400 per year. This credit would be in addition to the deduction currently available for the cost of such insurance.

Mr. KENNEDY. Mr. President, I have been working on the issue of affordable health care for many years. Never have we been closer to guaranteeing affordable health care for all our people than we are today.

And never has the need for action been greater, because we face a two-pronged crisis in health care that threatens the health and well-being of every American.

Too many Americans are uninsured and underinsured—and the number is growing every year. No American family can be secure that the health insurance they have today will protect them tomorrow. And health care costs are too high and growing at astronomical rates.

In this rich land of 250 million Americans, 34 million of our fellow citizens have no health insurance whatsoever.

At various times over the next 2 years, 30 million more will have no health care coverage for substantial periods. And another 60 million have insurance that even the Reagan administration said was inadequate.

During the great depression, President Franklin Delano Roosevelt called us to action with his statement that "One-third of a nation is ill-housed, ill-clad, and ill-fed." Today, more than a third of our Nation lacks the basic health insurance coverage that every other industrialized country except South Africa deems a fundamental human right.

A family without health insurance must live every day with the knowledge that an accident or an illness could wipe out the savings of a lifetime. But the danger is more profound than the loss of economic security alone.

Every year, 1 million Americans seek health care, but are turned away because they cannot pay. Another 14 million do not even look for care they need, because they know they cannot afford it.

Two-thirds of the uninsured with serious health symptoms such as spontaneous bleeding or loss of consciousness do not see a doctor. A recent study in Washington, DC, found that almost half of the uninsured people admitted to the hospital could have avoided hospitalization if timely care from a family doctor had been available.

The problem is especially devastating to America's children. Eight million American children have no health insurance. One in every three poor children has no coverage. Forty percent of the Nation's children do not even get basic childhood vaccinations. The United States ranks first in wealth, first in military power—and a dismal 22d in preventing infant mortality.

Every American child should be guaranteed a healthy start in life, but too many are not getting it. Soaring costs threaten to price health care out of the reach of working Americans. Today, we are spending in excess of $700 billion a year on health. Costs are going up twice as fast as wages. Corporate expenses for health care are actually greater than corporate profits. The amount American families pay for health care that insurance did not cover has almost tripled in the last 10 years, from $63 to $162 billion.

Exploding costs would be a problem under any circumstances. But these immense expenditures have not brought us the health care system the American people need or that the American people deserve.

They have not kept newborn American infants from dying at rates higher than almost every other industrial country. They have not raised life expectancy as high as 12 other nations. They have not bought insurance for millions of working families or adequate protection for millions more.

Caught between the twin problems of increasing numbers of the uninsured and escalating costs, some of our most important health care institutions are imperiled. Hospitals committed to serving the uninsured are increasingly swamped in a tide of red ink. Half of all public hospitals are operating at a loss. One-third of all rural hospitals are operating at a loss. Six hundred are likely to close in the next few years.

In New York City, it is not uncommon to wait 3 days in an emergency room before a hospital bed becomes available. Forty-one States report

similar problems. In Los Angeles, more than half the private hospitals have dropped out of the trauma care system, because they cannot afford the uninsured patients who arrive in emergency room. Nationally, a of all hospitals have dropped out of the trauma care system. The message is ominous—"Don't get into an auto accident—whether you are rich or poor, insured or uninsured, your life is at greater risk."

Even in hospitals with a wealthy, well-insured clientele, costs continue to soar. This imbalance is yet another mark of our failure to establish a rational, humane, and effective national health care system. Health care is the fastest growing failing business in America.

The plan we are proposing today builds our current system but corrects its worst faults. It is a practical, achievable proposal that will get the job done.

It will guarantee basic health insurance for every American family, and it will put in place a comprehensive program to control health care costs.

Under the plan, every business will be required to provide health insurance coverage for its workers and their families, or contribute to their coverage under a new Federal-State program called AmeriCare. Two-thirds of the uninsured are workers and their families. These Americans work hard—most of them 40 hours a week, fifty weeks a year, but all their hard work cannot buy them the health insurance they need, because their employer refuse to provide it.

The vast majority of businesses already assume this obligation. It has been more than half a century since we required all employers to pay a minimum wage, to contribute to Social Security, and to participate in worker's compensation and unemployment insurance. In 1991, the time is long overdue for all employers to provide or contribute to health care.

The unemployed deserve the basic right to health care, too. AmeriCare will make coverage available to them with premiums based on ability to pay.

Coverage under the plan will be phased in over a 5-year period, beginning with coverage for every child. Businesses with 100 employees or more will be required to provide or contribute to coverage immediately. The obligation will be phased in for smaller businesses. By the fifth year, every American will be guaranteed coverage on the job or through AmeriCare.

The plan includes a number of provisions to make it easier for smaller businesses to afford the cost of their increased obligations. These provisions include insurance reform, so that small businesses will finally be able to buy coverage at a fair price, regardless of whether their employees are healthy or not. It includes new tax credits to provide fair tax treatment for the costs of the self-employed and to pay up to 25 percent of the costs of small businesses that might have trouble affording coverage. And it phases in the provisions of the plan so that small businesses will have time to adapt.

Our plan includes the most comprehensive program to deal with the excessive cost of health care ever introduced.

First, it includes strong steps to squeeze unnecessry care out of the system. Studies by the RAND Corp. of selected medical procedures found that 15 to 30 percent, depending on the procedure, were clearly unnecessary or even harmful. A 5-year study of Medicare has found that 10 to 20 percent of care to be unnecessary. The Pepper Commission estimated that as much as $18 billion worth of medical care annually was unnecessary. Our program will required stepped-up development of practice guidelines so that unnecessary medical care can be clearly identified and eliminated. Managed care, with cost-effective providers, will be encouraged. And outcomes research will be increased so that for many medical procedures whose value is unclear, effectiveness will be established and in effective procedures eliminated.

Second, the plan will cut billions of dollars in unnecessary administrative costs. The current system is strangling in redtape that burdens physicians, hospitals, and patients alike. Over 1,200 separate companies are selling health insurance today, and the multiplicity of different forms and payment procedures, as well as the repetitive and inconsistent review of medical practice that results, diverts time and money that could be better spent on medical care. When insurance companies sell a policy to a small business or an individual, as much as 40 to 50 cents of every premium dollar goes to cover sales and administrative costs and profit. This money that stays with the insurance companies doesn't buy even a single band-aid.

Our program will reform the insurance market, so that overhead is reduced and a greater share of premiums is used to cover medical care costs, not insurance company redtape. Billing and claims forms will be standardized, and small insurance companies will be required to join consortia for the purpose of paying doctors and hospitals. Economies of scale and standardization will make cost-effective paperless processing easier to implement and will cut the resources devoted to administration. A new quality improvement program will exempt large numbers of doctors and hospitals from the necessity of wasting time and money justifying tests and procedures to insurance companies.

Third, the plan will end the blank-check payment policies that have allowed doctors and hospitals to charge whatever they want for care. We need the best health care system money can buy, not the most wasteful and expensive one.

Under this program, a new Federal Health Expenditure Board, with the stature and independence of the Federal Reserve Board, will be created. The Board will collect, analyze, and publish data on doctors and hospitals in every community in the country, so that patients and insurers can compare costs and quality. The Board will establish tough goals for total spending, and bring providers and purchasers together to negotiate ways to achieve the goals. And States will be encouraged to take additional steps to control costs.

Finally, the program will end cost-shifting by assuring that every American is covered, and that every business does its fair share. Today, health insurance costs for those who have insurance are as much as 15 percent higher than if everyone were covered. When people cannot pay their medical bills, the costs are picked up in the form of higher charges for everyone else.

My family has been fortunate in always being able to afford the best medical care. The time is long overdue to guarantee every citizen that same access to the care they need. I believe the introduction to this bill marks the beginning of a process that can achieve that goal, and make decent health care a reality for every American family.

Mr. RIEGLE. Mr. President, today I am introducing S. 1277, Health America: Affordable Health Care for All Americans, with Senators MITCHELL, KENNEDY, and ROCKEFELLER. I want to commend the majority leader for his leadership in this area.

Health America is the product of almost 2 years of work of the Finance Subcommittee on Health for Families and the Uninsured to provide health care coverage for all Americans. In the 101st Congress, the Finance Committee's Subcommittee on Health for Families and the Uninsured was created at my request to enable us to find a solution. At the first hearing of our Subcommittee, the lead off witness was Senator KENNEDY, chairman of the Labor and Human Resources Committee and we agreed to work together—and have done so—along with the majority leader, Senator ROCKEFELLER and others like Senator PRYOR and Senator METZENBAUM. Over the months all points of view have been weighed and balanced in the package we're presenting today.

We began as a bipartisan process. And it is my hope that this legislation will prompt the administration to act now on the crisis of high health care costs and lack of availability of health care coverage.

I first introduced a bill to provide health care to the uninsured in December 1982 in the 97th Congress and introduced bills on this issue every Congress until the 101st when I asked

for the creation and became chairman of the Finance Subcommittee. I began by focusing on unemployed people without health insurance and have since broadened to more comprehensive legislation.

America's health care crisis is part of a larger problem of a shrinking American middle class where our people have less and less economic power to meet their basic needs. Skyrocketing health insurance costs for those who have coverage—and the growing group of Americans with no health insurance coverage—are signs that our health care system must be reformed.

While health care reform has many complexities we must not get lost in the detail and lose sight of the fact that this is an urgent issue facing our people.

In Michigan alone, there are a million people today without a penny of health insurance, and 300,000 of them are children. Nationally, an estimated 34 million Americans have no health insurance coverage. Those that do have health insurance are finding their rates rising sharply and their coverage being reduced by rising deductibles, copayments, and diminished benefits. We can and must do better—and that requires the comprehensive health insurance plan we are introducing today.

Mr. President, more than ever before, we need a national strategy for addressing the current health care crisis in this country. Our health care system—the most advanced and sophisticated in the world—is failing us in two important ways. Tens of millions of Americans are without health insurance or the financial resources to purchase health care services when they or families need care. Yet at the same time, our health care system is the most expensive in the world. A more efficient, better designed health care delivery system could provide care to all Americans without utilizing additional national resources.

Every day we read or hear about these issues—and the problems are only getting worse. We now know that even more Americans, over 60 million, lacked health insurance protection for a period of time each year. A recent study I requested from the GAO underscores the fact that the uninsured span all ages, income levels, employment status, ethnic groups, and geographic regions. The uninsured are also more likely to die after entering a hospital and less likely to have certain procedures performed when compared to insured persons. In fact, in Michigan, this subcommittee has heard testimony from people that have since died as a result of delaying medical care specifically because they had no health care insurance.

Health care is increasingly becoming unaffordable for all Americans. In some cases, premiums continue to rise in double digit figures. These pressures on the current system will 1 day lead to a complete collapse, leaving millions more without health insurance.

A General Accounting Office [GAO] study I requested shows just one dramatic example of why we need comprehensive reform of our current health care system. The primary reasons for the closing of 60 hospital trauma care units in major urban areas were the costs of treating uninsured people without the means to pay and unreasonably low medicaid payment rates to hospitals. Hospital trauma centers can't stay open in an environment where they are losing money on the people they must serve. For three hospitals in Detroit, the total losses exceed $10 million a year for emergency and trauma care alone. Parts of our health care system are collapsing around us while the need for comprehensive health care reform has been stalled by an executive branch largely indifferent to the problem.

When essential services, like hospital trauma centers, are forced to shut down due to inadequate funds we all suffer. Trauma centers are not the only problem, hospital emergency rooms are closing, hospitals are closing down entirely, and doctors are finding it harder and harder to treat a growing number of our people. In Michigan alone, hospitals lost $350 million last year providing care for those who could not or would not pay. Ultimately, the financial distress of hospitals and doctors that provide large amounts of uncompensated care threatens the quality and availability of this care and, in fact, is threatening to shut down hospitals all across America as well as reduce the number of doctors providing care, particularly in areas where they are needed the most.

The plan we are unveiling today begins the reform process. We've spent the past 2 years analyzing all the relevant data and weighing the viewpoints of the various parties at interest. In fact, in March last year a document of proposed options was distributed for public comment to hundreds of groups, and at least 100 groups in Michigan alone. The principles we have used in designing our program mark a breakthrough that will, in stages over the next 5 years, bring basic health insurance coverage to every person in America.

It does so by implementing important cost-saving reforms at the same time we broaden health insurance coverage—starting universal coverage first with 10 million American children who now lack health insurance and would begin to receive it once the program takes effect. By matching cost-saving reforms with broadened coverage—we can achieve needed efficiencies and cost saving throughout our entire health care system.

This bill strikes a fair and carefully structured balance among competing objectives—and none of the various parties of interest will find it precisely to their liking. I consider that a measure of its practicality and why it should be—and will be—enacted.

Mr. President, Health America addressed two major shortcomings of our health care system—rising health care costs and lack of health care coverage for millions. Our plan would, in stages over 5 years, provide health care for all people who currently do not have health care coverage, building on the current private and public system. Children and pregnant women are covered in the first phase. Of integral importance, we have also developed a significant cost containment program. Our cost containment program makes this bill different from proposals in the past which deal only with access.

About two-thirds of the currently insured get their coverage from their employer. Another 15 percent get their coverage through public programs, primarily the Medicaid Program. That leaves about 16 percent of our population with no coverage at all. Our plan fills in the current gaps in coverage by restructuring the current system. Employers would be encouraged through tax incentives and disincentives to provide coverage; so most people would get coverage through their employer as they do today.

We have a series of special provisions to ease the burden on small businesses including tax credits, small group insurance market reform and special phase-in periods for coverage. Since we phasein our cost reduction program sooner than the coverage of the uninsured, we hope to make health care plans more affordable for small businesses. Many businesses would like to provide health care coverage but the costs are too high. We hope that making health care benefits more affordable and providing direct tax credits will entice businesses to voluntarily provide coverage. I would also say at this point that we owe Senator PRYOR a debt of gratitude for all his hard work in this area.

Anyone who does not receive health insurance through an employer will have access to our new public health insurance program called AmeriCare.

Unlike medicaid, which it replaces, AmeriCare is not a welfare program. All people are eligible for its coverage including workers and their families from businesses that do not provide private health insurance.

Also, AmeriCare will provide a uniform health benefit package and higher reimbursement rates for providers—both significant changes from the current Medicaid Program. States would administer AmeriCare within these tighter Federal standards creating a uniform health care program across America. Medicaid now varies tremendously by State. In addition, States usually cover only single women with children and on average cover only some 40 percent of all people living in poverty. We increase funding to the States for AmeriCare

during the time the program is being phased-in.

Here is just one example of who would be helped by this type of prog

arkable young woman age 28 from W[illegible]ven, MI, Cheryl Eichler, had Crohn's disease for 13 years. She left a hospital bed in June 1989 to testify before a finance subcommittee hearing in Michigan. Cheryl earned $12,000/yr (2 times the poverty level) at a 7-11 store but her employer did not offer health care. When she quit her job due to her illness, she did not qualify for medicaid because as a single woman with no children she did not fit one of the current categories under medicaid. We tried to help her. Within 6 months she died—and I am convinced her tragic and premature death occurred because she did not receive the proper care she needed at the right time.

AmeriCare could have helped Cheryl Eichler; she would have had immediate access to essential health care services. She would not have had to fit into an arbitrary category in order to get health care. If she had received immediate medical care throughout her illness, I'm convinced she'd be alive today. Our country is diminished by her death. We can and must save lives like Cheryl's—this program will let us do that.

Our Plan would help those currently insured by the private sector by significantly controlling health care costs. We do this by reducing unnecessary care, decreasing administrative costs, and constraining price increases. Savings to the health care system for p[illegible] our cost containment program is [illegible]ated at close to $80 billion over a 5-year period.

Our program is a significant step towards a more rationale health care system. Among many provisions, we establish a new independent Federal Health Expenditure Board that will establish voluntary annual expenditure goals by health care sector and by State or regional. The commissioners appointed by the President and approved by the Senate, on the board would be insulated from the political process. They would convene negotiations between purchasers and providers to establish rates and other cost controlling mechanisms in order to establish fair prices. At the State level, a similar process would occur. Both the Federal and State activities in this area would set forth a process where all relevant players—purchasers and providers—are involved and are intended to help constrain health care prices.

This bill would also go a long way towards reducing unnecessary by expanding the current outcomes research effort to determine appropriateness of care and by expanding technology assessment. We also expect to reduce overall administrative costs by promoting cost-effective managed care sy[illegible]; providing purchasers better in[illegible]ation cost and quality and es[illegible]ng uniform claims and billing fo[illegible] to be utilized by all providers. Finally, in order to address the current problems relating to medical liability, we would set up grants to States for short reform or alternatives to this, such as alternative dispute resolution.

IMPACT ON BUSINESS

Experience shows that companies that provide health insurance to their employees are finding that their rates are going through the ceiling because they are indirectly paying for the medical care of uninsured people. The costs of uncompensated health care costs which are shifted to private payers have sharply increased the cost of private health insurance.

This severely damages the ability of U.S. companies to compete internationally. Chrysler's health care cost per vehicle—$700—exceeds our international competitors' costs by nearly $500 per vehicle.

Our bill would help American businesses in several different ways. The bill would reduce the current uncompensated care cost shift, often 15 percent of their total health care costs.

Businesses will also be better able to help manage health care costs by participating in the Federal Health Expenditure Board and State consortia. Businesses working together will have increased bargaining power with providers encouraging more efficient delivery of health care services. We will also reduce overall administrative costs by standardizing billing and by implementing practice guidelines to determine appropriateness of services, thus reducing unnecessary care.

We also significantly reduce the current cost shift to business from presently inadequate public programs by mandating higher reimbursement rates.

Mr. President, the political dynamics around this issue have changed dramatically. All sectors of society now recognize the need for change and are working to find solutions.

Big business, facing increasingly competitive world markets, must find ways to control health care costs. Small businesses fear government-mandated health benefits for employees and are looking at alternatives to mandates.

State governments are finding that health care costs are an increasingly large percentage of their budgets. The Governors have formed a task force to develop their own recommendations on this issue.

Doctors and hospitals, concerned about the lack of adequate payment for services, want answers to the uncompensated care problem. Insurers are looking for new ways to keep costs down so their customers do not move to other forms of care or to self-insurance.

Health care is now the major issue in the vast majority of collective bargaining negotiations. Organized labor recently united in supporting the need to achieve universal access and significant cost containment, through building on the Nation's existing employer-based system. A majority of consumers, have also overwhelmingly expressed a need for substantial health system reform.

Mr. President, we need to act now on both universal access to health care and rising health care costs. We have done enough study of the issues. It's now time to move forward on a health care program for all Americans. I hope that my colleagues in the Senate will join me in cosponsoring this important piece of legislation to ensure affordable high quality health care for Americans.

Mr. ROCKEFELLER. Mr. President, I am extremely pleased and honored to rise today with the majority leader, Senator MITCHELL, my colleague on the Finance Committee and chairman of the Subcommittee on the Uninsured, Senator RIEGLE, and the chairman of the Labor and Human Resources Committee, Senator KENNEDY, to introduce a bill that would reshape our Nation's health care system.

It has just been a little more than a year ago that the Pepper Commission—which I chaired and on which Senator KENNEDY served—released its recommendations on how to achieve universal access to health care for all our citizens. At that time I said that our job had just begun and hard work lay ahead. Introduction of today's bill is evidence of some of that hard work and brings us even closer to the day when we can say that every American man, woman, and child has decent, affordable health care coverage.

We all know that the current path of rationing health care based on a person's ability to pay is not acceptable, nor are the costs of our health care system sustainable. It is simply immoral to pour billions of dollars into the world's most sophisticated, high-technology health care system—but deny prenatal care to the 433,000 pregnant women who lack health insurance and to lag behind Singapore and 21 other industrialized countries in infant mortality.

Mr. President, I will not spend my time this afternoon outlining the problem, that's the easy part. The hard part is putting forth a solution and, unfortunately, there is not a magic solution or a quick fix to make the inequities in our system disappear overnight, or to slow down health costs. Even a single payer, Canada-style solution, which sounds simple and has a certain appeal, would require a massive shift and reallocation of resources. It took the Canadians 25 years to create their current health care system, and their per capita health costs are rising as rapidly as ours.

Last year, the Pepper Commission recommended a comprehensive strategy with a fair sharing of public and private responsibility. We came to this decision because we felt our mission was to recommend practical, common sense, and enactable answers for

health care reform. Because 85 percent of private insurance is provided by employers and because 75 percent of the ininsured are members of working families, we recommended building on our job-based system while at the same time providing special assistance to small employers—which accounts for 65 percent of the working uninsured.

The Affordable Health Care for all Americans Act takes that same job-based approach, including the structural reforms recommended by the Pepper Commission that are vital if participation is required in our health care system.

Foremost among these structural reforms is small group health insurance reform. While we leave insurance regulation and enforcement in the hands of the States, similar to legislation we passed last year for Medicare supplemental policies, we require that Federal minimum standards be met.

To make private health insurance more available, insurance companies would no longer be allowed to engage in cherry-picking the good risks and selecting out the unhealthy, or those deemed likely to incur high medical bills because of where they work or where they live. Insurance companies would be forced to go back to managing risk and to start managing care. We prohibit medical underwriting and huge premium hikes, or outright cancellation of policies, due to changes in an individual's health status.

We preempt over 700 State benefit mandates and replace them with a basic health benefit package. And, in a step designed to make private health insurance even more affordable for small businesses, we allow previously-uninsured small businesses to elect the use of Medicare reimbursement rules. This will give small businesses the market clout they have so far lacked in order to negotiate better deals with providers. We require insurers to offer managed care plans to small businesses if they offer these plans to large employers in the area, while at the same time we preempt State antimanaged care laws.

In addition to the reforms of the marketplace, we provide a permanent 25 percent tax credit toward the cost of health insurance for employers with less than 60 workers and whose salaries are less than $20,000. We increase the deductibility of health insurance from the current level of 25 to 100 percent for the self-employed. And, because of our recognition of the fragility of new businesses, we exempt new, small businesses from providing health insurance during a 2-year start-up period. The third year of operation, new small businesses would only be required to contribute one-half what would otherwise normally be required under the public program.

Employers have told us, overwhelmingly, they would like to provide health benefits to their workers but that cost and availability often are barriers. So, finally after a period of time, after putting all these reforms into effect and making special assistance available, we measure the success of these efforts. If the vast majority of working uninsured do not have coverage, small firms will be required to either provide basic health benefits directly or contribute toward public coverage for their employees. If most workers are uninsured, the Federal Government must find ways to guarantee coverage for the remaining citizens.

Mr. President, in addition to the special measures targeted toward small businesses, this bill contains a variety of mechanisms to slow down national health care expenditures.

Simply by providing universal access, we will end the cost shifting of uncompensated care that employers—as well as doctors and hospitals—detest. Through malpractice reforms and outcomes research, we will lessen America's addiction to defensive medicine and to unnecessary tests and surgeries. Through mandatory cost sharing by individuals, we will instill a sense of consumer responsibility and sensitivity to health care costs. Through managed care, health care will be delivered in settings that emphasize quality and appropriateness.

These were all the cost containing tools called for in the Pepper plan, and I am absolutely certain that they will help. But, for various reasons, they fall short of the test. The solution to the access problem requires bigger, and yes, more dramatic ways to contain cost.

Take individual cost sharing. Making consumers more price sensitive has only a limited effect on whether or not an individual initially seeks care. Once initiated, research shows that courses of treatment generally are the same—since those decisions have traditionally been left up to the doctor.

As for outcomes research and practice guidelines, I could not be a bigger believer in the importance of this work—and not just for cost reasons. But practice guidelines, once developed, will need to be disseminated and, more importantly, adopted by practicing doctors. And, just as we will find instances of inappropriate and unnecessary care through outcomes research, we will, no doubt, find instances of underuse of care. So we might need to spend more in certain cases.

Insurance reform is potentially a powerful tool. That's why I will fight proposals that allege reform, but are actually far too weak. We can save almost $14 billion over 5 years by eliminating medical underwriting and limiting preexisting condition exclusions through small group insurance reform.

This legislation includes several ways to promote managed care and make it more available. Here again, I am a believer. But managed care means many things to many people, and some models are more effective than others. Furthermore, according to CBO's Director, Bob Reischauer, research to date shows only one-time savings from managed care. Managed care has had little or no impact on growth of spending over time.

The chairman of the Finance Committee and a proven leader on health care issues, Senator BENTSEN, has held a series of hearings this past spring on health care reform. At one hearing, the president of Southern California Edison, Michael Peevey, testified in favor of a federally created "all-payor rate negotiation to ensure that every health care payor, no matter how small, can benefit from the low rates negotiated by the largest purchasers." Moreover, he called for a national health expenditure target and limits on capital expenditures.

This comes from the president of a company that has compiled a remarkable record in cost control. Edison saw no increase in its health care costs between 1988 and 1989 and their projected long-term trend rate is down to the 10 to 12 percent range. Even so, at their current rate of increase, their health care costs will double every 6 years.

Mr. Peevey was not alone in calling for dramatic action. Another example: The chairman and CEO of Bethlehem Steel, Walter Williams. Mr. Williams testified that in spite of increased employee cost sharing and extensive managed care programs, their costs rose 26 percent in 1990. His recommendation: Federal cost containment legislation to make sure public and private payors pay the same for health care and regional reimbursement schedules to insure that all payors—pay the same—for the same care. He, too, called for a national health spending target to keep annual increases in health care costs at acceptable levels.

Their calls and others for tougher cost containment have not fallen on deaf ears. If others are to gain access to our health care system, we must simultaneously get a handle on its costs.

Through the creation of an independent Federal Health Expenditure Board, voluntary goals for national, and State-specific, health care spending would be set and a process for national negotiations between providers and purchasers of health care on reimbursement levels would be established. State flexibility and innovation would be preserved through the establishment of State-level consortiums that could perform a variety of cost-saving activities, including further State-level negotiations on reimbursement levels and volume, reduction of administrative costs by streamlining the processing of claims, or capital allocation.

These recommendations stop short of setting mandatory caps on health spending or national payment rates to allow for any necessary adjustments during the transition to universal access. And once fully implemented,

we will have the necessary data and information on how well we have done the job of holding down health care costs, so we can adequately judge where we might need to do more work, or in other areas less.

Mr. President, all together the cost containment measures outlined in this bill have been estimated, by an independent consulting firm, to have the potential to reduce health spending in this country by almost $80 billion over 5 years. Over time these savings will grow.

My colleagues in the Senate and I have laid out in great detail a way to achieve universal access, while at the same time make a significant dent in the costs of our health care system. Just a week and a half ago I introduced a bill, S. 1177, that laid out in great detail the recommendations of the Pepper Commission for universal access. While different in some respects, the general approach is the same.

I have said all along that concessions and accommodations will have to come from all corners—from business, from the insurance industry, from health-care providers, and from the public—if we are to have any hope of real change. In other words, no one can demand their first choice and expect to see results. So, for example, although the Pepper bill, S. 1177, includes my preference for a federally run public program to replace Medicaid, I was willing to compromise with my colleagues in order to move the debate, and it is my fervent hope to move health reform legislation along. I know my Senate colleagues would join me in saying to our colleagues and to others that we are open to further debate and discussion to refine or to add or subtract. It is time to take a seat at the table.

The majority leader, Senator MITCHELL, has shown tremendous leadership in introducing this legislation today. I would welcome a similar display of leadership from the White House. I hope introduction of this bill spurs the administration to come up with its own plan for health care reform and not just ignite another round of stone throwing.

In cities, suburbs, and rural towns across America—health care is the pocketbook issue. Over 70 percent of the uninsured are not poor. They are families in which fathers and mothers have lost their jobs because of the recession. They are working people whose employers cannot afford today's insurance rates. They even include people with ample incomes, but who cannot buy insurance because of a health condition or past illness.

The Director of the Office of Management and Budget, Dick Darman, so recently testified before the Finance Committee that he has yet to come up with an intellectually satisfying solution to the problem of the 9 million uninsured children in this country. What about a morally satisfying solution? What about one that admits the cost of inaction is simply unacceptable and that failure to act threatens our future economic security?

ADDITIONAL COSPONSORS

S. 4

At the request of Mr. BENTSEN, the name of the Senator from Maryland [Mr. SARBANES] was added as a cosponsor of S. 4, a bill to amend titles IV, V and XIX of the Social Security Act to establish innovative child welfare and family support services in order to strengthen families and avoid placement in foster care, to promote the development of comprehensive substance abuse programs for pregnant women and caretaker relatives with children, to provide improved delivery of health care services to low-income children, and for other purposes.

S. 25

At the request of Mr. CRANSTON, the name of the Senator from California [Mr. SEYMOUR] was added as a cosponsor of S. 25, a bill to protect the reproductive rights of women, and for other purposes.

S. 190

At the request of Mr. GRAHAM, the names of the Senator from Utah [Mr. HATCH], the Senator from Massachusetts [Mr. KERRY], the Senator from North Dakota [Mr. BURDICK], and the Senator from Arkansas [Mr. BUMPERS], were added as cosponsors of S. 190, a bill to amend 3104 of title 38, United States Code, to permit veterans who have a service-connected disability and who are retired members of the Armed Forces to receive compensation, without reduction, concurrently with retired pay reduced on the basis of the degree of the disability rating of such veteran.

S. 200

At the request of Mr. PRYOR, the name of the Senator from Idaho [Mr. CRAIG] was added as a cosponsor of S. 200, a bill to amend the Internal Revenue Code of 1986 to exclude small transactions from broker reporting requirements, and to make certain clarifications relating to such requirements.

S. 239

At the request of Mr. SARBANES, the names of the Senator from Missouri [Mr. DANFORTH], the Senator from Alabama [Mr. SHELBY], and the Senator from Arizona [Mr. MCCAIN] were added as cosponsors of SF 239, a bill to authorize the Alpha Phi Alpha Fraternity to establish a memorial to Martin Luther King, Jr., in the District of Columbia.

S. 267

At the request of Mr. REID, the name of the Senator from Montana [Mr. BURNS] was added as a cosponsor of S. 267, a bill to prohibit a State from imposing an income tax on the pension or retirement income of individuals who are not residents or domicilaries of that State.

S. 280

At the request of Mr. SASSER, the names of the Senator from Nebraska [Mr. KERREY], the Senator from Wisconsin [Mr. KOHL], and the Senator from Georgia [Mr. NUNN] were added as cosponsors of S. 280, a bill to provide for the inclusion of foreign deposits in the deposit insurance assessment base, to permit inclusion of non-deposit liabilities in the deposit insurance assessment base, to require the FDIC to implement a risk-based deposit insurance premium structure, to establish guidelines for early regulatory intervention in the financial decline of banks, and to permit regulatory restrictions on brokered deposits.

S. 323

At the request of Mr. CHAFEE, the name of the Senator from Connecticut [Mr. LIEBERMAN] was added as a cosponsor of S. 323, a bill to require the Secretary of Health and Human Services to ensure that pregnant women receiving assistance under title X of the Public Health Service Act are provided with information and counseling regarding their pregnancies, and for other purposes.

S. 416

At the request of Mr. DANFORTH, the name of the Senator from Utah [Mr. HATCH] was added as a cosponsor of S. 416, a bill to amend the Internal Revenue Code of 1986 to make permanent the tax credit for increasing research activities.

S. 489

At the request of Mr. HATCH, the names of the Senator from Mississippi [Mr. COCHRAN] and the Senator from New Hampshire [Mr. RUDMAN] were added as cosponsors of S. 489, a bill to provide grants to States to encourage States to improve their systems for compensating individuals injured in the course of the provision of health care services, to establish uniform criteria for awarding damages in health care malpractice actions, and for other purposes.

S. 574

At the request of Mr. CRANSTON, the names of the Senator from Maryland [Ms. MIKULSKI] and the Senator from Ohio [Mr. METZENBAUM] were added as cosponsors of S. 574, a bill to amend the Civil Rights Act of 1964 to prohibit discrimination on the basis of affectional or sexual orientation, and for other purposes.

S. 597

At the request of Mr. DODD, the name of the Senator from North Dakota [Mr. CONRAD] was added as a cosponsor of S. 597, a bill to amend the Public Health Service Act to establish and expand grant programs for evaluation and treatment of parents who are abusers and children of substance abusers, and for other purposes.

force more quickly, more effectively, and into a wider range of jobs, with the help of these technology networks.

Finally, a word about what this bill is not. It is not a telco bill. It is not a cable bill. Rather, it is a bill to bring the information age to all Americans who wish to participate.

I applaud the foresight and leadership of Senator BURNS on this legislation and urge the Senate to match Senator BURNS' effort in working toward its passage.

The PRESIDING OFFICER (Mr. FORD). The Senator from Wisconsin is recognized.

DEMOCRATIC HEALTH REFORM PACKAGE

Mr. KOHL. Mr. President, this morning I would like to briefly commend my colleagues, who have worked so hard in crafting the comprehensive health care reform bill to be introduced today.

We need not repeat the numbers of underserved. We know them. We need not repeat statistics on the benefits of prevention—we are paying dearly for those past failures. We need not repeat health cost inflation figures. Nor the tragic stories about citizens young and old who have been denied access to quality care. Each of us has heard those numbers and those stories in hundreds of ways.

The problem is real. Our health care system is in crisis. And we have a responsibility to lead the Nation out of that crisis.

Our colleagues from West Virginia, Massachusetts, Maine, and Michigan—among others—have met the challenge in offering this blueprint for national health care reform. It is a commendable and meritorious plan. It offers hope and answers to questions of universal access, quality, and cost.

I believe we are faced with a real opportunity here and I hope we do not let it pass. We have had similar chances in the past—in the late 1960's and early 1970's when President Nixon offered the Nation a plan for employment based health care; in the late 1970's when President Carter, through Secretary Califano, offered a comprehensive employment based plan that also included Medicaid reforms. For various reasons, we let those opportunities pass us by. It has cost us dearly.

I believe it will be easy for each of us to sit back and critique this package. Surely each of us—and each of our constituencies—can find fault with one aspect or another. I hope we resist that easy path for it will take us nowhere once again. Those who have not been close to the drafting of this legislation have an obligation to study it carefully. We need to go back to our States and talk to our people about it. But, we have a responsibility to study and consider it from a positive perspective. And that is what I intend to do.

I thank our colleagues and their staffs who have worked so hard for so many months and years to bring us to this new threshold.

Mr. President, I suggest the absence of a quorum.

The PRESIDING OFFICER. The clerk will call the roll.

The assistant legislative clerk proceeded to call the roll.

Mr. HOLLINGS. Mr. President, I ask unanimous consent that the order for the quorum call be rescinded.

The PRESIDING OFFICER (Mr. ROBB). Without objection, it is so ordered.

REVISED CONGRESSIONAL BUDGET OFFICE COST ESTIMATE OF S. 210, THE COMPREHENSIVE URANIUM ACT OF 1991

Mr. JOHNSTON. Mr. President, on May 23, 1991, I submitted on behalf of the Committee on Energy and Natural Resources Senate Report 102-63, to accompany S. 210, the Comprehensive Uranium Act of 1991. Included in the report was a May 10, 1991, letter from the Congressional Budget Office that estimated the cost of the bill.

In its May 10 letter, CBO concluded that certain provisions of the bill as originally approved by the Committee would have resulted in direct spending during fiscal years 1992 through 1996.

As explained in Senate Report 102-63, the Committee on Energy and Natural Resources amended S. 210 on May 22, 1991, to remove the direct spending identified by CBO from the bill.

Accordingly, CBO revised its cost estimate. In a May 31, 1991, letter, CBO stated that S. 210 as amended and reported "would not affect direct spending over the next 5 years, and would not be subject to pay-as-you-go procedures under section 252 of the Balanced Budget and Emergency Deficit Control Act of 1985."

I ask unanimous consent that CBO's revised cost estimate for S. 210 be printed in the RECORD in its entirety.

There being no objection, the estimate was ordered to be printed in the RECORD, as follows:

U.S. CONGRESS,
CONGRESSIONAL BUDGET OFFICE,
Washington, DC, May 31, 1991.

Hon. J. BENNETT JOHNSTON,
Chairman, Committee on Energy and Natural Resources, U.S. Senate, Washington, DC.

DEAR MR. CHAIRMAN: The Congressional Budget Office has prepared the attached cost estimate for S. 210, the Comprehensive Uranium Act of 1991, as amended by the Senate Committee on Energy and Natural Resources on May 22, 1991. This bill, as amended, would not affect direct spending over the next five years, and would not be subject to pay-as-you-go procedures under section 252 of the Balanced Budget and Emergency Deficit Control Act of 1985.

If you wish further details on this estimate, we will be pleased to provide them.

Sincerely,

ROBERT D. REISCHAUER.

COST ESTIMATE

MAY 31, 1991.

1. Bill number: S. 210.

2. Bill title: Comprehensive Uranium Act of 1991.

3. Bill status: As amended by the Senate Committee on Energy and Natural Resources, May 22, 1991.

4. Bill purpose: S. 210 would reorganize the government's uranium enrichment enterprise and assist the domestic uranium industry.

Title I would establish a wholly owned government corporation to replace the existing Department of Energy (DOE) program for providing uranium enrichment services to commercial nuclear powerplants and to government defense and research programs. Key features of the proposed corporation are summarized below. This bill would:

Set the corporation's initial debt at $364 million, payable with interest to the Treasury over a period of 20 years. Payment of the $364 million debt would constitute all of the recovery of past costs associated with the uranium enrichment program. By contrast, the General Accounting Office (GAO) estimates that unrecovered federal costs for uranium enrichment now total about $11 billion.

Provide the uranium enrichment corporation with up to $2.5 billion in borrowing authority, but would not allow the corporation to borrow from the Treasury's Federal Financing Bank. The corporation would fund its spending through a combination of its revenues and borrowing from the public. Under current law, the Congress provides an annual appropriation to fund the DOE program.

Provide that the proposed corporation be managed by an Administrator and a corporate board, both appointed by the President. The Secretary of Energy would have general supervision over the Administrator for health, safety, environment, and national security concerns.

Transfer current DOE production facilities for uranium enrichment to the corporation. The corporation would then issue capital stock to the Treasury to represent the book value of assets transferred.

Require the corporation to set prices to (1) recover its initial debt; (2) pay for its costs of service; (3) recover costs of decontamination and decommissioning; and (4) provide a "normal business" profit—to be paid in dividends to the Treasury.

Exempt the corporation from sequestration under the Balanced Budget Act (Gramm-Rudman-Hollings). With the exception of initial set-up costs, the corporation's spending would not be subject to annual appropriations.

Title I also would establish a fund for the decontamination and decommissioning (D&D) of the government's uranium enrichment facilities.

Title II contains provisions that would assist and attempt to revitalize the domestic uranium industry by:

Establishing a program that could lead to increased purchases of domestic uranium by nuclear utilities;

Establishing a national strategic uranium reserve (consisting of uranium stocks currently held by the the U.S. government);

Directing the Secretary of Energy to encourage the use and export of domestic uranium;

Requiring the federal government to purchase only domestic uranium for defense needs; and

Establishing a program for partial reimbursement, by the federal government, of remedial action at active uranium and thori-

ates (including affiliates described in paragraphs (6) and (7) of subsection (c)) necessary to verify transactions conducted with such Bell Telephone Company that are relevant to the specific activities permitted under this section and that are necessary to the State's regulation of telephone rates. Each State commission shall implement appropriate procedures to ensure the protection of any proprietary information submitted to it under this section.

"(l) As used in this section:

"(1) The term 'affiliate' means any organization or entity that, directly or indirectly, owns or controls, is owned or controlled by, or is under common ownership with a Bell Telephone Company. Such term includes any organization or entity (A) in which a Bell Telephone Company and any of its affiliates have an equity interest of greater than 10 percent, or a management interest of greater than 10 percent, or (B) in which a Bell Telephone Company and any of its affiliates have any other significant financial interest.

"(2) The term 'Bell Telephone Company' means those companies listed in appendix A of the Modification of Final Judgment, and includes any successor or assign of any such company, but does not include any affiliate of any such company.

"(3) The term 'customer premises equipment' means equipment employed on the premises of a person (other than a carrier) to originate, route, or terminate telecommunications.

"(4) The term 'manufacturing' has the same meaning as such term has in the Modification of Final Judgment as interpreted in United States v. Western Electric, Civil Action No. 82-0192 (United States District Court, District of Columbia) (filed December 3, 1987).

"(5) The term 'Modification of Final Judgment' means the decree entered August 24, 1982, in United States v. Western Electric, Civil Action No. 82-0192 (United States District Court, District of Columbia).

"(6) The term 'telecommunications' means the transmission, between or among points specified by the user, of information of the user's choosing, without change in the form or content of the information as sent and received, by means of an electromagnetic transmission medium, including all instrumentalities, facilities, apparatus, and services (including the collection, storage, forwarding, switching, and delivery of such information) essential to such transmission.

"(7) The term 'telecommunications equipment' means equipment, other than customer premises equipment, used by a carrier to provide telecommunications services.

"(8) The term 'telecommunications service' means the offering for hire of telecommunications facilities, or of telecommunications by means of such facilities.".

SEC. 4. ADDITIONAL AMENDMENT TO THE COMMUNICATIONS ACT OF 1934.

Section 220(d) of the Communications Act of 1934 (47 U.S.C. 220(d)) is amended by deleting "$6,000" and inserting in lieu thereof "$10,000".

SEC. 5. APPLICATION OF ANTITRUST LAWS.

Nothing in this Act shall be deemed to alter the application of Federal and State antitrust laws as interpreted by the respective courts

TITLE—I—GENERAL PROVISIONS

SEC. 101. SENSE OF THE SENATE REGARDING THE NATIONAL VICTORY PARADE FOR THE PERSIAN GULF WAR.

It is the sense of the Senate that any country—

(1) for which United States assistance is being withheld from obligation and expenditure pursuant to section 481(h)(5) of the Foreign Assistance Act of 1961; or

(2) which is listed by the Secretary of State under section 40(d) of the Arms Export Control Act or section 6(j) of the Export Administration Act of 1979 as a country the government of which has repeatedly provided support for acts of international terrorism,

should not be represented, either by diplomatic, military, or political officials, or by national images or symbols, at the victory parade scheduled to be held in Washington, District of Columbia on June 8, 1991, to celebrate the liberation of Kuwait and the victory of the United Nations coalition forces over Iraq.

Mr. HOLLINGS. I move to reconsider the vote.

Mr. DANFORTH. I move to lay that motion on the table.

The motion to lay on the table was agreed to.

Mr. HOLLINGS. Mr. President, I take this opportunity to thank our distinguished staff. I can tell you they have worked around the clock and done yeomen's work, John Windhousen, Toni Cook, Linda Morgan, Jim Drewry, Loretta Dunn, and Kevin Curtin, the whole Commerce Committee staff over there, plus my own staff.

I want to thank our distinguished counterpart and former chairman, the distinguished Senator from Missouri [Mr. DANFORTH], Walter McCormick, of his staff, and others. We have had a bipartisan effort, as is obvious from the vote.

Mr. DANFORTH. Mr. President, I simply want to express my appreciation for the work of our chairman, Senator HOLLINGS. This has been a remarkable accomplishment. Many people have said for a number of years that we have to do something about the present state of affairs in our telephone industry where a Federal judge basically makes the decisions. We have now moved in the direction of Congress taking over the decisionmaking, which is exactly what should be the case.

This is a major accomplishment. I think that we are going to have some difficulties with the administration, and, hopefully, there can be some room for give with respect to the domestic-content provision.

I supported my chairman in this connection. I intend to continue to work with him as the bill progresses, and my hope is that we can end up with something that the President would be willing to sign.

MORNING BUSINESS

Mr. HOLLINGS. Mr. President, on behalf of the leadership, I ask unanimous consent there be a period for morning business with Senators permitted to speak therein.

The PRESIDING OFFICER. Without objection, it is so ordered.

ACCESS TO HEALTH CARE FOR ALL AMERICANS

Mr. KENNEDY. Mr. President, on a matter which was addressed earlier today by the majority leader and a group of Senators in advancing the cause of access to health care and effective cost containment, I noticed during the afternoon that there were negative comments from some of our colleagues about what I consider to be an excellent proposal that has now been introduced.

The majority leader indicated that it represented the joint effort of a number of Senators, building on the work that has been done by Members on both sides of the aisle, and he indicated during the course of his press conference that he was eager to work with all of those in this body and outside this body who are concerned, as he is, with the increasing costs in our health care systems.

We are facing a health care crisis. Health care is the fastest growing failing business in America. In 1970, the United States was spending $65 billion on health care. Now we are spending $650 billion a year. The best estimate is it will be $1 trillion 500 billion by the year 2000.

The time has come, Mr. President, for action. This public policy issue has been studied to death. Real people are hurting. The 10 million children in our society who have no coverage are hurting. Millions of workers without coverage are hurting. They work hard every day, 40 hours a week, 52 weeks of the year, and have no health insurance coverage. They're playing Russian roulette with their health. They are hurting. Sixty million more Americans have health insurance that even the Reagan administration said was inadequate. Approximately 100 million of our fellow citizens in this country of 250 million have inadequate coverage or no coverage at all.

Employers are paying too much today because they are also paying the bills for those who have no coverage. They're paying in the form of higher premiums, because other firms refuse to provide coverage. Workers in plants and factories all over this country are effectively paying the bill for charity care for other workers who are not covered.

We face increasing problems in dealing with AIDS and substance abuse, not just in urban areas, but in rural areas, as well. Our whole health care system is in a state of crisis. We do not have time to keep studying the issue and keep refusing to deal with it.

Senior citizens were hurting in the Depression, and with Franklin Roosevelt's leadership, we adopted Social Security. We did not wait for the various States to try to deal with that problem. In the 1960's, when we adopted Medicare, we were not saying: Let us wait to see what the States do. We had national leadership to deal with the

problem. We need the same sort of leadership now.

Mr. President, I again want to say [illegible]w important today has been for this [illegible]itution. The majority leader took [illegible] responsibility and advanced the debate on health care. I commend his assurance that he will make every effort to see that we are able to debate this issue and achieve the action we need.

I hope this time when we debate it, and when some Senators find reason to oppose it, they will have the decency not to use the Capitol health facilities or go out to Walter Reed Army Hospital or Bethesda Naval Hospital. I hope they will not be so hypocritical as to say "no" to the American people, and then continue to use these Federal facilities we make available for ourselves.

It is the height of hypocrisy. If they are not going to vote for decent health care for the American people, they should not take advantage of it themselves. I think the American people will be watching, and watching very closely, what we are doing, and what we are failing to do.

Those who have worked so hard to advance the debate and discussion should be commended, and I welcome, the constructive attitude suggested by a number of our colleagues about the desire to work together. If this movement had not taken place now on this issue, another Congress could have [illegible]e past without the opportunity for [illegible]fledged debate and action.

[illegible]know the majority leader is interested in working with our colleagues on this side of the aisle and the other side of the aisle. Many of us have been very much involved in the discussion of health policy over a long period of time. The time is fast moving by, and the time for action is now. I am very hopeful that in this Congress we will be able to take the kind of action necessary to deal with this issue. It is of enormous importance to the American people.

CIVIL RIGHTS

Mr. KENNEDY. Mr. President, the House of Representatives today passed the civil rights bill with the same broad, bipartisan majority as last year. I commend the House for its action, but I deplore the bitterness and the charges and counter-charges that have tarnished the debate and obscured the real issues on this essential measure.

There is still time to find common ground on the two critical issues that have divided us for the past year. Both sides agree that women and religious minorities do not have adequate remedies for intentional job discrimination.

Both sides agree that the Supreme [illegible]urt's decision in the Wards Cove [illegible] should be overruled. The distance [illegible]ween us is actually much less than [illegible]e overheated rhetoric of this debate would suggest.

For months, the debate has focused on one word—"quotas." I oppose quotas, and so does everyone else who favors this bill. Quotas are illegal today, and they will remain illegal after a civil rights bill is enacted.

For many years, the cause of equal justice for all has enjoyed broad bipartisan support in Congress and in this country. The landmark Civil Rights Act of 1964 would never have been enacted without the leadership of Everett Dirksen and Hubert Humphrey.

The landmark Americans with Disabilities Act would not have been enacted in 1990 without the leadership of Lowell Weicker, DAVID DURENBERGER, and TOM HARKIN.

Over the past year, I have enjoyed working closely with Senator JEFFORDS of Vermont to achieve a fair civil rights bill.

I particularly commend Senator DANFORTH for his efforts this year. Recently, Senator DANFORTH advanced the debate and discussion with his series of recommendations.

His proposals are constructive, and many of their features deserve serious consideration. Other provisions, however, fall short of providing the full protection against job discrimination that all working Americans deserve.

I look forward to working with him and with many other Senators in the days ahead to agree on a civil rights bill that everyone in this body can support and that the President can sign. There is still time to reach a civil rights compromise that will bring us together, not drive us apart.

TERRY ANDERSON

Mr. MOYNIHAN. Mr. President, I rise to inform my colleagues that today marks the 2,272d day that Terry Anderson has been held captive in Lebanon.

RHODE ISLAND GENERAL ASSEMBLY PASSES LEGISLATION ON LIBERIA

Mr. PELL. Mr. President, the civil war in Liberia has been devastating. All of us have been deeply moved by the reports of violence, death, and destruction resulting from the conflict. As a cosponsor of the Liberian Relief, Rehabilitation, and Reconstruction Act of 1991, introduced by Senator KENNEDY earlier this year, I believe that the United States has a responsibility to help Liberia rebuild as it moves toward reconciliation.

One outgrowth of the strife in Liberia is especially troubling: The status of Liberians residing in the United States. Countless Liberians, many of whom reside in my home State of Rhode Island, have been displaced because of the fighting. This aspect of the Liberian crisis has been effectively characterized in a resolution passed by the Rhode Island General Assembly last month. The resolution, introduced by State representatives Newsome, Lamb, Dumas, Barone, and Rickman, notes the grave situation in Liberia and calls for increased cooperation between the Federal and State governments to alleviate the Liberian national crisis. I believe the resolution makes an extremely important contribution to United States policy on Liberia. I commend the Rhode Island legislators for their efforts, and I support them fully.

Mr. President, I ask unanimous consent that the full text of the resolution be printed in the RECORD at this point.

There being no objection, the assembly resolution was ordered to be printed in the RECORD, as follows:

HOUSE RESOLUTION—STATE OF RHODE ISLAND

Whereas it is acknowledged that a civil war of horrific proportions is now being waged in the West African nation of Liberia; and

Whereas that conflict has caused widespread misery, death and destruction, where approximately half the 2.5 million Liberian population has been displaced inside the country, and another 760,000 have sought refuge in the neighboring countries of Ivory Coast, Sierra Leone, Guinea, Ghana, Mali and Nigeria; and

Whereas over 7,000 Liberian nationals have found temporary refuge in Rhode Island—where more Liberians reside than in any other state—in part because there exists an excellent support network of extended families and friends; and

Whereas Liberia was settled in 1822 by freed American slaves and many of its major cities are named after past United States presidents (the capital city is Monrovia); and

Whereas it is the policy of the State of Rhode Island to acknowledge our historical ties to Liberia and to welcome those Liberian nationals who are seeking refuge here until a lasting peace is restored; now, therefore, be it

Resolved, That this House of Representatives of the State of Rhode Island and Providence Plantations hereby declares it to be the policy of the State of Rhode Island to cooperate fully with our federal government in relocating displaced Liberians to this state, and to assist in every way possible with the reunification of families; and be it further

Resolved, That we call upon the United States Congress to review its immigration laws with a view toward expressing maximum sympathy and humanitarian support for Liberians who have been temporarily displaced by the civil war; and be it further

Resolved, That this House of Representatives and people of Rhode Island welcome additional Liberians who are seeking entry to the United States as tourists, students and/or refugees an call upon the Congress to clarify its immigration laws to allow for the increased entry of those Liberians deemed most vulnerable—namely, Liberian women under 40 with minor children, seniors over 55, and those seeking official political asylum; and be it further

Resolved, That we call upon Rhode Island educational institutions to cooperate by enrolling a limited number of Liberian students on "good faith" for the academic year 1991-92 in situations where transcripts are not available but where there is demonstrated interests and capability in continuing their formal studies in the United States; and be it further

emphasize to all Senators that his is one of the more meaningful statements in this entire debate, and his comments are right on the mark.

It is not surprising since the distinguished Senator, as has been noted, chaired the Governors Conference on the Telecommunications Task Force. He has kept up and led the way in the U.S. Senate.

We appreciate very much his support, and we value very much his suggestions. I too am concerned about what we see on television and ensuring that the communications industry is competitive.

We thank the Senator for his comments and his support.

The PRESIDING OFFICER. The Senator from Utah, Mr. HATCH.

Mr. HATCH. Mr. President, I ask unanimous consent that my remarks be considered as in morning business.

The PRESIDING OFFICER. Without objection, it so ordered.

HEALTH CARE

Mr. HATCH. Mr. President, I have been interested that the majority leader is talking in terms of a Democrat health care plan for America. And from what I understand about the plan, I would like to just say a few words about it because I think it is very important that this debate begin.

I believe that health care is one of the two or three top issues in the minds of everybody in our country today. There is no question we are in trouble. Health care costs are rising at an annual 12.5 percent of the gross national product rate. That is too fast and too much. Compared to any other country in the world, we spend more per capita than any country in the world. Something has to be done. I do not think this administration or anybody else can stand back and say we want to do it in a leisurely pace. Health care costs are going to 18 percent unless we find some way of containing the escalation of those costs.

Having said all that and having also indicated that I am pleased that the majority leader and my fellow colleagues on the other side are willing to do something in this area, I am pleased that they will file a bill that will begin the debate and will begin discussion and will cause people to sit down and consider these very delicate and important, complex matters.

Having said all that, I would like to say a few things about the bill itself that I have been led to believe is to be filed by my friends on the other side.

One thing that I have great difficulty with is employer mandates. As I understand it, the Democrats' bill would have an employer mandate because if an employer did not provide health insurance that employer would have to pay an 8 percent payroll tax into a public program.

The thing that bothers me about that is there is too much of that attitude in this body. The typical Democratic Party solution is the always-make-somebody-else-pay-for-it or always-make-someone-else-do-it approach. Spend somebody else's money. This will cost at least $30 billion. And whose money? It has to be the American workers. You can say we will just have American business pay for it. Ultimately that is taken out of the hide of the workers of America.

Our employer-based health insurance system is a historical accident that is in part responsible for our current health care mess. As health care costs have increased, many employers have found they cannot offer health care benefits and stay in business. Most employers offer health insurance, if they can afford it.

Mandates on employers limit both employers' and employees' flexibility, damper their creativity, and, in the case of health insurance, may threaten their very survival. It is particularly disconcerting that the pay-or-play mandate will fall hardest on employers who offer entry-level jobs—the very jobs that we need in this country to enhance family and societal stability in high-risk situations. Often those entry-level jobs are part-time or a second job or spousal employment. These kinds of employees often choose not to be covered by health insurance. The Democrat approach, or pay-or-play, will provide them something that they may not need or may not want, in fact probably will not want, and perhaps at the expense of having no job at all.

It is clear that many of these employers are on a thin margin. An 8-percent increase in their taxes—essentially applied to their gross receipts, since their expenses are heavily payroll and they have no profit—could drive them out of business. As small employers fail, so does most of our job creation capacity. Everybody knows that the largest part of small business' expense happens to be with payroll. If you have a tax of 8 percent of payroll, you are disproportionately hitting small business where it hurts.

In reality, this pay-or-play approach is a mandate on the backs of American workers. What they get is a loss of jobs, loss of flexibility, and loss of wages. Before we mandate new expenses on the backs of American workers, we better get health care costs under control.

I would like to spend a minute or two on the national expenditure targets. The Mitchell plan sets "voluntary spending targets" for health care spending. If spending exceeds a specified amount, certain rate regulations are likely to go into place. This is rate regulation pure and simple. It is also a gutless Federal Government approach to rationing from the worst possible position—centrally, "on high."

Hospital costs in rate-regulated States have increased faster than the national average and much faster than in nonregulated States. Medicare physician expenditure targets, the RBRVS, have led to increased costs because of volume phenomena. All this has led to more proposed regulation.

Rate regulation ignores the only proven way to control costs, and that is the market. Rate regulation tends to freeze inequities as they currently exist, and there are plenty of them. Current inequities include no access to health care for over 30 million of our citizens, while many of them overconsume, driving up costs. Who is to say how much we should spend on health care? That should depend on individual freedom of choice as long as market incentives are not distorted. Expenditure targets would ration care from on-high while leaving horrible distortion in our centrally planned health care system if that is what we opt to go for under this particular plan.

Why cannot my colleagues who are sponsoring this bill learn a lesson from Eastern Europe and the Soviet Union? Regulation does not work. Unencumbering the market does work. And the approach of those who are filing this bill is once again more encumbrances. I wonder if my democratic colleagues have ever wondered why no innovations in health care have emerged from socialist countries.

I have problems with mandated benefit packages. The Mitchell plan would either define a set benefit plan or have a Federal board do it. Thus my colleagues who are sponsors of this bill seem to accept that over 700 State mandated benefits have contributed to our current problems. But they again insist on mandating highly specific benefit packages, which will be very costly for employers and employees. They will have to pay for this while giving little or no flexibility to employees. What is the difference between State and Federal mandates?

Mandated benefits increase cost, decrease insurer flexibility to custom tailor insurance packages, and remove individual freedom of choice. As a nation of individuals, we thrive on our diversity. One-size-fits-all solutions are inappropriate for us; most important, they will not improve our collective health, but they will increase our costs.

Let us let the market define benefit packages which individuals, exercising free choice, can choose among. Let us given them the choice. Let us not have government bureaucrats or ourselves define those packages. The market will work to provide appropriate benefits at a minimum cost if we let it. I do not know one American who cannot tell me what he or she needs when it comes to health care.

Now, this pay-or-play system bothers me a great deal. As usual, those who support this type of approach cannot pay for the program, except on the backs of employers and American workers. They will not constrain the overconsumption which results from

overinsurance. They will not make individuals responsible for their own health care choices. They prefer to build inefficient bureaucratic regulatory mechanisms which always, in every case, increase costs.

They contend that a single payor claims system will save money. They tried that as a public program in Massachusetts. Administrative costs were 30 percent. They created the mess in Massachusetts. Why cannot they learn from it?

Let me just say this. I have said some fairly crusty things about the Mitchell plan, or the plan of our friends on the other side of the aisle. But I also want to say that they have done the country a service in filing something because there are some good things in their plan. Based upon what I know about the Democrat plan I would say this: The Democrats have adopted several of the ideas that Senator KENNEDY and I have been working on for years. We have been talking about them for years. We put them in various bills, and so forth. They now seem to admit that the liability crisis exists in settings other than the community health centers. We can work together on medical liability reform, and I commend my colleagues and particularly Senators MITCHELL and KENNEDY, and others on the other side, who have acknowledged this and who agree that this is something that just has to happen. It has to happen.

We agree that new initiatives in statewide quality assurance activities are essential. I think that is a good point in their program.

We can work together to establish and publish standardized cost and quality data for each provider on a State-by-State basis.

We agree that State-mandated benefit laws and restrictions on managed care must be preempted.

We can come to an agreement on the reform of the small group health insurance market.

We can work together, as we have in the past, to develop practice standards based on excellent medical outcomes research.

We will continue to work toward expansion of Medicaid, including increased eligibility and improved reimbursement schedules.

We can jointly develop increased emphasis on preventive health approaches. I think all of those are important.

The fundamental disorder in our current health care system is high costs, which are getting higher every minute. Inflation in health care has been 2 to 3 times the basic inflation rate almost four times, as a matter of fact, last year. And, in some sectors of the industry, health insurance premiums, for instance, costs have increased 20 percent over the last year.

Increased costs have many derivatives. Access to the system is limited. Wise preventive approaches are squeezed out. Health manpower is distorted in terms of specialties chosen and geographic distribution of practice location. Care is often delayed until a time when outcome has worsened and costs are higher. Underfunded public programs increase their cost-shifting to other payers, further driving up costs.

We cannot increase access until we control costs.

The most important mechanism for controlling costs is to make individuals more responsible for their own health care, including their health care spending. All sectors of the health industry—employers, insurers, providers, professionals—must take responsibility for restraining costs. And, the government must make sure that there are proper incentives for cost constraint by all of these sectors, and do its part in funding safety-net programs.

My proposal would:

No. 1, require publication of quality measures and costs of health care by specific unit of service, for all providers and professionals in each State. A prudent consumer cannot make informed shopping decisions if they do not have information about quality and cost. I reject a utility or rate regulation model, because they do not work.

No. 2, provide grants to and expand programs in medical outcome research in order to catalyze development of medical practice guidelines. Practice patterns vary substantially often even within a small geographic area. Practice patterns are often professional whims, not proven effective mechanisms. With research data driven practice standards, remibursement would be limited to only appropriate care and not to individual whim.

No. 3, cap the existing deductibility of employer provided health insurance costs at probably around $3,000, which would generate $21 billion in savings to the taxpayers and $3,600 would generate $16 billion. Overconsumption of unneeded care is encouraged by the perception that health care is prepared and free. Capping the deduction would make individuals more aware of and responsible for their own health care costs.

No. 4, we would pass a very similar medical liability reform bill, but it would have more teeth than what the approach is going to be in the Mitchell proposal.

No. 5, preemption of State-mandated benefits laws and of State restrictions on managed care. States would define a basic health insurance premium amount within which insurers could compete by defining various benefit packages.

Let the insurers do it and let the people buy what they need. Do not have mandated State mandates that literally no State legislator can fight against.

The State-defined amount would limit State tax deductibility; regardless of a State's defined amount, Federal deductibility would be limited.

No. 6, encourage development of consolidated claims management and claims payment mechanisms on a State or regional basis. Current administrative costs of our pluralistic system may approximate 30 percent of all health insurance costs. This could be substantially reduced by consolidation, saving perhaps as much as $60 billion per year. Consolidation does not mean rate regulation or an all payers system.

No. 7, small group health insurance market reform is essential. Make health insurance a guaranteed issue for all employees and employers, regardless of size, and moderate the currently outrageous costs for small employers.

No. 8, develop new provider and professional cost containment and quality assurance mechanisms within States through grants to States.

No. 9, increased emphasis on prevention. Individual responsibility plus employer incentives to offer work place health education and maintenance activities, I think, is essential.

The above cost containment-restraint-rollback mechanisms should be allowed to work for 10 years. If universal access has not been achieved after all the reforms the industry has requested have been in effect for 10 years, a penalty will be assessed on all sectors of the industry to provide funding for a public program for the uninsured.

The Federal Government must also do its part. Everyone must share the pain. The Federal programs must stop passing their costs onto the States with Medicaid, onto providers through inadequate reimbursement levels, and onto the private sector through cost shifting. We will federalize Medicaid and refocus it on poor women and children by decanting reponsibility for the elderly to Medicare and for the disabled to a new Federal program. The new Medicaid Program will increase to at least 115 percent of poverty, and improve reimbursement rates to Medicare levels.

The costs of federalized Medicaid can be met through the $20 billion savings from the tax cap on employer deductibility and through the savings from medical liability reform.

The States must also do their part. Each State will be required to design and fund a catastrophic insurance program, individualized for the uniqueness of each State. Having responsibility for catastrophic coverage fall to the States will keep resource allocation decisions, that is, rationing, properly decentralized. It will also require regional cost-demographic distortions be dealt with at the local level and not cost shifted to a national level. Utah should not have to help Massachusetts pay for its excesses, nor should Massachusetts have to help Utah pay for its excesses, although I do not think there are many excesses in the State of Utah.

Mr. President, these are just broad outlines but, nevertheless, outlines that we have been working on for years and outlines that I think would help to bring us to an affordable national health system that would really work.

I have the same problems with the mandates and the other things that I have discussed regarding the Mitchell plan, but again I want to commend the majority leader for having the guts to file a plan and to get this particular issue started and to bring it into the public debate and to see what we can do, hopefully, ultimately to have a bipartisan approach to this subject.

I also want to pay particular tribute to my friend, JOHN CHAFEE, on our side, who has worked long and hard to try and come up with various approaches that will work from a bipartisan national health approach. I hope that before it is all said and done we will be able to do that.

Mr. President, I yield the floor.

(Mr. WELLSTONE assumed the chair.)

Mr. HOLLINGS. Mr. President, it is my understanding that my distinguished colleague from Rhode Island would like to address the Senate respecting health care and we will yield, as if in morning business, for 10 minutes.

My problem, Mr. President, is I do not want word to go out that we are going into other matters. We went into China lectures yesterday, the civil rights lectures, the health care lectures. Now we have said we should not have a flag by the Bell Operating Cos. of Syria or, at least, the Bell Operating Cos. should not operate in Syria.

The truth of the matter is that we have completed all amendments. I heard there was a head count going on preparatory to an amendment. I heard that at 12 noon and it has taken 3 hours to get that head count and we still do not have our amendment. The best way to get a head count is to present the amendment, if they will present the amendment. Otherwise, we are going to be moving toward third reading. We are not going to sit here all afternoon listening to lectures on matters unrelated to this bill.

The Senate has terribly important business. I know the Senator from Rhode Island has some important comments to make, but the Senator from Pennsylvania has been waiting to debate on the bill.

Mr. CHAFEE. Mr. President, first of all I want to thank the distinguished manager of the bill for giving me this time.

Before I start, I thank the distinguished Senator from Utah, who made some very cogent comments on the Democratic proposals, for some suggestions that he has, and that, also, I have. We have been working together on this.

Also, I thank the distinguished junior Senator from Pennsylvania for allowing me to interrupt him at this time.

THE DEMOCRATIC PROPOSAL ON HEALTH-CARE REFORM

Mr. CHAFEE. Mr. President, today a group of Democratic Senators is introducing a bill to expand access to health insurance to all Americans. I applaud their efforts in this area, and believe some of their proposals represent a strong step forward. However, I also have concerns about the direction they have taken, and would like to address some of the details of the proposal.

Before I do that, I would like to express some general thoughts. I strongly believe that we must significantly improve our health care system in the United States. Our costs are spiraling out of control, our health status—especially among children—is not improving, and too many Americans are without access to affordable and appropriate health care. As a veteran in this area, however, I know that it is much easier to make that statement than it is to gather a large enough consensus to solve the problem. Throughout the 1970's and 1980's, calls for comprehensive health care reform came in cycles. We all had proposals which we felt would solve the problem. Leaders dug their heels in and insisted that they had the best approach. We got nowhere.

We are now in another such cycle. If history is a teacher, surely we can learn from our mistakes.

We have another chance now, and I hope we will not let it slip through our fingers for political reasons. Many Republicans in the Senate agree, and in July of last year formed a Republican Health Care Task Force to study this issue. I have the privilege to be chairman of this task force. There are 32 members. Many of us have been working to pull together proposals that we believe have a chance of becoming law. In this process, many of us have had to compromise our desire to attack the whole system in one fell swoop. We are developing a package which we believe will move us significantly forward, even though it may not solve all of our problems.

Many areas of our Nation are experiencing severe recessions. We are facing a tremendous Federal deficit. Mandated employer coverage of health insurance will be vigorously opposed by small business. Neither Federal and State governments nor businesses are prepared to significantly increase health care spending.

Yet, a number of Members of Congress and interest groups insist that the time has come to enact a national health plan which would guarantee that everyone has health care insurance coverage. The bill my Democratic colleagues have introduced may promise health insurance to all Americans, but it does not have much of a chance of passage. No such proposal will pass without the support of some Republicans and a majority of Democrats in Congress and without the Bush adminstration's support. Neither are prepared to endorse such a plan. There is no broad support for this approach, inside or outside the beltway. Small business, and even some larger businesses will not support this proposal. Yet, we have momentum for change, and I believe that we should take advantage of it.

It is critical that we move forward on health care reform in the next 18 months. There are Americans who are at risk because they do not have access to health care services. I hope that the Democrats will not allow the temptation of using this as a campaign issue to take priority over passing something that will at least move us closer to a goal we all share—ensuring that all Americans have access to health care services.

The Democrats have addressed the growth of health care costs through encouraging managed care plans, preempting health benefits currently mandated by the States, encouraging the use of single claim forms to lower administrative costs, and reforming the insurance market's treatment of small business. We have discussed all of these ideas on a bipartisan basis for the past 18 months, and I am glad to see them party to this package.

They also have at least acknowledged that solving our health care access problem can not be accomplished solely through health insurance expansion. They have adopted an idea I have promoted—to significantly expand community health centers which provide needed care in medically underserved areas.

What about the other provisions included in the proposal?

Clearly the "pay or play" component of this proposal is a rerun of the Pepper commission recommendations. I have strong concerns about the ability of employers to comply with the requirement that they offer health insurance to all full-time employees or pay a very large surtax. Until we make significant reforms in the insurance market for small business and institute real cost containment measures—and they are proven effective—there is no guarantee that health insurance costs will be lowered enough to be affordable to all small businesses.

I question whether in our current economic situation it is wise to impose significant costs—either through insurance premiums or a payroll tax of 8 percent—on our business community. Can we really afford to take the risk that those small businesses which are operating on the margin now will be forced out of business? After all, businesses with less than 100 employees employ 46 percent of American workers.

It also concerns me that one of the most critical health care costs—medical liability—is not adequately ad-

dressed in this proposal. The proposal would provide grants to States to experiment with alternatives to our tort system. While grants could be a small useful component to medical liability reform, simply throwing grant dollars to a State will do little to encourage development of alternative dispute resolution systems and urge plaintiffs and defendants to use them. The cost of medical liability—including premiums and defensive medicine—accounts for about $12 to $14 billion per year.

The proposal also includes an entirely new public program. However, there is a requirement that all individuals be covered, and the States will be required to pay a significant share of the cost. Unless they significantly increase Federal matching funds to States, a costly proposition, this could be a real problem for the many States which are already facing severe budget problems.

Now, it is easy to criticize a proposal. My response to critics is generally, Do you have any better ideas? In this case the answer is "yes," I think some of us do.

As I mentioned earlier, in the Republican Health Care Task Force our goal has been to pull together a proposal that may not offer all things to all people, but that is reasonable and has a chance of getting beyond the rhetorical stage—in other words, policy over politics.

We are looking at ways to encourage employers to provide health insurance coverage to their employees. This could be done by making insurance more affordable to small businesses. We are discussing providing incentives for small businesses to form purchasing groups so they can gain market strength to negotiate more effectively with insurance companies.

We are looking at reforms in insurance market practices which make it difficult for small employers to provide coverage to their employees. Such practices include underwriting and rate setting policies, which exclude high-risk individuals or groups.

We are discussing development of a model benefits package, which could be used to allow employers to offer lower-cost benefit packages. In order to do this, we would have to preempt State mandated benefits which can significantly increase the cost of health care insurance. These mandates range from in-vitro fertilization to treatment for hair loss.

If we are going to control costs within our system, we must examine current Federal expenditures on health care. When we think of health care entitlement programs, we think of Medicare and Medicaid. There is, however, another significant Federal health care entitlement program. I am referring to the treatment of health care benefits under the Tax Code. This loss of revenue to the Federal Treasury amounts to almost $40 billion annually, and is the third largest Federal expenditure on health care, behind Medicare and Medicaid.

Under current law, all employer contributions to an employee health insurance plan are excluded from the employee's taxable income. An individual who does not receive employer-based insurance not only will pay more for insurance because he is purchasing it outside of a group, but also will pay for it with after-tax dollars. Thus, we are subsidizing health care for a significant number of upper- and middle-income individuals. Workers in businesses that do not provide insurance, usually low-wage workers in the service industry or seasonal workers, do not receive this subsidy.

We are examining the placement of a cap on the deductibility of very generous employer provided plan, given that so many in our society have no health care whatsoever.

We are looking at expanding the deductibility of health costs to those who purchase insurance outside of an employer group, as well as to those who are self-employed. Another method of expanding access to both insurance and services is through the use of credits for low-income families and small businesses which is a proposal we are examining.

We are also considering changes which will help control the spiraling cost of health care, such as preempting State laws which create obstacles to managed care arrangements. Another issue we will address through significant reform is medical liability. Health care providers are paying outrageous premiums, and are practicing defensive medicine to ensure they have the ability to defend against a negligence suit.

We are also looking at increasing the availability of health care services for low-income individuals who do not have access to employer-based coverage. I and a number of my Republican colleagues have introduced legislation which will increase access to critical health care services for individuals living in medically underserved areas. All too often, we as policymakers forget that just giving someone a Medicaid card, or private insurance for that matter, does not necessarily guarantee access to health care.

In both rural and inner-city areas there are shortages of qualified medical personnel. In addition, there are shortages of health professionals who will accept Medicaid patients. Community health centers are one solution to our health care delivery problems. They provide cost-efficient high quality primary and preventive care services to the uninsured, as well as persons with Medicare, Medicaid, or private coverage. We are looking at a significant increase in the funding available to these centers.

We are also considering proposals to give States increased ability to enact statewide health care reforms. This could help us to determine what strategies we should pursue on a Federal level. Only through experimentation such as this can we best determine how to address most effectively, deficiencies in our health care system.

I will be the first to admit that these proposals will not solve all our problems. I would like to go further. It is easy to support providing health insurance coverage for all Americans. It is easy to say that we should create a new public program for all uninsured individuals. It is easy to point to Canada, West Germany, and Sweden and say, "If they can do it, so can we."

Simply put, we have neither the support nor the resources to enact such proposals. The harsh reality is that there is no consensus on what radical reform should include, and how it should be paid for. The Democrats can't agree, and neither can the Republicans. The business community cannot agree, nor can consumer groups, nor can health care providers.

We can make significant strides toward what may one day be a radical change in our health care system—not by revolution, but by evolution.

It is my hope that once the bill is introduced, the Democrats will go back to the drawing board with us and try to develop an approach to this critical problem that really can be enacted. Clearly, nothing will pass that does not have the support of business, conservative Democrats, Republicans, and the President.

Mr. SPECTER. Mr. President, I have been waiting on the floor to address the pending legislation, Senate bill 173, but before doing so, I will take just a moment to congratulate my distinguished colleague from Rhode Island, Senator CHAFEE, for his outstanding work as chairman of the Republican Task Force on Health Care. I similarly compliment the Democratic Members who have offered health care legislation. It is an extraordinarily complex problem. As I traveled my State extensively, it is an issue I hear raised as much if not more than any other.

With some $660 billion or 12 percent of the gross national product being allocated to health care, we still find millions of Americans not covered. It is an issue which has to be addressed. We have to find a policy that we can pay for.

As Senator CHAFEE noted, I have been working with him on the task force, and it is an issue which must command considerable attention by the Congress of the United States and by the administration.

TELECOMMUNICATIONS EQUIPMENT RESEARCH AND MANUFACTURING COMPETITION ACT

The Senate continued with the consideration of the bill.

Mr. SPECTER. Mr. President, as I have noted, I have been on the floor

Mr. DURENBERGER. Mr. President, I ask unanimous consent that the order for the quorum call be rescinded.

The PRESIDING OFFICER. Without objection, it is so ordered.

Mr. DURENBERGER. I ask unanimous consent that I might proceed for up to 10 minutes as though in morning business.

The PRESIDING OFFICER. Hearing no objection, that will be the order.

Mr. DURENBERGER. I thank the Chair.

NATIONAL HEALTH CARE REFORM

Mr. DURENBERGER. Mr. President, let me first thank the managers of this bill for the opportunity to take this time to congratulate my colleagues in this body, especially those from Maine, Massachusetts, and West Virginia—Democratic Senators MITCHELL, KENNEDY, and ROCKEFELLER—on the occasion of the introduction of their landmark legislation on health crae reform.

Regardless of the shortcomings of this particular proposal—and I believe there are several—this event today is a very major milestone on the road to urgently needed health care reform in America. It literally is a first.

Today, we have on the table a serious proposal for the national reform of health care which is as close to comprehensive as anything we have seen. For want of a better alternative, this bill sets the agenda for the Congress. It begins the long and difficult process of health care reform.

Because we all tend to focus on the day-to-day challenges around here, we often cannot take in the longer view of legislation. For our colleague, Senator KENNEDY, this is not a 1-day event. It is yet another step in a 30-year effort to bring access to health care to all Americans. This is not an issue to him; it is a passion, and I commend him for that.

I also want to commend the other key players in this proposal who are, relative to our colleagues from Massachusetts, new kids on the block. It has been my privilege to have served with both GEORGE MITCHELL and JAY ROCKEFELLER on the Medicare Subcommittee of the Senate Finance Committee as long as they have been in the Senate. GEORGE and JAY epitomize Senators of the modern era. They are both good listeners and serious thinkers, and they have an ability to push through the complexities of the issues that we face to reach far-reaching solutions.

I commend them for that effort and the efforts they have made over the last several years to understand and master the health field and for much good policy which they now lay before us. JAY ROCKEFELLER, I must say, also made physician payment reform a reality and made the Pepper Commission work.

Democrats and Republicans in the Congress have been working on changes in the way America pays for health care since I arrived here in 1979 to meet the specter of something called hospital cost containment. There can be no question that America must change the way we produce, the way we well, and the way we buy medical services.

Just as health is a basic issue to every person, it is a fundamental issue for every business, every institution, and every level of Government in America. Like a person with very high blood pressure, each institution of our society today is threatened with an explosive increase in medical costs. This year American health expenditures will be $750 billion. By the turn of the century—only 8½ years from now—that amount will have tripled, to over $2 trillion. Can employers afford three times their current health care costs? Can Government? Can individuals and families? Of course not.

We have 31 million Americans who have no health insurance at all, with millions more soon to join the ranks because of cost increases. We have major sectors of our society—in rural and urban areas—grossly underserved. Change is urgently needed.

I commend my colleagues for laying this proposal on the table.

As I look over the proposal, I see a number of very necessary reforms which have been discussed in the Finance Committee and in the Pepper Commission. The bill is a great improvement on the Pepper Commission final report because it begins to address a major gap in the document—cost containment.

I wish to thank the sponsors for including a number of proposals which I have just put forward over the last several years, and I am especially pleased to see a small business insurance reform component which I have been working on since March of last year and on which I have introduced S. 700, the American Health Security Act.

But, Mr. President, before I sound any more like a cosponsor of this proposal, which I am not, there are several flaws which will cause this bill to fall short of its own ambitious goals. This afternoon I will mention just four.

First, introducing a bill without any financing to it is like wrapping up an empty box and putting it under the Christmas tree. It is designed to disappoint. One of the lessons we were supposed to have learned from the 1980's is that government should not promise for what it cannot pay, or is unwilling to pay.

Unfortunately, this bill falls into that trap. The bill is quite explicit about what we will do for the American people and silent on how they will pay for it. It proposes $6 to $8 billion in Medicaid changes. From where is that money going to come? It proposes a payroll tax on businesses that do not choose to provide insurance. How big will that be—10 percent, 15, 20? This legislation gives no answers. The failure of the sponsors to agree upon a financing mechanism even among themselves does belie the so-called comprehensive nature of the bill.

Second, by relying on employer mandates to solve the uninsured problem, the bill prescribes a treatment that has already failed clinical trials in the State of Massachusetts. There is a major problem of the working uninsured—people who have jobs but cannot get insurance in the workplace. But the problem is not that their employers—mostly small businesses—will not provide insurance; it is simply that their employers cannot.

Finding and keeping affordable insurance in the current cost spiral has been nearly impossible, and to add a mandate to buy insurance in this situation is simply to mandate bankruptcies.

The bill requires employers to either provide a health plan for their employees or pay into a State insurance fund; in other words, "play or pay." The eventual result will be employers abandoning their responsibility to insure workers and dumping them into a huge State system. In other words, we will get a Canadian system by the installment plan.

But the greatest unfairness in this mandate is it treats all employers and all businesses as though they were the same; it ignores differences which are crucial to how these employers make their health care decisions, even the decision to play or pay.

There are differences between employers located in urban and those in rural areas, different kinds of businesses—manufacturers, service industry—the kind of business that can pass on these costs on goods and services and those that cannot. There are differences between the coastal areas of this country and its heartland. To say these disparities do not exist guarantees bad policy outcomes.

The third flaw in this bill is that it leaves totally unreformed $100 billion a year in Federal health spending on the tax side of the ledger. There is a very large hole in the Nation's health bucket that simply must be plugged if we are going to get the kind of efficiency we need in this system. Every year, we hand out $100 billion in tax benefits—or the taxpayers do—for health expenditures, and the American people get no better system for it.

We subsidize the average lawyer in this city about $2,000 a year for his health insurance, a tax subsidy paid for by farmers in Minnesota who do not get that kind of subsidy and have to pay twice as much for their premiums without the benefit of a deduction.

Fourth, I am sure the sponsors would also agree that even passage of

their bill today would not nearly finish the job of health reform. We still have to deal with Medicare restructuring and optional services for long-term care. We have to deal with the medical arms race in this country which is raising costs by 11, 12 percent a year. We have to deal with restoring individual resonsibility and changing the wasteful way in which health care is currently delivered in this country. This is the real key to cost containment in America today, changing the way people access health care and changing the way medicine is practiced.

I would suggest that if every health professional in America practiced as part of a Mayo Clinic we would double quality assurance in America, and I know we would cut the costs by at least a third.

The majority leader, Senator MITCHELL, in his statement said this is a "comprehensive bill to reform the Nation's health system to provide access to affordable heath care for all Americans."

But without the details of the financing, without a sustainable solution to the uninsured problem, without a tax component or reform in other major areas, this bill will have trouble living up to that reputation.

Mr. President, the process of health reform will be a long and difficult one. Changing how 13 percent of the GNP in this country operates when it is operating in a drug company over here and in a small town clinic over there, is a huge challenge. But we have to start some place. And some place is the bill our colleagues, Senators KENNEDY, MITCHELL, and ROCKEFELLER, have put before us.

I commend them for their leadership and for the correct choices they have made, and I look forward to working with them in the areas—and there are many—where we will have disagreements.

This will be a long journey—10 years' worth of work perhaps. But we cannot get there unless we get started.

Credit belongs to those Senators today. Because of their efforts, we are finally underway.

Mr. President, I suggest the absence of a quorum.

I yield the floor.

TELECOMMUNICATIONS EQUIPMENT RESEARCH AND MANUFACTURING COMPETITION ACT

The Senate continued with the consideration of the bill.

Mr. KERREY. Mr. President, I rise to state my support for S. 173, and in particular I want to call my colleagues' attention to what I think is an extraordinary accomplishment on the part of the distinguished senior Senator from South Carolina, who has fought this battle long and hard. I am very grateful he has been willing to do it.

There has been a considerable amount of opposition, persuasive arguments on the other side, and I suspect we are rather close now to passing this piece of legislation.

I have had a great deal of interest in telecommunications for some time. I was chairman of the National Governors Association's Task Force on Telecommunications Policy and, as a consequence of that, we took some regulatory action while I was Governor. And the object of the deregulation action was to try to encourage the local phone companies to invest more in communications technology.

The jury is still out as to whether or not that will occur.

I am pleased with some of the action that has occurred, and not so pleased with some others.

Mr. President, I believe this is an appropriate legislative response to an inappropriate judicial situation. Since Federal District Judge Harold Greene's modified final judgment on the breakup of AT&T went into effect in 1984, the RBOC's have been barred from manufacturing telecommunications equipment. The RBOC's created in that divestiture, and as a part of that divestiture agreement and the consent decree, as a consequence were not allowed to get into the business of manufacturing telecommunications equipment.

This edict on the part of Judge Greene—in fact, a consent decree signed between the U.S. Government and AT&T—was targeted toward legitimate ends. That end is to protect the consumer from unduly high phone bills and shielding other telecommunications firms from unfair competition.

I emphasize this is a legitimate regulatory objective. These are still companies with highly monopolistic characteristics particularly deserving of regulation.

The result has been one of unelected judicial officials now doing more than perhaps any elected official to shape America's telecommunications policy. And the result has been a restriction of the RBOC's that is broader than needed to protect wallets of American consumers and the competitive interests of American manufacturers.

I believe the sponsor of the bill, as I have indicated earlier, the distinguished Senator from South Carolina [Mr. HOLLINGS], has done a tremendous job, an admirable job in crafting this legislation in a way that balances the various interests, the various conflicting interests.

It erects quite concrete barriers to prevent the RBOC's from using their regional monopolies over the phone service to cross-subsidize their manufacturing operations, and to that end I believe the amendments offered by the distinguished Senator from Ohio improve the extent to which we will be able to monitor and prevent that cross-subsidization.

Further, the legislation takes steps to ensure the RBOC's will reenter the manufacturing competition on a playing field that will remain level. It includes measures that will enhance America's position in global trade.

For these reasons I plan to vote in favor of this bill. But for other reasons I will vote for the bill with some regret. What I regret is simply this: America's elected leadership, in particular the administration, is doing so little to set and achieve a bold and broad-reaching telecommunications vision for our Nation's future.

All of us in political life, any who have been in business, understand automatically the power of modern telecommunications.

There can be no doubt that the nature of our telecommunications system in the next century will shape America's destiny as powerfully as our rail, water, and highway systems have done over the past two centuries. If we took the right steps today, we could begin to revolutionize every aspect of our lives: The way we educate our children, the way we obtain our health care, and the way we do our jobs. I have seen some of those possibilities demonstrated already in some of the Nebraska schools.

Mr. President, it is very exciting. One portrait of what we can achieve was recently painted by George Gilder in the Harvard Business Review. Mr. President, the article is too long for inclusion in the RECORD, but I recommend it to my colleagues.

Mr. Gilder presents to us a rather exciting proposal. It is one that has a considerable amount of risk attached to it, as well. But the proposal, Mr. President, says that what is missing in the United States is the infrastructure; not the high-end infrastructure, but the infrastructure that connects the American home and family to that high-speed network that we generally use with long-distance phone systems.

That pared copper line that connects every American home and most of America's businesses with our phone system is the greatest barrier, I believe, not only to our being able to develop a fully integrated information system in our country, but in seeing that marketplace, information marketplace, explode and grow even more rapidly than it has in the 1980's.

What Mr. Gilder proposes is that we are simply not regulating for the right objective; we have not taken into account changing technology and what that technology has done for us. It has given us the opportunity to refashion our laws, not without some risk.

I assume Butler Aviation, both at National and Dulles, is doing a lot of business this week. I assume there is a lot of heavy iron coming in trying to influence our vote. I have seen a considerable amount of evidence of that out in the rotunda. There will be a lot more heavy iron in town if we were, in my judgment, to consider that what Mr. Gilder is saying is, in fact, correct. That is this, Mr. President: What we

THE WALL STREET JOURNAL TUESDAY, JUNE 11, 1991

Wrong Prescription for the Uninsured

By JOHN C. GOODMAN

To solve the problem of 34 million Americans without health insurance, Senate Democrats have unveiled a new health-care plan. Ever faithful to the big government, big bureaucracy point of view, George Mitchell (D., Maine), Edward Kennedy (D., Mass.), John Rockefeller (D., W.Va.) and Donald Riegle (D., Mich.) propose to take a manageable problem and turn it into a major disaster.

Under the bill's "pay or play" plan, employers would have a choice: pay a federal tax, tentatively set at about 7% of payroll, or provide health insurance to their workers containing core benefits defined in Washington. If employers decide to pay the tax, government will assume responsibility for providing health insurance and employees will pay premiums that vary based on income level.

For example, a $2,500 family health insurance premium for a worker earning $20,000 costs 13% of payroll, not 7%. In this case, the obvious choice for the employer is to pay the tax and turn the problem over to government. Indeed, considering that about 95% of all uninsured workers earn less than $30,000, in the vast majority of their cases employers will have strong incentives to pay the tax rather than to begin providing coverage themselves. (The cost of the core-benefit package will vary depending on the benefits included, and the age, occupation and geographical location of employees. The $2,500 example is a very conservative number; the current average cost per employee in the U.S. is $3,217.)

Temptation

This is not necessarily good news for the uninsured. Assuming uninsured employees are already paid a fair wage, a 7% payroll tax means that their employers will have to cut wages by 7% or lay off workers. Since those earning the minimum wage can't by law take a wage cut, they stand the greatest risk of becoming unemployed.

Employers who already provide health insurance to their employees also will compare the 7% tax with the cost of a health-insurance policy containing federally mandated benefits. A great many of them will be tempted to pay the tax and drop existing coverage. Nor is this mere speculation. A Kennedy aide says the bill's sponsors expect this to happen.

Lee Iacocca will like this plan. For years he's wanted to dump Chrysler's health-care costs on government, and the Senate Democrats are offering him a chance. Instead of paying what I estimate to be close to $4,000 per employee for private insurance, Mr. Iacocca could pay a tax of less than $3,000, have government provide each Chrysler worker with health insurance, and make a handsome profit. (If they have any sense, Chrysler workers will resist this mightily.)

If employers decide to provide health insurance to their employees, they will be required under the bill to include mental-health benefits (the fastest-rising component of health-care costs) and preventive procedures, including mammograms, pap smears and well-child care (items for which costs double when the administrative costs of third-party insurers get factored in). The required out-of-pocket deductible is only $250. Employers could charge a higher deductible only if they provided additional benefits to those in the core package—not to cut costs.

Count on the benefits expanding and the costs rising once the special interests get their hands on the bill. In response to provider pressures, state governments have enacted more than 800 cost-increasing mandated benefits, requiring insurers to cover services ranging from acupuncture to in-vitro fertilization. All this means that individuals have to pay for coverage they do not want. Though the Senate Democrats' bill would override these state mandates—in an attempt to control costs—the lobbyists can be expected to move to Washington and continue their push for coverage of more and more services.

Lee Iacocca will like this plan. For years he's wanted to dump Chrysler's health-care costs on government, and the Senate Democrats are offering him a chance.

If employers exercise the option to pay the tax rather than provide health insurance, what happens to the workers? Rather than purchasing a private health insurance policy on their own, they will be required to join Medicaid. In fact, if you have any desire to toss away your private health insurance and join Medicaid, you'll love the Senate Democrats' new health-care plan.

Granted, under the Democrats' plan Medicaid would be reorganized. It would also have a new name—"AmeriCare." But Medicaid under any name is still Medicaid.

In most places, Medicaid pays doctors and hospitals 50 cents on the dollar—sometimes even less. As a result, doctors increasingly won't see Medicaid patients and access to hospital care is increasingly limited to charity hospitals.

Because Medicaid underpays, health-care rationing is inevitable. And more severe rationing is right around the corner as the hospital marketplace becomes more competitive, cost-shifting to other patients becomes less feasible and government at all levels has less money to spend. So far, only Oregon publicly admits that rationing in its Medicaid program is routine. Medical providers know the same thing is happening in every state.

If readers get a sense of *deja vu*, it's probably because they *have* heard this before. The Senate Democrats have endorsed the very plan that Michael Dukakis created for Massachusetts. Voters may recall Mr. Dukakis's 1988 boast that everyone in Massachusetts had health insurance. Well, not quite. The Massachusetts Legislature wants to delay the private sector's entry into the program until 1994, and the current governor wants to kill the whole program.

One problem is that government is inherently incapable of administering an insurance program that prices risk accurately. Witness the deposit insurance debacle at the federal level and the auto liability insurance crises in California, New Jersey and Massachusetts. In Massachusetts, auto insurance has become so politicized that any possibility of rational premium prices has vanished and 65% of all premiums now go to the state risk pool.

The Senate Democrats have already signaled they have no interest in insurance prices based on real risks. The 7% payroll tax has no relationship to the actual cost of health for any particular employee. And they are proposing a quasi-cartel in the small-group health insurance market to guarantee that private insurance premiums won't reflect real risks either. This will speed the exodus of people into Medicaid (oops, AmeriCare), the risk pool of last resort.

A second problem both for Massachusetts and the Senate Democrats is small business, which employs most of the noninsured workers. Does it really make sense to heap new taxes on small business—the job-creating sector of the economy—in the middle of a recession? One suspects that even the senators would answer "no."

In fact, one suspects they're not really serious about the proposal at all. The plan proposes a two-year grace period for new small businesses and a five-year grace period for firms with fewer than 25 employees—the firms where almost half of all uninsured workers are employed. Like Mr. Dukakis, the Senate Democrats propose to talk now and act later—definitely after the next election.

A third problem is health-care costs—which are bound to rise as more people acquire health insurance. Initially Senate Democrats propose "voluntary" spending limits with targets for the total amount spent on physicians fees and hospital services throughout the country. But since the nation's 5,000 hospitals and 500,000 doctors could not possibly agree collectively on anything, the targets are bound to be missed, and "voluntary" will soon become "mandatory."

This is precisely the approach taken in countries with national health insurance, where governments set arbitrary budgets for hospitals and area health authorities and force the providers to ration health care. The result is a lower quality of care and more—not less—inefficiency.

While 700,000 people wait for surgery in Britain, at any one time one of four hospital beds is empty. While 50,000 people wait for surgery in New Zealand, one out of five beds is empty. As the waiting lines grow in Canada, the politics of bureaucracy determines who gets the next brain scan. In all three countries, about one in every four hospital beds is filled with the chronically ill elderly, using the hospital as an expensive nursing home.

Listen to Bentsen

Bureaucratic health-care rationing is anything but fair. Although health care is theoretically free in England, 12% of the population now has private health insurance. In New Zealand's "free" health care system, one-third of the population has private insurance and one-fourth of all surgery is performed privately. In Canada, where private health care has been virtually outlawed, the U.S. border is the safety valve. For example, about 100 Canadians get heart surgery every year at the Cleveland Clinic.

Before taxing small business to pay for an expanded Medicaid program with health-care rationing required by limits on spending, the Senate Democrats should listen to their colleague Lloyd Bentsen (D., Texas), author of refundable tax credits for the purchase of health insurance. Instead of pushing more people into a government rationing program, the Bentsen approach would empower low-income families and make them real participants in the health-insurance marketplace.

Mr. Goodman is president of the National Center for Policy Analysis, a [illegible] based research institute.

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Health Care Cost
PAYROLL TAX WILL NOT COVER COST
OF SENATE DEMOCRATS' PLAN, ECONOMIST SAYS

WASHINGTON (BNA) -- The payroll tax envisioned under the Senate Democrats' universal health care bill probably would not be sufficient to cover the costs of the public plan, an economist said July 24.

Moreover, the shortfall could force the plan's creators to seek additional tax to pay for the program, Stuart Butler, director of domestic and economic policy studies at The Heritage Foundation, predicted.

Butler was one of several economists who appeared before the Senate Labor and Human Resources Committee to discuss the economic impact of S 1227, the health reform proposal unveiled by Senate Democrats June 5 (18 BPR 959). Under the "play-or-pay" scheme, employers would be required to provide a certain level of benefits to all workers or pay an unspecified payroll tax. The tax would be designated by the Secretary of Health and Human Services.

Senate Majority Leader George Mitchell (D-Maine), one of the chief sponsors of the bill, has said he does not expect the payroll tax to cover the cost of the entire reform package. He said the Congressional Budget Office estimated supplemental costs to be $6 billion in the first year.

"Dumped" Employees

Butler expressed concern that far more working individuals than anticipated would be shifted or "dumped" into the so-called AmeriCare public program by employers that did not wish to provide private insurance.

"I think there will be far more people shifted into the public program while still employed than previous estimates have indicated," Butler said. This would place the federal government at risk of adverse selection into AmeriCare, Butler said.

As a result, the cost of the public program ultimately will be in the hands of employers, he concluded.

In his prepared remarks, Sen. Orrin Hatch (R-Utah), ranking Republican on the committee, said he had reviewed estimates that as many as 60 million persons could be "cast off" from employer-provided insurance programs to public programs under the bill. Butler said any estimates of likely shifting are difficult to determine because they are influenced by many other factors.

Another economist took issue with Butler's use of the word "dumping" when referring to a shift of persons to public plans. "I disagree that it is

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'dumping' any more than covering the elderly or disabled is 'dumping' (into the Medicare program)," said Karen Davis, professor and chairman of the Department of Health Policy and Management at The Johns Hopkins School of Hygiene and Public Health. Providing a public program guarantees coverage for these individuals and under a "play-or-pay" scheme it gives two attractive options to employers, she argued.

Davis spoke in favor of enacting S 1227, saying the proposal would provide health insurance coverage for 33 million more people, while incurring "at most" a loss of 50,000 jobs. The losses would be more than offset by the expansionary impact on the health insurance industry, which would expand to provide needed health care to those who currently are uninsured, she added.

Savings Cited

Davis was joined in her views by Kenneth E. Thorpe, associate professor with the University of North Carolina-Chapel Hill's School of Public Health, Department of Health Policy and Administration. At current trends, the nation will spend nearly $2 trillion, or 19.6 percent of gross national product, on health care by the year 2000, he said. "Even with a relatively modest reduction in cost growth, similar to the rate of increase observed in many rate-setting states, our nation would spend 14.9 percent of GNP on health," he said. The potential savings to U.S. employers would be $150 billion, he said.

A significant part of the legislation is a proposed national expenditure review board whose task would be to moderate the rate of growth in health care spending, Thorpe said. "By setting expenditure goals, the board represents a critical first step in allowing our country to moderate the rate of increase in cost, and encourage the diffusion of technologies which examine both benefits and costs."

Butler, however, took aim at the expenditure review board, saying the United States cannot have a fixed medical budget while maintaining the freedom of choice among providers and services that is prized by its citizens. "The British system has a fixed budget and it holds costs down compared with this country" by using specific measures--like waiting lists--that may not be acceptable to U.S. citizens, he said.

"I don't know that we have any evidence that rate regulation would work in this country," Butler said. "If you stop consumers from demanding resources, then you can do it. But if you try to maintain the current system of choice with a fixed budget, it's an impossible combination," he added.

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PR Newswire

July 31, 1991, Wednesday

SECTION: Financial News

DISTRIBUTION: TO NATIONAL, BUSINESS AND MEDICAL/HEALTH EDITORS

LENGTH: 844 words

HEADLINE: HIAA PRESIDENT SCHRAMM SAYS 'HEALTHAMERICA' WOULD MEAN SPIRALING HEALTH CARE COSTS

DATELINE: WASHINGTON, July 31

KEYWORD: bc-Health-Insuran-cost

BODY:

The HealthAmerica plan offered by the Senate Democratic leadership contains provisions that would result in "spiraling health care costs" and proposes a public program "guaranteed to lose money," according to Carl J. Schramm, president of the Health Insurance Association of America (HIAA).

Schramm, testifying today before the Senate Labor and Human Resources Committee in opposition to the HealthAmerica plan, was particularly critical of provisions that would impose community rating in the small group market -- traditionally, companies that employ 25 or fewer people -- and that would expand the existing Medicaid program to people who could be served by private health insurance.

"A movement toward community rating will have negative side effects," noted Schramm. "A community rated system would increase costs for populations least able and willing to pay (especially young workers) ... and compromises local accountability for health care costs, since the actions of an employer (to reduce costs) would have little if any effect."

"The ultimate result of community rating," added Schramm, "could well be spiraling health care costs for insured populations and a growing number of employees without adequate protection."

As for the proposed " Americare" program that would expand and replace the existing federal/state Medicaid program, Schramm noted that historically, Medicaid has been "chronically underfunded," and remarked that the proposed funding mechanism for Americare would do nothing to improve financial adequacy.

The "pay or play" provision of Americare would compel employers either to pay into the public Americare program or "play" by buying private health insurance, continued Schramm. Employers who anticipate that their employees' health care costs would exceed the Americare premium -- those with older or less healthy workers -- would have an incentive to take part in the public program, while employers with younger, healthier workers will not participate, he added. "In other words, Americare is guaranteed to lose money on the employer-based population that opts into it," he remarked.

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Confronted with large and mounting losses, the Americare program, noted Schramm, would require "a major new infusion of public funds," financing from groups of people originally intended to be outside of the program, and/or lower reimbursement rates to providers, which "... would result in an unsustainable and unfair cost-shift from Americare to non- Americare enrollees."

Instead of Americare, Schramm advocated a more modest expansion of public coverage to poor and near poor people. He also recommended adoption of certain aspects of the HealthAmerica proposal that would reform the small group market by guaranteeing availability of health care coverage, continuity of coverage and extending a 100 percent tax deduction to the self-employed and special tax credits to low wage earners.

Additionally, Schramm commended the cost containment provisions in HealthAmerica "... that prohibit states from hindering the capacity of managed care plans to select providers to make up networks, to limit the number of participating providers, to pay providers in innovative ways and at alternative rates, and to incorporate incentives for consumers to use participating providers."

However, HIAA does not support the establishment of a new government entity to be known as the Health Expenditure Board that would set and enforce spending targets and provider rates.

"Is it appropriate to treat medical care in a way that is so radically different from virtually all other areas of the economy?" asked Schramm. "If the answer is yes, isn't this properly a legislative function, rather than one that should be turned over to an independent agency that is beyond the direct control of the legislature and thus the people? How can any agency determine rationally what is the 'right' amount to spend for medical care?"

Perhaps most troubling, Schramm added, is a provision that would give the Health Expenditure Board authority to make non-binding recommendations of provider rates through a negotiation process, either at the national or state level.

"Providers, in particular, have an incentive to refuse to accept rates that substantially constrain their incomes," observed Schramm. "In the event of such an impasse, the board's non-binding authority would mean that everything is left largely as it is now."

"Some of the 'answers' that we propound today may be found wanting and in need of revision," Schramm noted in closing. "For these reasons, HIAA believes that access and cost proposals should retain significant flexibility, and that the states should be the principal locus of regulatory and oversight activity."

HIAA is a trade association of the nation's leading commercial insurance carriers that provide health insurance for approximately 95 million Americans.
CONTACT: Richard Coorsh of the Health Insurance Association of America, 202-223-7787

ORGANIZATION: Health Insurance Association of America

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July 2, 1991, Tuesday, NORTH SPORTS FINAL EDITION

SECTION: PERSPECTIVE; Pg. 14; ZONE: C; Voice of the people (letter)

LENGTH: 259 words

HEADLINE: AmeriCare's flaws

BYLINE: Tom Whisler, President, American Seniors, Inc

DATELINE: INDIANAPOLIS

BODY:

The newly unveiled Democratic health plan, " AmeriCare, " looks highly flawed to seniors familiar with Medicare, Medicaid and the late unlamented Catastrophic Care Act. The zeal to take care of everyone has again carried our representatives into the woods.

Advocates argue that: 1. It will be more efficient because it eliminates all the overhead costs resulting from numerous private insurance firms. Those who like this argument should recall the two pre-unification Germanys. In socialist East Germany, the "efficient" government provided one automobile for everyone - the Trabant, a wretched, polluting, tiny automobile, available usually only after years of waiting. In capitalistic West Germany, the government allowed total "inefficient" competition of private auto firms. There, almost everyone had a car, and one of his choice.

2. It will control costs. This magic will be achieved, first, by price controls on doctors and hospitals - a prescription that is already beginning to diminish the quality of health care under Medicare. The choice of physicians and of available treat-ments is increasingly limited by the actions of the regulators.

Our representatives are mesmerized by the belief that health costs can be controlled by tweaking up the present system of employer-provided health care plans, and are not seriously thinking about alternative ways of providing true health insurance for most of our citizens in affordable fashion. The socialist approach is likely to be self-defeating. Why are they trying to sell us a Trabant?

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Pension Reporter

June 17, 1991

Vol. 18, No. 24; Pg. 1000

LENGTH: 1029 words

SECTION: NEWS: Health Care.

TITLE: SEN. HATCH SAYS 'PLAY-OR-PAY' PROVISION WILL INCREASE EMPLOYERS' COSTS, LOSE JOBS.

TEXT:

Sen. Orrin Hatch (R-Utah) June 11 strongly criticized the "play-or-pay" provision in the Senate Democrats' health care proposal (S 1227).

The requirement that employers either provide health insurance for employees or pay a payroll tax would be costly for businesses and could result in the loss of some jobs, Hatch asserted. "The pay-or-play mechanism makes this legislation a job-loss bill, not an enhanced access to care bill," he said.

The senator's comments came during Senate Labor and Human Resources Committee hearings held June 11-12 on the Democratic proposal which was introduced June 5 by Senate Majority Leader George Mitchell (D-Maine), along with Sens. John D. Rockefeller IV (D-WVa), Don Riegle (D-Mich), and Edward Kennedy (D-Mass), who chairs the Labor and Human Resources committee (18 BPR 959).

Despite his criticism of "play-or-pay," Hatch did applaud the Democrats, in particular Kennedy, for their reform proposal. However, Hatch said it is essential that the Senate develop a bipartisan approach to health care reform. "The plan is not in a bipartisan mode but we can get it there," Hatch said.

In separate testimony June 11, former government officials Joseph Califano and Elliot Richardson both supported the general approach of the Democrats' plan. In particular, Richardson, who was secretary of the Department of Health, Education, and Welfare during the Nixon administration, said the reform plan includes two major innovations -- the "play-or-pay" provision and a comprehensive cost-control program.

'Triple Crown Winner'

Similarly, Califano, who served as secretary of Health, Education, and Welfare during the Carter administration, said the reform plan is a "Triple Crown winner." Not only does the proposal ensure continuous and affordable access to health care, but businesses will find that health care costs are "restrained and fairly distributed," Califano said. Furthermore, he said physicians, hospitals, and other providers will face lighter administrative burdens and will not be burdened with uncompensated care.

In a prepared statement, Kennedy said the play-or-pay provision was central to the Democrats' comprehensive plan. In addition, he said the cost problem will be addressed through provisions dealing with all parts of the problem, i.e., cost-shifting, unnecessary care, excessive administrative costs, and the

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blank-check reimbursement to providers.

But Hatch charged that the financing mechanism of the Democrats' bill -- which includes the payroll tax and a supplementary source of revenue to be decided on by the tax writers -- is "all too typical."

"Break the bank; make others pay the costs," Hatch said.

Hatch further said the mandates in the play-or-pay scheme could result in the loss of 3.5 million jobs. In particular, he said that employers with heavy payroll expenses would be especially hard hit.

Hatch also raised the possibility that the play-or-pay mandate may encourage current employers to drop private insurance coverage and pay into the government program.

Preventive Care

Preventive care for pregnant women and children must be a key aspect of health reform legislation, representatives of children's health organizations told the committee June 12.

Universal provision of high-quality medical care beginning in the first trimester of pregnancy, and continuing for the infant after birth, could reduce the risk of infant mortality and morbidity by one-quarter, according to Reed Tuckson, senior vice president for programs at the March of Dimes Birth Defects Foundation. In prepared remarks, Tuckson noted that the United States ranked 19th among nations in infant survival.

Birth defects, low birthweight, and prematurity are the leading causes of infant death, Tuckson stated. Over 100,000 of the 400,000 disabling conditions that result from conditions of birth could be prevented through enhanced access to comprehensive maternal and infant health services, he said.

While S 1227 is to be phased in over a five-year period, children come first, Kennedy said in his opening remarks. "[T]he very first phase of the program will guarantee affordable health insurance to every child," he said.

The American Academy of Pediatrics is generally supportive of S 1227, but believes that certain preventive services included in a proposed federal-state health program also should be included in the basic benefits package that is another component of the bill, according to testimony given by Antoinette Parisi Eaton, president of the American Academy of Pediatrics.

Preventive Services

The proposed federal-state program, known as Americare, would include early and periodic screening, diagnosis, and treatment for beneficiaries -- encompassing such services as assessments of health, developmental and nutritional status, appropriate immunizations, and vision, hearing, and dental screens, Eaton noted. However, these services are not part of the employee benefits package included in S 1227. These services are important to effective preventive care for children and youth at all income levels, she said.

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Kennedy noted that "consistent with current business practices, most preventive services are not covered [in the basic benefit package], but coverage is required for prenatal care and well-baby and well-child care."

The committee also heard testimony from parents of children with disabilities or conditions whose special health care needs are not covered by insurance. Pam Punteney of Omaha, Neb., said her son has slipped through the cracks of both the military and commercial insurance systems.

Punteney's family was covered by the Civilian Health and Medical Program of the Uniformed Services (CHAMPUS) while her husband, Richard Punteney, served in the Persian Gulf. During this period Punteney's son was struck by a car. Richard Punteney has since returned to the United States and the family's CHAMPUS coverage expires June 27. Meanwhile, no commercial insurer will cover health care services related to Punteney's son's accident. "We have learned the hard way that a person can't move freely from policy to policy in the current insurance climate," she said.

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Copyright (c) 1991 The New York Times Company
The New York Times

June 15, 1991, Saturday, Late Edition - Final

SECTION: Section 1; Page 22; Column 1; Editorial Desk

LENGTH: 555 words

HEADLINE: Half a Medical Plan Is Better . . .

BODY:

President Bush spoke on domestic policy this week without even mentioning the crisis in health care. But at least the Senate took notice, with hearings on a Democratic plan to provide medical insurance for all Americans. Well, make that half a plan; it would achieve universal coverage, but only waves at spiraling costs.

Senator Mitchell, the majority leader, and the other sponsors thus duck a stark truth: Effective reform will require sacrifice by doctors and patients. But even half a plan beats no plan, which is what the Bush Administration offers.

The bill adopts a play-or-pay system whereby employers provide basic medical insurance or else pay a tax to enroll workers in a public program called AmeriCare. For a fee based on income, AmeriCare would cover anyone otherwise uninsured, including those now on Medicaid.

Pay-or-play puts the insurance burden on employers. It would force them to compensate by ratcheting down wages -- a disguised tax -- or laying off workers. Yet pay-or-play is defensible because it would cover 30 million uninsured Americans by building upon existing institutions.

Less defensible is the attempt to control costs with a dizzying array of toothless provisions. A board made up of payers and providers would negotiate spending targets and fees. But nothing would require agreement or impose sanctions. So much for tough cost control.

The bill's major flaw is to preserve, even protect, the principal reason for rising medical costs -- the prevailing fee-for-service system. Doctors are rewarded for providing lots of services, even if unnecessary, to patients who don't mind because they pay only a fraction of the bill. And because patients choose their doctors, insurers are unable to negotiate treatment and fees. The upshot: a system spinning out of control.

The best answer is managed care. A sponsor, perhaps a large employer or public agency, directs enrollees to a designated group of doctors and hospitals. The sponsor negotiates treatment practices and monitors quality. Because sponsors wield tremendous market power, they are able to negotiate premiums below fee-for-service plans.

Managed care restricts choice. But it's the only plan that has proved it can provide quality care in the U.S. at reasonable cost. Mr. Mitchell's bill would encourage managed care, but ineffectively. The AmeriCare program, for example, was not designed as managed care.

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Another key to cost control is to make patients cost-conscious. A cap on tax-deductible insurance premiums, for example, would give consumers an incentive to choose cost-effective managed care over fee-for-service plans. This, too, is missing from the bill.

Nevertheless, the bill contains many thoughtful reforms. Treatment guidelines would be developed to insure quality care and eliminate the need for wasteful tests as a defense against frivolous malpractice suits. Insurance companies would be prevented from extracting high premiums from the chronically ill. And small businesses would be encouraged to join forces to negotiate insurance contracts.

These are important ideas. But without taking on the payment system, or capping tax subsidies, they won't get to the core of the problem. Before Mr. Mitchell's bill can become the last word on health care reform, it will have to find some guts.

TYPE: Editorial

SUBJECT: MEDICINE AND HEALTH; EDITORIALS; HEALTH INSURANCE; RATES

NAME: BUSH, GEORGE (PRES)

GEOGRAPHIC: UNITED STATES

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CONGRESSIONAL QUARTERLY

Weekly Report

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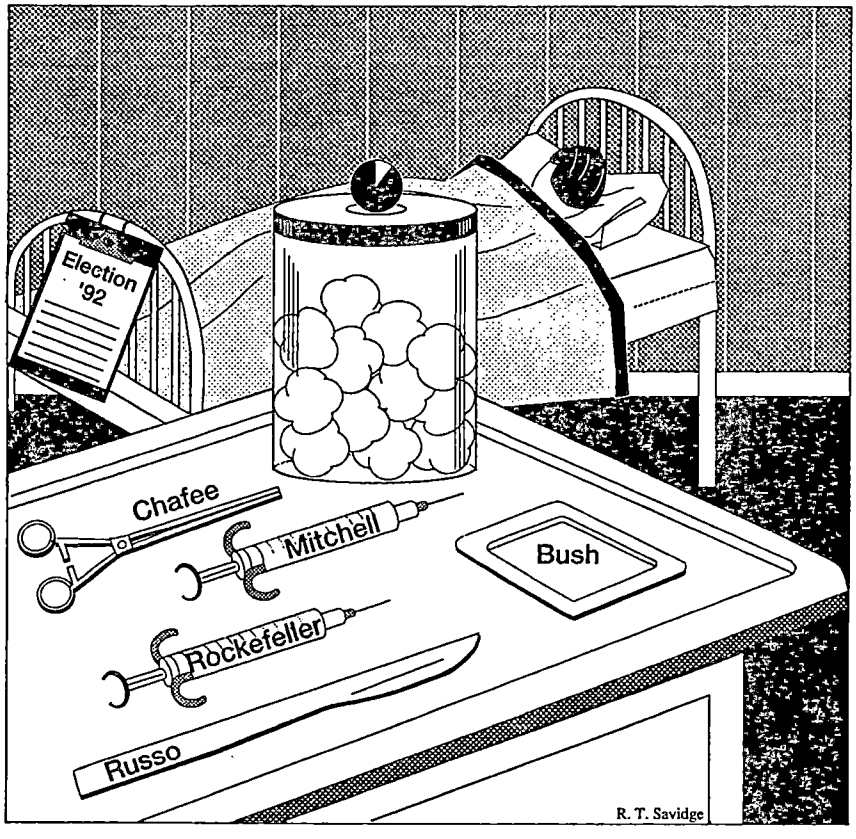
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Political Emergency

Democrats, GOP Rush To Prescribe Cures To Soothe Public Ire Over Health Care



CQ November 16, 1991 • Volume 49, No. 46 • Pages 3349-3424

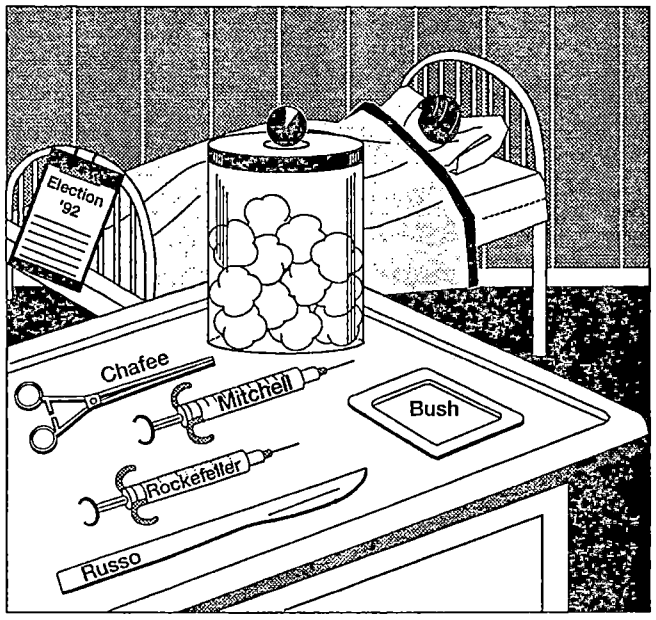
COVER STORY

Growing Health-Care Debate Widens Partisan Divisions

Voters may have spoken on need to overhaul system, but politicians differ over how far to go

A day before Pennsylvania's special Senate election, goes the story on Capitol Hill, a health-care overhaul proposal on which Senate Republicans had been working for more than a year had two cosponsors: author John H. Chafee, R.I., and Minority Leader Bob Dole, Kan. But the day after Democrat Harris Wofford pulled an upset with a platform calling for national health insurance, the number of cosponsors ballooned to 20.

Chafee denies the story but concedes that Wofford's win "certainly didn't do us any harm" in garnering cosponsors. And just the fact that people are telling it illustrates how the outcome of the Pennsylvania election has altered the dynamic of health-care reform in Congress.



ROBERT T. SAVIDGE

Efforts to revamp the nation's $660-billion-and-growing health system have been perking along all year, but action has been confined mostly to a dozen or so Hill health experts trying to convince confused and reluctant colleagues that an overhaul could be good policy and good politics. Still, no one was sure how such a complicated and potentially divisive issue might play with voters.

But now, the voters, at least in one large state, seem to have sent a message: Do something about the health system, or else.

"The American people signaled, I think particularly in the Pennsylvania election, that they want some attention to this problem," said House Speaker Thomas S. Foley, D-Wash., on Nov. 13. "It's the one that's causing more anxiety for their economic future than any other."

By Julie Rovner

But the health-care issue's rise from a "might" to a "must" on the congressional agenda brings political risks as well as opportunities, particularly as members struggle with such controversial details as who will foot the bill.

Wofford's election, said Sen. Dave Durenberger, R-Minn., "confirmed the diagnosis we've suspected for years. The health system is sick. But what it did not do was prescribe the cure."

Since the Pennsylvania election jump-started the health debate:

- Chafee and a dozen colleagues on Nov. 7 unveiled the long-awaited Senate GOP plan. The bill (S 1936) depends largely on incentives to encourage employers to offer workers insurance. It emphasizes preventive health care and would overhaul the handling of malpractice claims.
- The National Leadership Coalition on Health Care Reform, whose membership includes business and labor groups as well as former Presidents Gerald R. Ford and Jimmy Carter, on Nov. 12 announced a plan that would impose a "play or pay" system. The plan would require employers to provide workers and their dependents with health insurance or else pay into a fund from which insurance would be provided. Play-or-pay is also the central concept in the Senate Democratic leadership's bill (S 1227) introduced in June by Majority Leader George J. Mitchell of Maine. Although the coalition's plan is a second-generation version of a proposal put together by many of the same people in 1989, in the new health-reform environment the announcement led network newscasts and The Washington Post. *(Weekly Report, pp. 1507, 419)*
- The House Democratic Caucus on Nov. 14 unanimously approved a resolution calling for "comprehensive national health insurance legislation" that would guarantee insurance coverage to all Americans and contain health-care costs. The move marked the first step toward resolving a feud between House Democrats who support the play-or-pay approach and those who prefer a "single payer" plan such as Canada's, in which the government pays all the nation's health bills.
- Mitchell announced Nov. 13 that the Senate Democratic Policy Committee would sponsor field hearings between Dec. 9 and 13 to highlight the health-care issue. The "road show," as it has been dubbed, is to travel to Detroit, Cleveland, Denver, Atlanta and Tampa, Fla.
- President Bush, who has yet to follow up on promises in his 1990 and 1991 State of the Union addresses to study the issue, is strongly hinting that he will soon make public a plan of his own. "I'd like to have a compre-

The Tide of History Turns Again . . .

On the surface, the political pressures today are similar to those that stirred Washington a generation ago. Americans talk of mortgaging homes and farms, fighting off bankruptcy or being unable to send children to college, all because of crushing medical bills.

Lawmakers, in turn, talk of plans to radically expand the government's role in guaranteeing health care for Americans.

But the political realities are different.

In 1965, President Lyndon B. Johnson was fresh off a landslide victory, with an expanding economy and a brute determination to pass his Great Society legislation. Even so, he focused his health-care attention on programs for two groups of Americans — Medicare for the elderly and Medicaid for the poor. And still, he had to compromise with a reluctant Congress and battle a hostile physicians' lobby. "It took all his horses," recalls Joseph A. Califano Jr., one of Johnson's top aides.



NATIONAL ARCHIVES

Truman rode the health issue to victory in 1948.

Now, Harris Wofford's stunning upset in the Nov. 5 Pennsylvania Senate election — and his middle-class appeal for national health insurance — has ignited a new political fire for broad reform. But this time, pivotal differences make congressional action more confusing.

Unlike Johnson, President Bush is headed into an election with his public approval rating falling. He faces a Congress controlled by the opposition party and he has yet to spell out a plan.

Moreover, Congress approaches the debate chastened by its last experience with a major health policy bill — the 1988 law to provide insurance for Americans who suffer catastrophic medical costs. Faced with voter outrage over the surtax to pay for it, Congess repealed it a year later.

That embarrassing turnabout illustrated the difficulty of translating political rhetoric into public policy, particularly when someone has to pick up the tab.

Over 75 years, complexity has been the one constant in health-care debate. The terms have shifted in response to consumer needs, and the coalitions for change have realigned, depending on who bears the cost. "There's always been a permissive consensus on the concepts," notes Theodore Marmor, a political science professor at Yale University. "But the more details people have, the less they support any program."

Roots of the Debate

Washington adopted its first government health insurance program in 1798, for merchant marine sailors who contributed a few cents a month to pay for hospital care provided by a marine hospital. But it was not until the early 20th century that the idea of mandating health insurance for the general public became an issue.

Doctors and lawyers argued for national health insurance. The 1915 recommendation of the American Association for Labor Legislation, a group of lawyers, academics and other professionals, prompted the first serious debate. Their proposal gained momentum in 1917, when the American Medical Association's (AMA) House of Delegates voted for a government health insurance program.

Labor leaders, among them Samuel Gompers, criticized the concept, arguing that national insurance would result in government control over the working class. But it was not labor that scuttled the idea; it was the anger of an important lobby — burial insurers, who complained that a proposed burial benefit would undercut a thriving private industry. "It was a simple tactical error, and tactics have always mattered," says Paul Starr, a sociology professor at Princeton University.

The idea remained dormant until the 1930s. As the nation reeled under the Great Depression, the coalition backing national health insurance reform had reversed itself. Then, as in the Medicare fight, the AMA stood in opposition, labor in support.

In 1934, President Franklin D. Roosevelt's Committee on Economic Security considered compulsory health insurance. But word that the panel was studying the matter "was responsible for so many telegrams to members of Congress that the entire Social Security program seemed endangered," Edwin Witte, the committee's executive director, told a historian. Roosevelt dropped the idea.

The national health service debate was revived less than a decade later, as the country called up men to serve in World War II. Nearly one-third of those between the ages 18 and 37 were found physically or mentally unfit. In response, the first comprehensive national health insurance bill was introduced June 4, 1943, by Sens. Robert F. Wagner, D-N.Y., and James E. Murray, D-Mont., and Rep. John D. Dingell Sr., D-Mich.

"Dad's bill was crafted with the help of the [Roosevelt] administration," says Dingell's son, chairman of the House Energy and Commerce Committee, who has reintroduced the bill in every Congress since he succeeded his father in 1955. "It's still the best national health insurance approach around."

In words that Pennsylvania's Wofford would echo nearly five decades later, Roosevelt included in his 1944 State of the Union address an "economic bill of rights" incorporating the "right to adequate medical care and the opportunity to achieve and enjoy good health."

But it was his successor, Harry S Truman, who made health care a political priority. "We should resolve now that the health of this nation is a national concern; that

. . . On National Health Insurance Ideas

financial barriers in the way of attaining health shall be removed; that the health of all its citizens deserves the help of all the nation," said Truman on Nov. 19, 1945.

Truman rode the issue in his narrow 1948 victory, and the Wagner-Murray-Dingell bill got its first hearing in 1949. But as the Cold War became a fact of American life, the AMA's dire warnings that the proposal amounted to "socialized medicine" reverberated across the country. After a few liberal senators campaigned on the issue and lost in 1950, Democrats dropped the idea.

Scaling Back to Medicare

The political atmosphere had changed. With the AMA's power proved and the new Eisenhower administration resisting national health insurance, Democrats scaled back their ambitious health-care plans. The idea of hospital insurance for the aged began to take hold, and the first bill toward that end was introduced in 1952.

"At that time, there were no retiree health plans, and the pressure for us to act came from the middle-aged, middle-class who were beginning to pay the bills for their parents," says Califano.

Dwight D. Eisenhower responded by launching the idea of catastrophic coverage for the low-income elderly, while Democrats continued to push broader insurance for the aged. Republicans and Democrats divided as John F. Kennedy made health insurance for the elderly an important piece of his 1960 presidential campaign.

In office, Kennedy tried to rally support with stories of people mortgaging their homes to pay for their parents' health care, and in 1962, he tried to personalize the issue for Congress. "I talked to a member of Congress from my own state a week ago," Kennedy said, "who told me he was going to send his daughter away to school but because his father had been sick for two years he could not do it. And congressmen are paid $22,500 a year — and that's more than most people get."

However, Kennedy struggled against formidable resistance within his own party: conservative Southerners led by Ways and Means Chairman Wilbur D. Mills of Arkansas. Congress took no action during Kennedy's administration.

In 1964, Johnson took the issue to the nation in his presidential campaign and came back with a mandate for action.

Johnson agreed to rework a funding formula for coverage for the poor that had been directing the overwhelming majority of funds to large states. That done, Congress enacted the 1965 Medicare-Medicaid bill, a jewel in Johnson's Great Society agenda.

A Call for Broader Coverage

Inflation in the 1970s revived calls for broader national health coverage. Presidents Richard M. Nixon and Jimmy Carter supported some form of broad health insurance reform, but the idea had no real champion and faced continued animus from the AMA and business.

The issue briefly took center stage as Sen. Edward M. Kennedy, D-Mass., challenged Carter over it. But as Kennedy prepared to enter the presidential primaries in 1980, the substantive debate was lost in the political tug between the two men. The election that year of Ronald Reagan, a longtime opponent of big government, temporarily ended talk of major changes.

The pinch on the middle class later forced Reagan to reconsider his position, however. In 1986, he called for a study on "how the private sector and government can work together to address the problems of affordable insurance for those whose life savings would otherwise be threatened when catastrophic illness strikes."

Over 18 months, Congress crafted legislation that went beyond Reagan's mandate to create the largest expansion of Medicare coverage since its inception. Reagan was presented the bill just weeks before the 1988 presidential nominating conventions, and he not only signed it, but hailed it as a bill that would "remove a terrible threat from the lives of elderly and disabled Americans." It wasn't long, however, before support for the program unraveled, as senior citizens became outraged over the program's cost. The bill was repealed in 1989.

Now the political climate appears to have shifted yet again. Part of the business community — squeezed by the high cost of health insurance premiums — is on board. And Harris Wofford's victory proved that middle-class voters are ready to demand action. "The question today is not whether we are going to have national insurance," says Professor Marmor. "The question is whether it's going to be any good."

—Beth Donovan

Quotables

"The best health facilities and the finest doctors in the world are not much help to the people who cannot afford to use them."

—President Harry S Truman, Oct. 15, 1948

"I will propose a program to insure that no American family will be prevented from obtaining basic medical care by inability to pay."

—President Richard M. Nixon, Jan. 22, 1971. *The next month, he sent Congress a proposal requiring businesses to provide basic health insurance coverage to employees.*

"Whenever senators and representatives catch a little cold, the Capitol physician will see them immediately, treat them promptly and fill a prescription on the spot. . . . If health insurance is good enough for the president, vice president and the Congress of the United States, then it is good enough for . . . every family in America."

—Sen. Edward M. Kennedy, D-Mass., Aug. 12, 1980

"I am committed to bring the staggering costs of health care under control."

—President Bush, Jan. 31, 1990

"Health care isn't a matter of privilege but a fundamental human right."

—Sen. Harris Wofford, D-Pa., June 1, 1991

hensive health-care plan that I can vigorously take to the American people," Bush told reporters in Rome on Nov. 8, saying it could come before next year's election.

Partisan Divisions

Since the beginning of the year, members of Congress have introduced more than three dozen health-care reform proposals. Wofford's win has also hastened the boiling down of those plans into Democratic and Republican camps.

"The race is now between the parties to flesh out some of the specifics," said Rep. Ron Wyden, D-Ore.

Democrats are emphasizing universal coverage — the guarantee that every American receive health insurance, whether the mechanism be play-or-pay or single payer.

"To assure that every American can exercise his or her right to affordable health care, we must require that health insurance is provided," said Mitchell on the Senate floor Nov. 13.

Republicans, by contrast, stress that the current system is good and only requires marginal fixing up.

"Our system has much to commend it," House Minority Leader Robert H. Michel, R-Ill., testified before the Ways and Means Committee in October. "We ought to seek solutions that build on what we have."

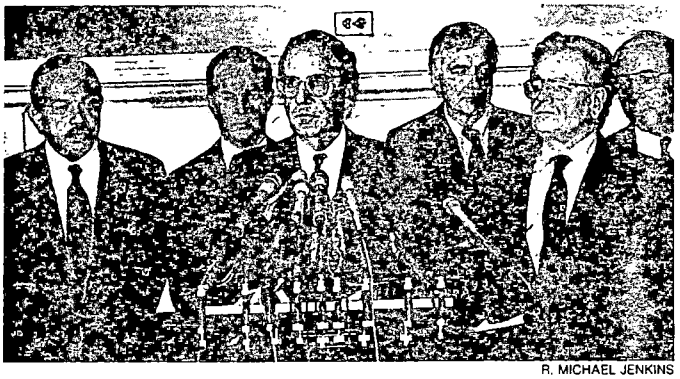
That is the basis of the GOP senators' plan, which Chafee said "builds on the good in our system, reforms the bad and encourages innovation in both the private and public sectors."

The proposal's centerpiece would provide tax incentives to encourage individuals and businesses who now cannot deduct health insurance expenses to buy insurance.

The measure also seeks to make it easier and less expensive for small businesses to obtain insurance by encouraging them to form insurance-buying groups and by requiring insurance companies to make small-business policies available and limiting rate increases.

The bill also emphasizes preventive health care, by both providing tax credits and upping authorizations for existing programs.

Finally, the plan gives states more opportunity to experiment with health reform by making it easier to "waive" federal rules and by allowing them to establish a program to provide health coverage to low-income, uninsured individuals not otherwise eligible for Medicaid, the joint federal-state health program for the poor.



R. MICHAEL JENKINS



Democrats, led by Sen. Mitchell — with governors, above — are talking about mandating coverage. Republicans, led by Sen. Chafee, want to fine-tune the current system.

Like the Senate Democrats' plan, the GOP version does not include proposals to cover the estimated $150 billion cost over five years.

Financing "is so controversial, no one party can step forward on it," said Chafee. "It's got to be a consensus."

That decision eliminated a proposal Republicans floated earlier this summer that would have capped the amount employers can deduct for health insurance premiums for their workers. Such deductions currently are unlimited.

"To say that's controversial would understate it," Chafee said.

House Republicans, however, are still grappling with the touchy financing question as they put the finishing touches on their plan.

But some House Republicans are worried that they may be left behind if they don't act soon.

"We've spent a lot of time dotting the i's and crossing the t's, and I'm not sure how necessary that is politically," said Fred Grandy, R-Iowa, a member of a House health task force. Wofford just won an election by saying 'I'm for health care, details to follow.' "

Do or Die

For House Democrats, action has been held up by the dispute about whether to proceed with a play-or-pay plan similar to Mitchell's or to line up behind a government-paid plan such as one (HR 1300) Marty Russo, D-Ill., introduced.

"Sometimes I think the play-or-pay people hate the single-payer people even more than they hate the current system," said one exasperated House leadership aide.

But the urgency of the issue — and the impending adjournment — appears to be forcing a compromise under which Democrats would endorse play-or-pay as a first step toward a single-payer system.

"It's an orderly way to move," said Henry A. Waxman, D-Calif., whose own proposal (HR 2535) embodies the play-or-pay approach, but only because he says it is more politically possible. "The advantage of play-or-pay is it requires fewer federal dollars up front and disrupts the health-care system less."

House Democratic leaders said after the caucus meeting Nov. 14 that they expected to have a consensus bill ready early in 1992.

Lawmakers from both parties acknowledge that there are dangers in developing the details, both because the issue is complicated and because reform, by definition, will outrage at least some entrenched interest groups. "We can't just wave some magic wand and make everything hunky-dory," said Chafee.

Still, said Sen. John D. Rockefeller IV, D-W.Va., "I'd much rather be in the minefield than out of the war." Added Rockefeller, who pressed hard on the issue last summer while exploring a bid for the presidency, "health care is an open door" for the Democrats. "If we botch it up by walking through it, that's our problem."

But others fear a presidential election year might not be the right time.

If members are not careful, warned Rep. Brian Donnelly, D-Mass., "we could charge ahead in this politically charged atmosphere and get into a bidding war that would make the 1981 tax bill look like reasonable policy." He was referring to congressional ac-

Talking Points

Members have introduced dozens of legislative proposals for overhauling the nation's health-care system, ranging from cosmetic changes to restructuring. Most of the plans share at least some general concepts:

Cost Containment

The Holy Grail of health-system reform is slowing the rise of medical costs, which have been climbing at double-digit rates for most of the last decade. No one knows for sure how to accomplish the broad goal, and sponsors of various bills apply the cost-containment label to any provision they think might save money.

For example, the Senate Democratic leadership's bill (S 1227), introduced by Majority Leader George J. Mitchell, D-Maine, would create a board similar to the Federal Reserve. It would set national health-care spending goals and organize negotiations between those who pay for health care, such as insurance companies, and those who provide it, such as doctors and hospitals.

Rep. Marty Russo, D-Ill., and other sponsors of bills calling for a single government-run health system say money would be saved by eliminating duplicative paperwork.

And the Senate Republicans' proposal (S 1936), introduced by John H. Chafee, R.I., lists under cost-containment its proposals to reshape the medical malpractice system, increase access to preventive care services, and broaden "managed health care."

Mandates/Tax Credits

After containing costs, the goal of virtually all of the overhaul plans is to expand access to health care for the estimated 34 million Americans who lack health insurance.

Most of the Democratic bills include some sort of required coverage, on the theory that that is the only way to guarantee that everyone is included. Under the "play or pay" schemes included in several of the plans, most notably those of Senate Democrats, employers would have to provide workers and their dependents with coverage or pay into a fund from which insurance coverage would be provided. The most sweeping mandate, in Russo's bill (HR 1300), would require the government to insure everyone for health care, as Canada does.

GOP plans, by contrast, eschew mandates as counterproductive, arguing that they would drive some employers out of business. Instead, Republicans prefer incentives to expand health insurance. Most of these plans, the Senate's among them, lean heavily toward providing tax credits and deductions for individuals and businesses to help offset insurance costs.

Malpractice Reform

Just about all the major plans, Democratic and Republican, seek to overhaul the medical liability system, and the Bush administration offered its own proposal in May. Studies have shown that "defensive medicine," such as unnecessary tests and lab work ordered by doctors who fear lawsuits, is driving up costs. Also, the physicians who are sued most often for malpractice frequently are not guilty, while many negligent doctors never get sued, studies suggest.



R. MICHAEL JENKINS

A clinic volunteer draws a blood sample from a patient.

The Bush administration's proposal and the Senate Republicans' bill would cap non-economic damages, such as those for "pain and suffering," arising from medical negligence. Both those plans, the Senate Democrats' plan, and several other free-standing bills also would encourage states to test ways to settle disputes out of court.

Prevention

Policy-makers agree that more and better preventive care, such as immunizations for children and prenatal examinations, can help hold down future health-care costs. Health and Human Services Secretary Louis W. Sullivan emphasizes that getting Americans to eat a healthy diet, exercise more, and reduce smoking and drinking can avert costly illnesses.

Most of the proposals that mandate coverage include language to ensure that preventive services are part of any insurance package. The Senate Republican plan, which has no mandate, would increase the authorizations for two existing programs — Community Health Centers and the National Health Service Corps — that currently provide primary and preventive care in medically underserved areas.

Managed Care

Finally, most of the overhaul plans give a nod to making "managed care" more available, long a goal of the Reagan and Bush administrations. These plans include health maintenance organizations, which charge a flat fee for all services, and preferred provider organization, which offer patients lower fees if they see certain doctors who have agreed to charge less. Managed-care plans seek to contain costs by providing patients with a single point of entry to the health-care system and restricting access to specialists and hospitals.

—Julie Rovner

tion on President Ronald Reagan's tax-cut proposal, when Democrats and Republicans competed over who could be most generous to taxpayers — ending with a bill that Democrats blame for today's huge federal deficits.

Without what are bound to be unpopular cost-containment proposals, said Donnelly, "you have a disaster of monumental proportions."

But the atmosphere could make inaction just as dangerous, say others. "I think it will boomerang if people play around with it as an issue for too long," said Sen. Paul Wellstone, D-Minn., who pushed universal health care in his own 1990 upset of Republican Sen. Rudy Boschwitz.

Wellstone fears Wofford's success at calling for health-care reform without giving details could become "the functional equivalent of kissing babies. Everyone will be for it until we get to the specifics."

Short-Term Solutions

Privately, just about everyone concedes that the most likely outcome before the election will be an incremental bill similar to legislation introduced in October by Lloyd Bentsen, D-Texas, and Dan Rostenkowski, D-Ill. They are the chairmen of the Senate Finance and the House Ways and Means committees, respectively.

Like the Senate Republican plan, the bills (S 1872, HR 3626) try to make health insurance more available and affordable for small businesses. They also increase the tax deductions for self-employed individuals and small businesses. The bills also would expand preventive services available under Medicare, the federal health insurance program for the elderly and disabled, and create a commission to advise Congress and the president on strategies for reducing health-care costs.

An overhaul, Bentsen told reporters in October, will take time "and in the meantime, a lot of people are going to suffer." He said his bill addresses "things we can do now, not things that will block more major reform later."

That is a strategy with which many Republicans agree. Congress should "do whatever we can do without waiting for utopia and perfection" said Rep. Bill Gradison, R-Ohio, at an October Ways and Means hearing.

Concurred Grandy, "All of us are committed to incremental reform before the election."

Those who want more can just point to Pennsylvania. Said Rockefeller: "A punitive public is our best ally." ■

HEALTH/EDUCATION

Two Similar Bills Aim at Loans For Medical Education

Legislation to reauthorize education loans and medical training services for health professionals moved forward in both the House and Senate the week of Nov. 11.

The House on Nov. 12 passed a bill (HR 3508) by voice vote to revise and extend existing programs for appropriations of up to $2 billion through fiscal 1994. In addition, the bill would authorize government guarantees in fiscal 1992 on up to $365 million in loans to students under the Health Education Assistance Loan (HEAL) program.

The next day, the Senate Labor and Human Resources Committee voted 17-0 to approve a similar measure (S 1933) that would authorize nearly $3 billion for the programs through fiscal 1996. That bill would authorize $400 million in student loan guarantees.

Both measures include new steps to cut down on the high default rate on these loans. One provision would change the way the government assesses fees on new loans.

Under current law, the same loan origination fee is charged to all who request loans under the HEAL program. The fees go into a pool that is supposed to cover defaults.

The House bill would allow the government to charge a loan origination fee based on the number of defaults for students in each field (podiatry vs. chiropractic, for example). The more defaults in a particular field, the higher the origination fee.

The Senate bill would do the same. It would also prohibit any loans to institutions with default rates of 25 percent or more. The Senate bill would cut the origination fee in half for borrowers who got a creditworthy co-signer.

In addition, the Senate bill would authorize $1 million in demonstration grants to experiment with direct government loans. The program would involve 20 schools with low default rates, and the schools would be responsible for all loan-servicing costs.

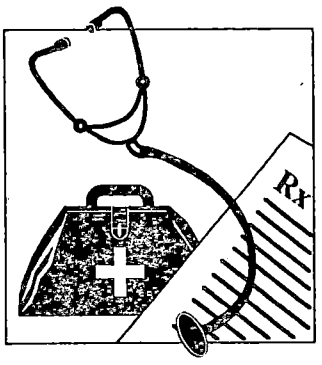
This is in response to a proposal floated earlier in the year by the Bush administration to scrap the loan-guarantee system and provide loans directly to needy students. The administration has since backed away from that idea, and it agreed to support the guarantees after sponsors revised their bills to crack down on defaults.

Both bills would add social workers and therapists to a program that educates health-care personnel on AIDS. The House bill would authorize $17 million for this program in fiscal 1992; the Senate would authorize $21 million.

Labor Committee Chairman Edward M. Kennedy, D-Mass., sponsor of S 1933, hopes to get it to the Senate floor before Congress adjourns.

Kennedy said he was pleased with the unanimous support for the bill, which moved through the committee without hearings or debate. "I was all ready to hold a series of hearings," he said. ■

By Elizabeth A. Palmer



BOXSCORE

Bills: HR 3508, S 1933 — Medical recruitment and training programs.

Latest action: House floor passage, voice vote, Nov. 12; Senate Labor Committee approval, 17-0, Nov. 13.

Next likely action: Senate floor.

Background: The measures would reauthorize two titles of the Public Health Service Act that provide financial assistance for medical education and training.

Reference: House committee approval, Weekly Report, p. 2960.

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6TH STORY of Level 1 printed in FULL format.

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SECTION: Section A; Page 19; Column 1; Editorial Desk

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HEADLINE: OBSERVER;
Dead Brains Society

BYLINE: By RUSSELL BAKER

BODY:

It's obvious the United States is ready for what used to be called socialized medicine. The Democrats ought to be leading the agitation for it and the fact that they aren't is further evidence suggesting their party is brain dead.

If it weren't, Democrats would surely be beating the feathers and dust out of George Bush for doing nothing while the country's rickety private health-insurance system totters toward collapse.

Statistics illuminate the political wealth waiting to be mined from the health-care issue: 33 million Americans with no health-insurance coverage at all, millions more afraid to move into better jobs for fear of losing their coverage and ever more insurers confining coverage to the healthiest, which is to say, people who least need it.

More: There's the skyrocketing price of insurance for people who can't get group coverage. For people who can, there are constantly rising costs or constantly shrinking benefits, sometimes both simultaneously.

The anecdotal evidence that this is a dynamite political issue is also compelling. High on the list of Great American Nightmares is catastrophic illness, so called not only because it is hard on body and soul but also because it wreaks catastrophe on a family's financial health.

Even big corporations are starting to cry "Mercy!" Not long ago A.T.& T. took a strike when it tried to lighten the ever-swelling burden of its employees' health plan. Wherever a new labor contract is being negotiated this spring, there you will find management trying to reduce its commitment to employees' health-care programs.

Large corporations are big mules in Washington. When they hurt, Congress and Presidents weep for their suffering, and relief is soon on the way. On health, however, even big business can't expect much from President Bush. Health care is just not a Republican issue.

Democrats' refusal to make it their issue shows how desperately they now need a risk-taking prophet to bring the party back from the dead as Barry Goldwater brought the Republican Party back from the other side in the early 1960's.

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Goldwater did the trick by standing for something. "Conservatism," he called it. It may have looked more like old-fashioned, radical Western populism, but whatever it was, it re-introduced ideology into a politics stultified by people who stood mainly for doing only what was necessary to get elected.

This was called "pragmatism," and Goldwater's suggestion that people in politics should stand for something was at first treated as lunacy. Goldwater's 1964 Presidential campaign slogan -- "In your heart you know he's right" -- was often edited by Democratic vandals to read, "In your heart you know he's nuts."

The Democrats now need just such a nut. Goldwater took a brutal beating from Lyndon Johnson in 1964, and in the process started his "conservatives" toward domination of American politics.

The 1992 election ought to be the natural opportunity for Democrats to renew their acquaintance with ideas about governing a country with staggering problems. If reports of President Bush's invincibility are not exaggerated, what an opportunity for some live Democrat to start calling the brethren up from the grave.

A party with nothing to lose can afford the luxury of being a party of ideas. After all these years Democrats could finally stand for something vital. For a national health-care program, for instance, even though it sounds daring and outrageous, having been long stigmatized by the medical lobby as "socialized medicine."

A nation being bankrupted at the hospital might not be so easily scared by the bugaboo word "socialized." Anyhow there are ideas whose time will come, and it's surely better politics, if you're doomed to lose, to stand for those ideas than to try out-Bushing Bush, as Democrats commonly do nowadays, by denouncing taxes and debt.

What a pathetic case the Democrats are when they try to be more Republican than the Republicans, when they cringe before the gun lobby, boast of their hatred for taxes and turn their backs on America's squalor because confronting it might hurt them politically.

Democrats aren't needed for such things. The number of Republicans available for the work is more than adequate. Hey, you Demos, get out of that grave -- there's a whole country out here waiting for somebody to stand for something!

TYPE: Op-Ed

SUBJECT: MEDICINE AND HEALTH; HEALTH INSURANCE; ELECTION ISSUES

NAME: BAKER, RUSSELL

GEOGRAPHIC: UNITED STATES

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The Scary Politics of Health

Bush and Congress will duck the issue for '92

In a rare and near-unanimous consensus, Congress and the Bush administration have agreed on two things about the nation's health-care system: it's a disastrous failure, and nothing much will be done about it at least through next year.

To be sure, Democratic elders in the Senate have unveiled a sweeping bill that would extend health insurance to all Americans, including the more than 34 million who now have no coverage at all. And administration spokesmen, pleading for action, have warned that health-care costs will soak up 37 percent of the gross national product by the year 2030 if nothing is done to slow them down. But the Democratic bill can't pass without George Bush's support, and Bush is waiting for it to be shot down before he comes in with his own measure calling on state and local governments to find ways to cut medical costs. And while both parties hope to use health as an issue in next year's campaign, neither wants to pay the political price of dealing with it before the election. "It's the scariest politics of all," says Republican consultant Mike Murphy, "because there's no easy answer."



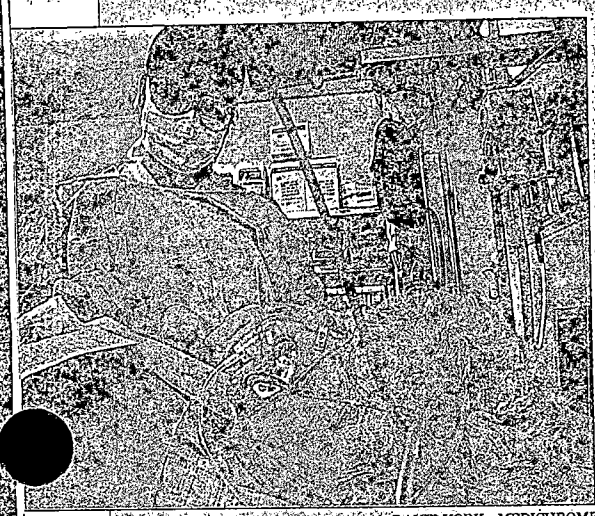
ROBERT FOX—IMPACT VISUALS

With any solution, an ox to be gored: *Union members demonstrate for a health-care bill*

Worst off are the uninsured. But there's no national will to help the have-nots, so Democrats who have long championed national health insurance to bring them into the tent are now trying instead to mobilize middle-class support. That means enlisting the 200 million Americans who have insurance but find it a bureaucratic nightmare or fear it may let them down in a real emergency. Once a week, West Virginia Democrat Bob Wise gives a one-minute speech on the House floor, telling a medical horror story: about a 2-year-old with cerebral palsy, for instance, who can't get therapy because his father's insurance plan doesn't cover pre-existing conditions, or a teenager with hemophilia whose father's insurance premiums have risen to $900 a month. "I'm putting faces in front of the statistics," Wise explains. "And I'm trying to puncture the myth that health is a problem of the poor and indigent."

The tactic is working. "It's becoming a middle-class issue because that's who's getting scared," says Ellen Goldstein, a private-pension lobbyist. But it works only up to a point: poll after poll shows that while voters consider health care a birthright, they are not willing to pay for it. "People want to hear about health care," Murphy explains, "but they don't like any of the messages—that it'll cost more or that doctors make too much money. There's no real applause line." Worse, any solution gores at least one big ox: doctors, hospitals, insurance companies, labor and big business all have their own angles on the issue. Lawmakers still flinch at the memory of the rebellion of the affluent elders two years ago when retirees were asked to pay part of the cost of catastrophic health care.

For all those hazards, lawmakers headed by Sen. Ted Kennedy have worked for two decades to pass a national-health bill. They have recruits these days in a band of younger legislators who sense the power of the issue. But it's a measure of the times that the Democratic bill proposed this month is remarkably similar to one that Kennedy scorned as inadequate when Richard Nixon offered it in 1971. The measure would force all U.S. businesses to "play or pay," either enrolling their employees in health-insurance plans or paying into an "AmeriCare" fund that would buy insurance for all Americans not enrolled in business plans. The scheme started as a bipartisan measure and



DAVID YORK—MEDICHROME

Bigger bills: *In an intensive-care unit*

The Costs of Care

Climbing medical charges are pricing many Americans out of the health-care market.

- The U.S. spent $671 billion on health care in 1990, twice the amount spent eight years ago.
- Canada's national health-care system spent $1,683 per capita in 1989 (9 percent of GNP); the U.S. spent $2,354 (12 percent of GNP).
- More than 34 million Americans have no health insurance.
- Of the uninsured, 85 percent are employed. About 27 percent of Hispanics are uninsured, 20 percent of blacks and 12 percent of whites.
- By one estimate, the U.S. will have 140,000 more physicians by the year 2000 than in 1986, adding $40 billion to the nation's health bill.

still has a surprising amount of qualified support from interest groups, including the National Association of Manufacturers. It would cost $6 billion in its first year, with funding largely unspecified, but its sponsors maintain it would save $78 billion in national health costs over five years.

For his part, George Bush made a campaign promise in 1988 to provide "access to health care for all Americans," and he has assigned Louis Sullivan, secretary of health and human services, to head a task force on how to do it. Sullivan, who says he's "a doctor first and a politician second," is eager to move. But when he went to the White House recently to report progress, he was told not to rush. The task force isn't expected to report for at least six months.

Sullivan is at odds with chief of staff John Sununu, whose polls show that health care is only the number-four priority for voters. Sununu argues that it's even less important to affluent Republicans, so why should Bush risk anything before he has to? "It's just too hot," says one of his aides. And Bush himself tends to side with Sununu, taking a minimalist approach in the belief that there's little the government can do in any case. As with other domestic matters (page 20), the president wants to throw the hot potato back to state and local officials.

'Avoiding it': So, while stalling on Sullivan's report, the White House strategy is to drop minor bills into the vacuum. Bush has already proposed a medical-malpractice reform, asking states to limit jury awards to $250,000 for pain and suffering and provide mediation for malpractice disputes. And he announced last week that he will ask Congress for $40 million next year for vaccines and clinics to immunize poor, inner-city children. "The idea is to make it look like we are tackling the health-care problem," says a disgruntled senior administration aide. "The reality is, we are avoiding it."

How the issue will play in political reality is anybody's guess. For West Virginia Sen. John D. (Jay) Rockefeller, sponsorship of the Democratic bill is a high-stakes gamble that could make or break his presidential hopes. Other Democrats, like Texas Sen. Lloyd Bentsen, worry about the bill's cost to small businesses. Republicans are quick to underscore that: Senate Minority Leader Bob Dole said the bill's sponsors are "looking for a new pocket to pick, and small business will fill that role." In the end, it will depend on how much fear of ruin Bob Wise and his colleagues can drum up. If the issue remains number four on Sununu's charts, the president has probably won his bet.

LARRY MARTZ *with* ELEANOR CLIFT *and* ANN MCDANIEL *in Washington*

Rocky for President?

With health care one of the nation's top pocketbook issues, Democrats want a candidate with a good bedside manner. West Virginia Sen. John H. (Jay) Rockefeller may be just what the spin doctor ordered. Rockefeller has name recognition, a towering physical presence, and the respect that comes from being one of the Senate's leading health-care advocates. "We have to act now to make sure you don't have to be a Rockefeller to afford decent health care in this country," he says. Rockefeller is among the latest undeclared candidates to be talked up as the Democratic standard-bearer in '92. Because of his expertise, he is better positioned than other presidential hopefuls to use health care as a metaphor for Bush's failure to address domestic problems. But Rockefeller has trouble translating his good intentions into crisp campaign speeches. He is a candidate in search of a sound bite.

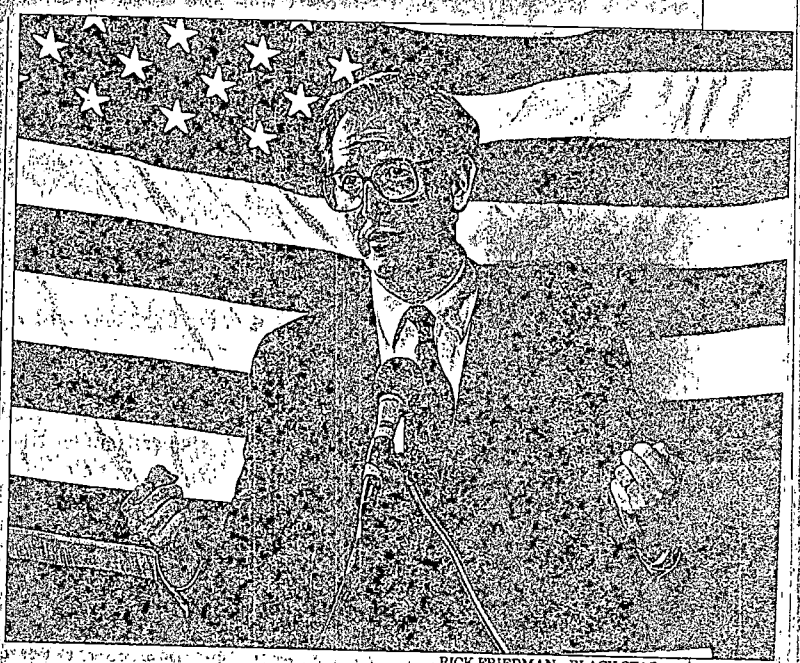
Rockefeller finds it hard to settle for the big-picture gloss. He is a cosponsor of the Democratic national health bill and, as chairman of the Pepper Commission, last year recommended a $66 billion overhaul of the health system. "The more serious matter is if there were nothing to reduce to a sound bite," he says. In the Senate, he is highly regarded for the zeal he brings to issues. Next week, he will report on the findings of a National Commission on Children. "I don't know if he's got *the* magic, or any magic," says Democratic consultant Michael McCurry. "But someone with a good basketful of ideas can go a long way in this race."

Rockefeller may find it hard to talk convincingly about the squeeze on middle-class voters. His wealth has been estimated at $100 million; his Washington home has 11 bathrooms and a treehouse that could pass for a starter home. But the Democrats have had good luck with the moneyed class (FDR, JFK). And Rockefeller has paid his dues. He was a VISTA volunteer in the 1960s, working with the poor in West Virginia. "I was a New Yorker; I had Washington license plates; I was 6 feet 6½ inches. I went around saying, 'I want to do good'."

Steel mills: The experience radicalized Rockefeller, a Republican and a nephew of Nelson Rockefeller, and prompted him to become a Democrat. He virtually bought his way into West Virginia politics, spending $12 million to be re-elected governor and $12 million on his 1984 Senate race. But it took decades before he convinced people he was motivated by more than ambition. "I'm the first Rockefeller in a thousand generations to put poor people to work and not make money at it," he once joked.

His two terms as governor aren't a compelling case for what he would do for the country. West Virginia's grinding poverty continues; what's left of its steel mills and coal mines symbolizes the past, not the future. But Rockefeller has overcome the suspicion of Yankee outsiders in one of the nation's poorest states. He says his forays around the country have been "exhilarating," and that he will decide whether to run this summer. He's not worried about raising money. "People get a kick out of writing a check to a Rockefeller," he says. But will anyone get a kick out of voting for him?

ELEANOR CLIFT



RICK FRIEDMAN—BLACK STAR

Trying to make health policy a winning issue: *Jay Rockefeller*

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27TH STORY of Level 1 printed in FULL format.

The Associated Press

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June 11, 1991, Tuesday, PM cycle

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LENGTH: 785 words

HEADLINE: WALTER MEARS: Health Insurance Is a Hot Issue, But Not at the White House

BYLINE: By WALTER R. MEARS, AP Special Correspondent

DATELINE: WASHINGTON

KEYWORD: What Health Care

BODY:

One of these election years, national health insurance is going to become an issue that can swing votes - but the White House seems to be wagering that it won't be 1992.

The administration is handling health care with a study and silence, except for President Bush's proposal to control spiraling medical malpractice costs by seeking to limit damage awards.

Bush will discuss his domestic agenda in a White House address Wednesday night, but an administration health care proposal is not expected to be part of it.

Democrats are pushing legislation to overhaul the whole system; while formulas vary, the objective is universal health insurance coverage. There are some Republican proposals along similar lines.

The measures come with titles that sound more like political slogans than laws: Health USA, Americare, Medicore, Health Care for All Americans. That may be appropriate on a subject that has been under political debate for decades.

It's been the topic of more talk than action, and may be again.

But let health care costs and needs continue unanswered, says Democratic Sen. John D. Rockefeller IV of West Virginia, and it will lead to economic collapse.

At current escalating rates, Rockefeller said, the $$765 billion that will be spent on health care this year will become $$2 trillion in the year 2000.

Rockefeller is exploring a bid for the Democratic presidential nomination, and health care is one of his issues. That amounts to a test case on the kind of complex problem that is hard to handle in the shorthand of a political

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campaign.

There's no question about the need to do something. The questions are what and when and how to pay for it with the government deep in the red and constrained by the spending limits of the 1990 budget deal, ceilings that last past the 1992 election.

The administration is considering health care proposals, but the topic is not high on the priority list.

That yields the subject to the Democrats, for whom it is not new business. They're been at it since Harry S. Truman's time. The Medicare program of health insurance for the elderly was a Truman administration proposal, but Lyndon B. Johnson was president before the bill became law, 20 years later. Truman also favored broader national health insurance, which didn't stand a chance in his time.

There have been Republican initiatives too. Richard M. Nixon proposed a national health insurance plan in 1971, with employers and workers to share the cost of basic coverage and the government to insure the poor. Democratic critics pointed to gaps and limits in the Nixon plan; Sen. Edward M. Kennedy of Massachusetts called it a formula for "poorhouse medicine."

But a debate once centered on health care for the needy now involves a problem that is reaching the middle class, as health costs and insurance rates soar, and employers cut back benefits or coverage.

And Kennedy is now co-sponsoring a plan that shares some features with that old Nixon proposal.

An estimated 34 million to 37 million Americans have no health insurance; more than 60 million are under-insured against the costs of major illness. The health care expenses of large U.S. businesses increased by nearly 22 percent in 1990. Health care costs equal more than 12 percent of the gross national product.

Proposals for change range from government health insurance to cover every American to voluntary systems with incentives to business to provide health coverage for their employees.

Senate Democratic leaders have proposed what Sen. George J. Mitchell, D-Maine., called a compromise, to guarantee coverage by requiring that employers provide insurance or pay an extra payroll tax to finance government health insurance.

That plan also would include medical cost controls, and government health insurance for the needy, at an estimated cost of $$6 billion, with no immediate proposal for raising the money.

That's one problem; another lies in Republican, conservative and small business opposition to the mandatory provision to insure or be taxed.

Still, after all the years of talk about health costs and insurance, something is going to happen, perhaps not immediately, but soon.

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The American Medical Association, a bastion of opposition to government involvement in health care in Truman's era and long after, now favors reform to guarantee that all Americans can get care. "An aura of inevitability is upon us," said an editorial in the AMA Journal.

"For millions of Americans ... health care is the pocketbook issue," said Rockefeller.

EDITOR'S NOTE - Walter R. Mears, vice president and columnist for The Associated Press, has reported on Washington and national politics for more than 25 years.

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5TH STORY of Level 1 printed in FULL format.

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August 5, 1991, Monday

SECTION: THE U.S.; Pg. 1

LENGTH: 819 words

HEADLINE: Rising Cost Of Health Care Could Hurt Bush

BYLINE: John Dillin, Staff writer of The Christian Science Monitor

DATELINE: WASHINGTON

KEYWORD: Stats

HIGHLIGHT:
Impact on family budgets concerns voters, pollsters say. QUESTION OF ACCESS

BODY:

EVERY time a Chrysler rolls off an assembly line in the United States, the cost includes at least $700 in health-care expenses for the company's employees.

Health-care costs at Chrysler Corporation, like thousands of other American businesses, are becoming an overwhelming burden that is driving up product prices, cutting profits, and threatening the prosperity of American firms and families.

Democrats say health care will be the most critical and controversial domestic issue of the 1990s. They say it could bring about a political showdown with George Bush that could put a Democrat back into the White House.

"Americans see major problems in the health-care system and want strong public solutions," says Celinda Lake, a Democratic pollster.

Republicans admit there is cause for concern. "The political future of the country is up for grabs here," says Doug Bailey, a Republican consultant. The domestic agenda, "led by health care, " is what the battle will be about, he predicts.

Thirty-five million people in the US have no health insurance, but Ms. Lake says the problem goes far beyond "compassion" for those uninsured Americans. Even people with good jobs and insurance sense that they are increasingly at risk, she says. Costs are escalating so fast that millions feel in danger.

Pollster Humphrey Taylor, president of Louis Harris and Associates Inc., agrees. "Fear of losing one's health insurance is now a major concern," he says.

"This is a pocketbook issue, not a compassion issue, for most voters," Lake says. As one voter recently told her in a focus group:

"Affordability is the biggest problem. If you speak of access, you should be able to afford it. Something could be there, available. But if you can't

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afford it, what good is it?"

The crisis that Lake and Mr. Taylor see in health care has sprung from several causes.

1. The middle class "squeeze." Ever since the 1970s, middle- class incomes have leveled off. Wives often must enter the workplace just to keep their families on the same economic level that a single breadwinner could attain in the 1950s and 1960s.

2. Job insecurity. Many sources of steady jobs - banks, auto companies, and steel mills, to name a few - have hit hard times. That has forced millions of people to take lower-paying jobs, often without fringe benefits like health insurance.

3. Soaring costs. Americans spent $604.1 billion on health care in 1989, or about $2,400 per person. That is double the per capita spending in many European countries where health-care access is guaranteed. Health-care inflation in the US has outpaced inflation in every other segment of the economy since 1981.

Lake explains the political fallout this way: "The 1992 election comes at a period when voters are worried about the economy, their standard of living, their children's economic future, and the general direction of the country. Today, rising prices are voters' top economic concern ... and the cost of health is central to those concerns."

The political question is: Can Democrats agree on a plan to solve the problem? Or will the Republicans co-opt them?

There are many competing ideas, ranging from the nationalization of health care to tinkering with the present system.

A number of leading senators, including majority leader George Mitchell of Maine, John D. Rockefeller IV of West Virginia, Edward Kennedy of Massachusetts, and Donald Riegle of Michigan, introduced the principal Democratic proposal June 5.

Senator Mitchell noted at the time: "We must find a way to bring health-care costs under control or we risk adding millions more to the rolls of the uninsured and ultimately face a total collapse of the health-care system."

The heart of their proposal is "play or pay." Employers would be forced either to provide health insurance or to pay a tax that would go into a fund known as AmeriCare. Those not covered by employers would have access to AmeriCare coverage.

The bill would also create the Federal Health Expenditure Board, which would set spending goals to hold down costs.

The American Medical Association supports a plan that would require employers to provide health insurance and would create risk pools to insure people now considered uninsurable. Medicaid would be expanded to provide uniform nationwide coverage for those who could not afford it.

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Others, such as Rep. Marty Russo (D) of Illinois, support a Canadian-style system in which the federal government would pay all health-care costs. This "single-payer" system would save so much in administrative costs that it could cover all of today's uninsured Americans with no increase in spending, its supporters claim.

Yet Robert Moffit of the Heritage Foundation sees danger in all this for Democrats: "Everybody says they want high- health care, but nobody wants to pay for it. The Democrats run the risk of overpromising.... It has lots of political danger."

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SECTION: NEW HAMPSHIRE WEEKLY; Pg. 1

LENGTH: 1199 words

HEADLINE: N.H. stakes rising for Democrats in '92;
NEW HAMPSHIRE WEEKLY

BYLINE: By John Milne, Globe Staff

DATELINE: ATKINSON

KEYWORD: NEW HAMPSHIRE POLITIC DEMOCRATIC PARTY

BODY:

Cindy Leuschner is a single mother of two from Salem who lost her job as an electronic-parts assembler last year. She has no insurance to pay for her 11-year-old son's allergy shots or for her 9-year-old daughter's eye surgery. Despite President Bush's popularity in the polls, Leuschner's economic condition may persuade her to vote for a Democrat.

"I have a lot of different feelings about Bush," Leuschner said. "I think Bush is for the people with money."

Barbara Parker is a resident of Epsom whose husband, John, a carpenter, is out of work. They lost their health insurance last week. "We're middle class," she said. "We don't get a tax break. We don't get squat."

Leuschner and Parker are the kind of voters the Democratic presidential candidates are looking for.

Politicians and insiders agree that this year the presidential sweepstakes is shaping up differently. The New Hampshire primary, now scheduled for Feb. 18, has always picked winners. No one has been elected president without winning in New Hampshire. But because of changes in the political calendar and the apparent decline in influence of the Iowa caucuses - few candidates are traveling through Iowa this month - some insiders contend that the nation's first primary will be even more influential this campaign.

The only announced candidate for president, former US Sen. Paul Tsongas of Massachusetts, has made several political trips to New Hampshire and expects to open a campaign office this month.

In the past two weeks, other Democratic hopefuls such as Sen. John D. Rockefeller 4th of West Virginia, Sen. Tom Harkin of Iowa and Senate Majority Leader George J. Mitchell of Maine have tested the waters. And other potential candidates have been calling prominent Democrats in the state. More entries in the primary are anticipated.

"I wouldn't be surprised to see as many as 12 candidates in the race," said Boston pollster Brad Bannon at a recent reception in Sunapee.

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Bush plans to announce for reelection this fall, aides say, and so far he has no Republican opposition.

Among the Democrats, the candidates "are all trying to come up with a message," said the state House Democratic leader, Mary Chambers of Etna. In 1988, most Democrats agreed on the issues and stressed personal and character issues. In 1992, candidates are offering Democrats a kind of multiple-choice test on which direction the party should take. "What you're going to see in 1991 and 1992 is a crossroads for the party," Tsongas said recently in Manchester.

This is why Leuschner stood on a steamy blacktop surrounding Palmer Gas Co. talking to Rockefeller, who said he is "aggressively pursuing the possibility of running for the presidency in 1992."

Health care, on which expenditures have doubled in a decade to $ 660 billion, is one area analysts say Bush is vulnerable. And health care is one area Democrats are trying to present an alternative.

Rockefeller said his 11-year-old had allergies, but because he is the great-grandson of one of America's most famous capitalists, he is able to afford medical treatment. Around them, newspaper photographers and TV camera crews jockeyed to get the 6-foot-6-inch Rockefeller and the 5-5 Leuschner in the same frame.

"If you want to get ahead of this problem, you've got to have health insurance reform," Rockefeller told her emphatically. "Only the federal government can do it."

When Parker made her plea at a reception in Concord, Harkin agreed with her. "I want to be a person who fights for working people," he said.

Harkin said he is leaning toward a national health care program such as the one Canada has, particularly one that spends money on prevention as well as treatment.

Rockefeller and Mitchell have been involved in drafting a "play or pay" proposal to be introduced this month that would replace Medicaid, the federal and state health insurance program, with Americare. Employers would either have to provide health insurance benefits at a specific level or pay a tax, estimated at about 8 percent of payroll, to provide coverage for the uninsured.

Other Democrats are proposing solutions to the nation's problems. Tsongas said he believes Democrats should have greater concern about economic growth, adding that the party has for 25 years "been worrying about how you redistribute wealth instead of how you create it." He said Democrats give off an antibusiness tinge, and Americans do not trust them to run the economy.

Mitchell is arguing that Democrats should pick traditional issues such as child-labor laws, civil rights, environmental legislation. "Every major step to expand opportunity, to create hope, to break down barriers of discrimination, every one was created by Democrats, usually over Republican opposition. That's our heritage," he said, "and we ought to be proud of it."

Harkin, who became the first Iowa Democratic senator to win reelection in a campaign in which both sides used negative advertising, said candidates should

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be fighters. "I don't think we've had a good populist candidate running for president in a long time," he said. Although Harkin has one of the Senate's most liberal voting records, he has rejected the notion that he wants to expand government.

Sen. Albert Gore of Tennessee, a 1988 candidate, is writing a book about the environment and is keeping in touch with New Hampshire supporters, said George Bruno of Manchester, a Democratic National Committee member. Gov. Douglas Wilder of Virginia made a trip to New Hampshire last summer.

Rev. Jesse Jackson has spoken in the state twice within the past year. Supporters expect that Gov. Bill Clinton of Arkansas will run, but Sen. J. Robert Kerrey of Nebraska has been cool to offers of support. Tossups include Sen. Lloyd Bentsen of Texas and House Democratic Leader Richard A. Gephardt. Gov. Mario M. Cuomo of New York has a a number of supporters, although he has said he does not intend to run.

Despite all this ferment, a survey commissioned last week by Times-Mirror Co. found that just 1 in 4 Americans, 24 percent, could name a Democrat who has been mentioned as a 1992 candidate. The biggest showings were still in single digits: Cuomo at 9 percent and Tsongas at 7 percent.

Politicians and activists have contended that this lack of broad candidate recognition will bring intensive campaigning to New Hampshire, because the primary may acquire greater importance. "New Hampshire, even if California comes in, will have even more importance than it has in the past."

Most campaigners and observers said that the late start of the race should not change the outcome much. "You spend an awful lot of time talking to activists who can't really help until the fall or winter," said Katherine Rogers, an organizing veteran. "And many of them want paid campaign jobs."

Said Judith Reardon, a longtime Democratic organizer: "In 1988 I ended up supporting former Sen. Gary Hart, and after he dropped out, I found it embarrassing to see the long conversations that Gephardt and Michael Dukakis had with very small groups of Hart people as they tried to convince me to support them. I found the whole process demeaning to the candidates."

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Middle-Class Medicaid

Medicaid was designed to help the nation's poor. But with help from government and smart lawyers, relatively well-to-do Americans are finding new ways to have the program pick up their nursing-home bills.

BY JULIE KOSTERLITZ

Harriet Fridkin tries not to let her personal opinions cloud her professional advice. But Fridkin, an information and referral specialist at the Alzheimer's Association of Greater Washington, which is located in an affluent suburb of the nation's capital, sounded slightly galled as she recounted the telephone call from a brother and sister, both young professionals. They wanted to know how they could get medicaid, the federal-state welfare program that's intended for poor people, to pick up the tab for their widowed mother's nursing-home costs while preserving her assets for their inheritance. "Dad didn't mean all that money to go for long-term care," Fridkin recalled them saying.

"It's not my job to prejudge them," Fridkin said. "It's my job to refer them" to books and professionals that can help. But Fridkin is also sympathetic to the plight of many of the growing number of callers who want to know how they can qualify for government help without bankrupting themselves. "Most of them think the system's unfair, and I go along with them on that," she said. "Many of them saved for a rainy day, and they get a rainstorm that never ends. When you place someone in a nursing home, that's the rainstorm that never ends."

Fridkin isn't alone with her split sympathies. While Congress continues its long-running debate on how best to reform the system, and the private insurance industry tries to tap deep into the elderly market, medicaid is increasingly being used to provide an expensive benefit—nursing-home care—for middle-class and affluent elderly.

The medicaid program, which is intended to provide such care for the elderly poor, has also long provided a safety net for elderly Americans of all income levels—after they exhaust their earnings and assets on nursing-home care.

But because giving up the savings and wealth of a lifetime in their hour of need is so repugnant to middle-class and affluent people, and so politically unpopular, the federal government and the states, over time, have made some concessions to take some of the sting out. A change still reverberating through the system came in 1988, when Congress passed a law to help avoid impoverishing the spouses of patients who receive medicaid-financed nursing-home care.

And, as Fridkin has learned, middle-class and affluent elderly have also been finding ways not sanctioned by government to hang on to family wealth and yet still take advantage of the publicly financed medicaid program.

Fridkin said that her parents have eschewed such legal maneuvers and paid for her father's care themselves, though it has meant some financial hardship for her mother. "He feels that's not what the system's meant for," Fridkin said. "He thinks it helps bankrupt the system."

Though no one knows how many people are manipulating the system, a burgeoning number of lawyers and financial advisers are counseling affluent Americans on how to shuffle, shed or shelter an elderly family member's assets to qualify for medicaid nursing-home benefits. Though most such maneuvers—euphemistically known as "medicaid estate planning"—are entirely legal, they clearly run counter to the intent of the law.

In addition, several states want to tinker with their medicaid rules to allow the affluent elderly to use the program while preserving some wealth. In broad strokes, the program would be opened to persons who buy private long-term care insurance to cover some of the costs. Advocates of this approach say that it's not only more humane, and preferable to having the affluent cheat the system, but that it could also help slow the disastrous rise in medicaid costs.

Congress has been ambivalent about the growing acceptance of medicaid as a middle-class program: concerned, but seemingly at a loss as to how to proceed. While many lawmakers have decried letting the wealthy dodge the rules to keep their wealth and get medicaid, no one has seriously contemplated a major crackdown.

The private insurance industry, which

sees the affluent elderly as a potentially large market for private long-term care insurance, has begun pressing Congress to investigate the problem, and a few carriers want lawmakers to go after the estates of deceased affluent people who ended up on medicaid. Such crackdowns, however, are not a politically popular option.

Some key members of Congress are uneasy about plans, including the proposed state experiments, that would promote private long-term care insurance, saying that it's too expensive for most elderly, doesn't have much of a track record and doesn't always deliver what it promises.

These lawmakers also have philosophical reservations about the state experiments. "I'm troubled by the idea of the medicaid program, designed to assist the poorest of the poor elderly, being used to subsidize private insurers by backing up a private insurance policy," Rep. Henry A. Waxman, D-Calif., chairman of the Energy and Commerce Subcommittee on Health and the Environment, said in an interview. "I don't think it should be a program to protect the assets of middle-class people; it should be a safety net program for the poor." Waxman prefers a broader overhaul of the system.

There may also be a political worry: Measures aimed at appeasing the affluent could rob the health care reform movement of some of its most powerful advocates.

Although Congress refused to grant permission for the state experiments last year, Connecticut recently found a loophole in the law that allows it to proceed anyway, and other states may follow suit.

But many state officials, including some who say they share Waxman's reform-minded ideas, contend that they can't afford to wait. "If there were a better alternative, I'd be more than glad to embrace it," said James Tallon, majority leader of the New York state Assembly and a leading supporter of the state's proposed long-term care experiment. "This discussion would not come up if we were anywhere near a broad-based national program of long-term care. We've been talking about it for a long time, but I don't sense we're close to sweeping reform."

MIDDLE-CLASS SAFETY NET

About 43 per cent of Americans turning 65 this year will eventually spend time in nursing homes. And when they do, they're in for a shock. The average cost of nursing-home care is about $30,000 a year, and medicare, the federal health care program for the elderly, doesn't cover it.

In recent years, private insurers have begun to market policies aimed at covering such care, but the policies are expensive: The typical annual premiums at age 65 for some of the more comprehensive policies currently range from $1,000-$3,000. Despite continuing improvements, these policies still draw fire from consumer advocates over whether they deliver all that they promise.

The elderly poor can have their nursing-home costs paid for by medicaid, and so can the middle class—once they've essentially bankrupted themselves by paying for care. Roughly 20 per cent of nursing-home residents who started their stays paying for their care end up on medicaid.

Watching their life savings ebb away as their health fails isn't a particularly palatable option for most elderly Americans. Nor is going on welfare or getting the second-class care that medicaid recipients often receive. Nevertheless, the medicaid program has become the payer of last resort for many middle-class elderly. Slightly more than half of all elderly medicaid recipients are poor enough to be on a cash welfare program. The rest are on medicaid because their medical expenses exceed their income and assets.

If this isn't ideal for the elderly, it's also a problem for public officials. The medicaid program, which is designed primarily to meet the short-term health care needs of poor women and children, has had to spend an increasing share of its limited funds for long-term care of the elderly. Elderly Americans in nursing homes or other long-term care facilities constitute just 5 per cent of medicaid beneficiaries but account for 22 per cent of spending under the program. Nationally, medicaid has come to pay for about 45 per cent of the nation's $53 billion nursing-home bill.

In recent years, the pressures on the medicaid program have gotten worse: year after year of higher-than-inflation increases in health care costs, program expansions dictated by Congress and, lately, the recession-caused double whammy of burgeoning welfare rolls and slowing tax revenues.

And the costs of long-term care are expected to stay on a steep upward curve, in part because the old are living longer, and in part because the vast numbers in the baby boom generation are only a few decades from old age. The Health Care Financing Administration (HCFA), which runs the medicare and medicaid programs, has estimated that medicaid's nursing-home costs will grow two-and-a half-fold by 2000.



Richard A. Bloom

Rep. Henry A. Waxman, D-Calif., chairman of the Health and Environment Subcommittee
"I don't think [medicaid] should be a program to protect the assets of middle-class people."

These pressures and the scarcity of funds create a de facto tug-of-war between two populations: poor women and children, and poor and middle-class elderly.

It's a dilemma that government officials don't like to acknowledge. Most think that welfare programs ought to serve only the poor. On the other hand, politicians don't like to confront the problem of middle-class constituents, or even their own families, bankrupting themselves solely to have the government share the cost of nursing-home care.

So far, however, those who are unhappy with the system haven't managed to surmount the political and fiscal difficulties of creating a public program that would offer universal coverage for nursing-home or home health care. A reform plan designed in 1990 by the U.S. Bipartisan Commission on Comprehensive

Health Care (the Pepper Commission) with wide bipartisan support from its blue-ribbon members, envisions a limited role for private insurers and, in its first year, would cost $43 billion. It's a tough sell, especially when added to the expected billions in costs to overhaul the broader health care system.

In the meantime, the federal government and the states have tried to make some accommodations. Many state governments have established comparatively lenient eligibility standards for the elderly to qualify for medicaid's nursing-home benefits. In 31 states, there is no limit on how much income elderly people can have and still qualify for medicaid, provided that their medical and nursing-home expenses exceed it. With rising nursing-home costs, people with progressively higher incomes have become eligible for the program. (There are still ceilings on the assets one can have and qualify, but the law makes some exceptions to these rules.)

Many relatively affluent Americans are angling to shuffle, shed or shelter their assets to qualify for medicaid nursing-home benefits.

And, in 1988, Congress made an important concession. The "spousal impoverishment" benefit—one of the few provisions to survive when the ill-fated medicare catastrophic coverage act was repealed in 1989—substantially raised the amount of income that spouses could retain before handing the balance over to medicaid to help defray the cost of a patient's nursing-home care. Federal law allows states to let "at-home" spouses retain as much as $66,480 of the couple's combined assets and as much as $1,662 in monthly income.

Although the new benefit got lost in the political hubbub over the catastrophic benefits bill, a few observers at the time cited it as an important symbolic move: toward more-humane treatment of elderly spouses, but also toward a greater role for medicaid as protector of the middle class. "If you look at what Congress has done, it has certainly liberalized [medicaid] and made it available to more people," said M. Garey Eakes, an attorney in Arlington, Va., who specializes in legal affairs of the elderly.

THE ARTFUL DODGERS

The medicare catastrophic act and the spousal impoverishment provision may also have expanded medicaid's role for the middle class in unintended ways.

For some time now, the unpleasant prospect of spending their way into poverty to qualify for help with nursing-home costs has spurred some among the affluent elderly to find other, more creative ways to qualify for medicaid. And the stakes have been getting higher as the nation's elderly have become a wealthier demographic group. Census figures cited in a new study by the Health Insurance Association of America (HIAA), for example, show that the median net worth of Americans age 65 and older increased from $68,600 in 1984 to $73,471 in 1988. (Over the same period, the median net worth of American households dropped 3 per cent, to $35,752.)

Some have simply lied about their assets and hoped they wouldn't get caught. Others have tried more sophisticated gambits, often on the advice of lawyers, that stayed within the letter—if not the spirit—of the law.

There are, as it turns out, numerous techniques for sheltering assets or transferring them to family members as a prelude to getting medicaid to pay the tab for nursing-home care. Among them: opening joint bank accounts; holding property in joint tenancy; investing in irrevocable, nontransferable annuities; and paying family members for services, such as shopping and transportation.

Although states can attempt to recoup money from the estates of deceased medicaid recipients, few do so aggressively. A 1988 report by the inspector general of the Health and Human Services (HHS) Department found that just over half the states tried to recover money from estates and that only two states placed liens on homes as an asset-recovery technique; moreover, most states recovered only a fraction of what they might have been able to. If every state recovered assets as effectively as Oregon, the most effective state, the report said, nationwide collections in 1988 could have been $589 million instead of the $74 million that was recovered that year.

Although hard data are lacking, many experts say that public interest in medicaid eligibility stratagems increased in the wake of the catastrophic illness insurance legislation. During the highly publicized campaign against the bill, which was waged primarily by affluent elderly who felt that it imposed a tax on them not commensurate with the added benefits, many Americans became aware for the first time that neither medicare nor the catastrophic illness benefit covered nursing-home care. Before passage of the bill, polls conducted by the American Association of Retired Persons (AARP) found that nearly two-thirds of elderly Americans thought such care was covered by medicare; after passage, that number dropped to roughly 33 per cent.

In addition, large numbers of elderly Americans began seeking legal help to understand the new spousal impoverishment benefit. The new wave of clients helped to fuel the growth of a hitherto small and peripheral legal specialty: elder law. The National Academy of Elder Law, founded just three years ago, now boasts 1,300 members. "Spousal impoverishment helped create the elderly law bar," said Nancy Coleman, director of the American Bar Association (ABA) Commission on Legal Problems of the Elderly.

Once merely a variant of estate planning, this specialty has increasingly come to focus on helping the affluent plan for disability in old age, including such matters as establishing a "living will" to govern choices in medical care or providing for power of attorney in the event of mental incompetency.

A sizable portion of the business, however, consists of "medicaid estate planning." Once in the door, clients seeking advice on the spousal impoverishment rule could find out about a whole host of other asset and income-shifting techniques.

Although Congress has passed a variety of laws over the past decade that are intended to guard against such abuses, most of them are fairly ineffective. According to Eakes, the president of the academy, a provision of the catastrophic coverage law that appears to make asset transfers more difficult actually makes them easier. Before the change, he says, someone in Virginia who transferred $12,000 in assets with the intent to qualify for the medicaid program would be penalized by being made ineligible for 40 months. Now, under the new law, such an offender would be ineligible for only 8 months.

The medicaid estate planning business is booming. For starters, there's been a spate of how-to books, including the brazenly titled *Avoiding the Medicaid Trap: How to Beat the Catastrophic Costs of Nursing Home Care* (Henry Holt, 1989): "By following the tips on these

pages, an older person . . . can save most or all of their savings, despite our lawmakers' best efforts," writes author Armond D. Budish.

Budish and other lawyers in the business say that they're providing an important service, principally for middle-class people who are in a tough spot. The very wealthy looking to shield large assets for posterity are, they contend, a minority. Even so, Eakes said, "Whether it's right or wrong with respect to financing long-term care, it's a pretty well-entrenched notion in this country that one of the best things you can do for your family is pass wealth to them at end of life."

Although the ABA's Coleman was among the founders of the National Academy of Elder Law, she confesses to being disturbed by many of its members' emphasis on medicaid estate planning. "I wish we had an adequate way of paying for it, but I don't think we should be robbing the poverty program to do it," she said.

"I harangue them constantly," Coleman said of her colleagues. "I explain to them the problems this creates for the public trust. . . . They argue that it's their ethical obligation as attorneys to explain to clients all the options that might be before them."

THE STATES JOIN IN

For different reasons and in different ways, a few states are also trying to find ways to allow more of the affluent elderly to benefit from the medicaid program. Over the past five years, with planning grants from the Robert Woods Johnson Foundation, seven states have been trying to devise experiments that would allow these elderly to hang on to more of their assets, and be entitled to medicaid benefits, provided that they bought long-term care insurance first.

The foundation's premise is that a costly new public plan is unlikely to be enacted any time soon. Moreover, the fledgling private insurance industry has too many problems to offer a major solution to the nursing-home needs of the middle class. Chief among the problems: Such insurance policies are a risky proposition for carriers and, in any event, are too expensive for many potential customers. But a well-crafted partnership between the public and private sectors might help solve these problems.

"The whole premise is that the public side cannot handle the whole burden and neither can the private side," said David Guttchen, a planning analyst with the Connecticut Partnership for Long-Term Care, the government office that's managing the experiment in the state. "Can we create a private market that meets a portion of the need, and beyond that help those who need public support?"

Under the experimental plan, elderly participants would contribute to the cost of their care in a more rational way: by pooling risks. With medicaid as a backstop, insurance companies could limit the risks they assume and, as a result, offer more affordable policies to consumers. This approach would avoid the indignities of impoverishment, foundation and state officials maintain, while presenting an alternative to cheating the system.

Such a plan, its boosters further maintain, would save the states money; the more middle-class people who buy insurance, the fewer who will "spend down" their savings and end up on medicaid at public expense.

Connecticut, the first state to begin developing the idea, envisions a system in which those who buy private insurance can keep a level of assets equal to the amount the policy pays out on their behalf and still be eligible for medicaid if and when the private benefits run out. Someone with modest assets who bought a one-year policy, for example, might be able to protect roughly $30,000 in assets should he or she then require medicaid's help.

To proceed, the states last year sought a congressional waiver of certain medicaid provisions. But during hearings by his subcommittee, Waxman and several witnesses questioned whether the proposed experiments would benefit all parties as advertised.

Private insurance has major pitfalls, warned Phyllis Torda, the director of health policy for the Washington-based Families USA Foundation, a group that's concerned with the low-income elderly. She expressed concern that only wealthy individuals could afford the insurance. Moreover, she argued, insurance companies can exclude people they consider to be bad risks and often find grounds for refusing to pay claims.

Lawrence H. Thompson, the assistant comptroller general for human resources at the General Accounting Office, also warned that the experiments could actually hurt low-income people. Some of them could allow in wealthy people who otherwise would not have participated in the program, he said, at the expense of needier individuals. Moreover, he pointed out, long-term care insurance is a risky, unproven line of business in which policies are often purchased 20 years in advance of need. What happens if insurers are unable to make good on the policies?

HCFA officials privately expressed their reservations to Capitol Hill lawmakers about launching an experiment that could take 20 years to produce meaningful results. Typically, medicaid law is waived only to permit short-term experiments.

But the real problem, many critics contend, is the implied change in medicaid's mission. Should a program designed for the poor help the rich pass wealth to their heirs? And should it serve as a stop-loss program that helps limit the risks faced by private insurers, and thus helps them market their products to the affluent?



Richard A. Bloom

Nancy Coleman of the American Bar Association
She's disturbed by "medicaid estate planning" practices.

"This whole question of the role of government in paying for the long-term care of people who are not poor is a very value-laden issue," said Gail R. Wilensky, the administrator of HCFA. "It has not come up and been resolved in the way we are going to have to do."

Although the Senate approved the legislation and the House approved a more restrictive version, the measure ultimately was dropped in conference last year.

But Connecticut recently found a way to proceed legally without congressional approval by exploiting a provision of the law that was originally intended to let states extend medicaid coverage to more of the poor and near-poor elderly. "That part of the law they are drawing on . . . was not [intended] for the purpose they're using it for," Wilensky said. She added, however, that HHS, HCFA's federal parent, was obliged to approve the plan.

Despite HCFA's reservations about the states' experiments, Wilensky said, she applauds their attempts to encourage collaboration between the public and private sectors on financing long-term care.



John Eisele

Stephen A. Moses, director of research for LTC Inc., which sells long-term care insurance Washington "should make it easy for those who need it to get care without playing games."

Lawmakers on Capitol Hill haven't tried to short-circuit Connecticut's experiment, but Waxman said that he might act if other states follow suit. Delineating the roles of the public and private sectors in long-term care needs to be done carefully and explicitly at the federal level, he contended. "If you're going to have a social insurance system of some sort, you have to think through what role, if any, [companies in] the private sector should have," he said. "If they have a role, it should be clearly spelled out and consumers adequately protected."

WASHINGTON'S INERTIA

As the philosophical underpinning of the medicaid program erodes around them, most of Washington's policy makers haven't yet focused on the problem. While some lawmakers and executive branch officials are worried, they seem to be at a loss for knowing how to respond.

The insurance industry has recently mounted a campaign to shake the congressional complacency. HIAA recently issued a report on the dodging of medicaid's "spend down" provisions, which it called "middle-class welfare," and it has begun shopping the report around to key Senators. (The Senate's Special Committee on Aging is currently considering whether to schedule hearings on the issue.) And LTC Inc., a Kirkland (Wash.)-based broker of long-term care insurance, has hired Stephen A. Moses, who wrote the HHS inspector general's report as a government employee, to research the issue and stump the country to make the case for a get-tough stance on estate recoveries.

Officials of the trade association say that they are acting out of concern about the impact on the program's primary mission of helping poor women and children. (The group's health care reform proposal urges that medicaid coverage be extended to a broader segment of the needy.) "This has been shoved under the rug for years and years," said Richard E. Curtis, its director of policy development and research. "But when the desperately poor and vulnerable are being hurt as bad as they are [by medicaid cutbacks during the recession], it's very important that we go back and look at this."

But insurance industry officials also concede that they hope such crackdowns will force more Americans to consider buying private long-term care insurance. Moses is outspoken on the point. The federal government, he says, "should make it easy for those who need it to get care without playing games, but there should be no transfer of assets. The quid pro quo is if you don't plan ahead [and buy insurance to protect your assets], you can't just give it away. There'd be a lien as a condition of eligibility on everything you own."

Such crackdowns are a tough sell politically. The dismal track record of states in estate recoveries, as documented by HHS's inspector general, suggests that state officials, who live closer to the governed, have instinctively grasped the political downside of such a policy. Those who haven't might want to consult the September 1991 issue of *Campaigns & Elections* magazine. In an article on how to defeat incumbents, the magazine advises challengers: "Never underestimate the ability of elected officials to say and do incredible and dumb things. Can you imagine a law allowing state government to foreclose on the homes of deceased medicaid recipients to recoup medicaid payments? Two states have such laws. Someone voted for them."

Moses and some state officials say that they would like Congress to provide them with some political cover by making such recoveries mandatory. To federal lawmakers, it sounds about as inviting as the proposition, "Let's you and him fight."

Moreover, many lawmakers are uneasy about the matter of exactly what role private long-term insurance should play in the system. Waxman and Energy and Commerce Committee chairman John D. Dingell, for example, have expressed concern over Connecticut's use of a legal loophole to forge ahead with its experiment, as well as reports that other states are planning to do the same. Although Connecticut has relatively strict limits on the income and wealth it allows privately insured individuals to retain once they are on medicaid and also has a variety of consumer protections in place, some policy makers are worried that other states could proceed without such limits and protections.

More important, some worry that medicaid's progressive drift toward accommodating the affluent elderly will get in the way of reform efforts. Joshua M. Weiner, a senior researcher at the Brookings Institution, faults the idea behind Connecticut's experiment: protecting assets. "That's absolutely the weakest card that reform advocates have to play," he said. "If this is only about asset protection, I don't think you'll get broad support."

Others, including John C. Rother, the director of legislation and public policy at the AARP, which opposed the bill permitting the experiments last year, worry that attempts to mold the medicaid program to help the nonpoor will make it tougher to get reforms for everyone. "When you say the top 10 per cent of the elderly can do this, you create a political problem getting support," he said, "because this group will have bought themselves out of the problem." ■

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June 11, 1991, Tuesday, City Edition

SECTION: OP-ED; Pg. 23

LENGTH: 630 words

HEADLINE: A plan that could aid Medicaid and the states' cash burden

BYLINE: By Robert L. Turner, Globe Staff

KEYWORD: MEDICAID COST MASSACHUSETTS

BODY:

Democrats are hungry for new ideas? How's this:

Federalize Medicaid.

Rep. Joseph P. Kennedy is preparing legislation that would take the whole, huge, budget-busting program of health care for the poor and give it to Washington.

Sure, it would cost a not-so-small fortune to take over the states' share of the massive program. In a time of massive and persistent federal deficits, many in the capital will dismiss the idea out of hand.

But cost is Kennedy's central argument. Now, he says, "with 50 different state programs, there is absolutely no cost containment."

Medicaid, according to Kennedy, should be modeled after - and combined with - the Medicare program that delivers health care to the elderly that is both better and cheaper, despite the fact that the pay scale for specific services is higher than Medicaid.

The secret, Kennedy says, is having a single payer to control "outrageously high annual cost increases."

Ways might be found to pay for a federal takeover. Kennedy says it can be done by raising federal taxes on gasoline, wine and beer. Others might suggest a trade-off, with the states agreeing to pay a large share of some other programs, such as transportation, which match state contributions at a higher rate. When state dollars are matched nine-to-one by Washington, there is an obvious incentive for extravagance.

The flip side of the cost argument is that federalizing Medicaid would give a heaven-sent windfall to the states, 35 of which are struggling with deficits - almost all driven partly or largely by Medicaid.

Nearly all these states have been raising revenues, through taxes or fees, and cutting services at the same time. These trends obviously can't continue simultaneously forever.

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The national recession, which has contributed to state deficits, will presumably go away eventually, but the budget-busters threaten to keep the states in hock forever, and Medicaid is chief among them.

Nationally, according to Kennedy, the cost of Medicaid went up 18 percent last year and is expected to rise 25 percent this year.

So his proposal is not simply a one-time bailout for the states, but a realignment of the federal-state relationship that may be necessary, sooner or later, if the states are to avoid perpetual penury.

Though Kennedy doesn't stress it, the politics could become interesting here, too. Several of the states with the worst deficit problems have Republican governors - Massachusetts and California for starters.

"There would be tremendous benefits for Massachusetts," Kennedy said - about $ 800 million a year.

For any governor, Kennedy said, "I would think this would be difficult to turn down."

While the questions of who wins and who loses, and who pays the bill, are important, Kennedy's proposal raises the more fundamental issue of where responsibility for health care in America properly belongs.

Leaving the Medicaid part of it with the states "just hasn't worked," he said.

There are gross disparities between some states over the quality and variety of services provided. In some areas people have difficulty getting access to the care they need because doctors and hospitals discourage Medicaid recipients. And the price tag is huge, and ballooning.

Kennedy estimates $ 8 billion could be saved that is now being wasted. The cost to Washington, he says, would still be $ 30 billion annually, or $ 22 billion if combined with Americare, the universal health proposal that would bring in some private insurance paid for by businesses. Other estimates will vary.

Kennedy hasn't even begun to seek cosponsors for his bill, which is being worked on in the legislative counsel's office.

But it is a proposal that deserves to stimulate some serious debate, and maybe even some real progress.

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BNA PENSIONS & BENEFITS DAILY

June 6, 1991

LENGTH: 2415 words

Health Care
SENATE DEMOCRATS UNVEIL COMPREHENSIVE PLAN TO REFORM U.S. HEALTH CARE SYSTEM

WASHINGTON (BNA) -- Senate Majority Leader George Mitchell (D-Maine), along with Sens. Edward Kennedy (D-Mass), Donald Riegle (D-Mich), and Jay Rockefeller (D-WVa), June 5 introduced a comprehensive health care reform package featuring a "play-or-pay" provision that would require employers to provide health insurance for employees or pay a payroll tax.

The health care package (bill number not yet available), which is intended to guarantee affordable health care for all Americans, builds on the current employer-based health insurance system and would provide public insurance for uninsured individuals, both employed and unemployed.

The goals of the plan, according to Democratic staff members, is to provide universal access to health care and to contain health care costs.

In unveiling the proposal Mitchell said Democrats are not critical of the administration for not coming forward with its own plan. Rather, he said, Democrats encourage the president to participate in this effort are hopeful the Bush administration will view this as a "serious, thoughtful effort."

To encourage businesses, particularly smaller ones, to provide health care for employees, the bill calls for a 25 percent tax credit for the cost of insurance provided to lower-income employers by small businesses. All businesses, including those eligible for the tax credit, would be able to deduct the cost of health insurance, and the 100 percent deduction would be extended to self-employed individuals. The insurance requirements for small businesses would be phased-in over a five-year period.

Provider Cost Controls

To control the volume and price of services furnished by hospitals, physicians, and other providers, the bill would establish national expenditure targets to be set by a new federal agency called the Federal Expenditure Board. The board would set national expenditure goals, in total and by sectors of the health care industry, as well as separate goals for specific states and regions.

In setting the goals, the board would bring together employers and other purchasers of care with providers to negotiate provider rates and other cost control methods. If the negotiations were successful, the rates would be binding; providers charging in excess of the rate would be subject to civil monetary penalties. Otherwise, the rates would be published as recommendations that providers and purchasers would use as guidelines.

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The bill would allow a insurance/purchasing consortia in individual states to establish different payment rates or alternative cost control methods, as long as they achieved the goals established by the national board.

At a minimum, states would be required to establish insurance/purchasing consortia that would combine insurance companies with small market shares for the purpose of paying providers-a requirement intended to reduce the number of payment entities that a provider must deal with. The consortia would make all direct payments to providers on behalf of insurance companies.

The sponsors also intend for the consortia to increase electronic billing for reimbursement to further reduce the administrative burden. In addition, a standardized claim form would be developed and implemented by the federal board.

"Play-Or-Pay"

At a technical briefing, Democratic staff members explained that the "play-or-pay" feature would not go into effect unless fewer than 75 percent of workers were covered by health insurance after a five-year period.

In the event "play-or-pay" does take effect, Mitchell explained, the amount of the payroll tax would be determined by the secretary of health and human services. At the technical briefing, Democratic staff members said that, in determining the tax rate, the HHS secretary would attempt to maintain a balance between the cost of private and public insurance coverage so that employers would not "bail out" of private plans.

One staff member told BNA the employer payment really is a contribution which allowed employees to purchase the government insurance, rather than a payroll tax. At the technical briefing, the staff members said that treating the employer payment as a contribution would avoid a possible constitutional problem raised by legislation which permits the Executive Branch to determine tax rates.

The premium cost for the government insurance, according to staff members, would be community rated, and would be subsidized by the federal government. Employees who participate in the government insurance plan, " Americare, " would be required to pay up to 20 percent of the premium cost, on a sliding scale depending on income. Similarly, employers who provide private insurance for employees could require covered employees to pay up to 20 percent of premium costs.

As for the possibility that some employees with generous health care benefits could end up with reduced benefits, one staff member said he was "confident it won't happen." He explained that since the employers' contribution for the government insurance plan is based on wage rates, only low wage firms will find it advantageous to use the public insurance system.

Additional Funding

Mitchell acknowledged that the payroll tax or employer contribution would not pay for the whole cost of the reform package and that additional funding would be needed in order to meet the requirement in last year's budget law

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that all new entitlement spending be offset by spending cuts or tax increases.

According to Mitchell, the Congressional Budget Office estimates that the supplemental cost of the program for the first year will be $6 billion. And, while estimates for later years are not yet available, Democratic staff members said the similar recommendations in the Pepper Commission report were estimated to cost $14 billion a year when fully implemented.

While staff members said they still are discussions underway about possible revenue sources, Mitchell said that the final decision on a revenue source will be left to the tax-writing committees.

Although staff members said the plan does not include any limit on the exclusion for employer-provided health care benefits, it is possible that the tax writers will look toward limiting this exclusion or possibly denying employers a deduction for health care costs, particularly since these items together represent one of the largest federal tax expenditures.

In press releases, Senate Finance Committee members John Chaffee (R-RI) and David Durenberger (R-Minn) both applauded their colleagues, efforts in introducing their proposal but said that any reform package also should include some restriction on the current tax expenditures for employee benefits.

A White House spokeswoman cited the similarity of the Democrats' proposal with the Pepper Commission report and questioned whether the Democrats' plan would be widely supported. "In the Pepper Commission, a similar proposal could not get the support of all Democratic members," she said, adding, "We look forward to seeing whether this plan obtains broad support."

Another Bush administration official described the Democratic proposal as "a warmed over version of the Dukakis plan."

Timetable For Action

The majority leader said that he was hopeful Congress could enact reform legislation during this session and rejected the notion that Democrats were introducing the legislation in an effort to frame health care as an issue for the 1992 presidential campaign.

Furthermore, Mitchell said he is confident the plan will move ahead, particularly because of the "growing and widespread" concern about the problem. Public attitudes are providing encouragement for action, he said.

Riegle said although the reform package started out as a bipartisan effort, Democrats found it necessary to move ahead. "There is an urgency to get the job done," he said.

Mitchell also said the health care reform package is the first part of a two-part strategy to address the U.S. health care problem. Mitchell said he plans to introduce a second measure to address the problem of long-term health care. "I am committed to enactment of a long-term care program," he said.

House Democrats, including House Majority Leader Richard Gephardt (D-Mo),

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are working on their own plan, which, according to Gephardt, may be ready by the end of the month. Mitchell said Senate task force members have been consulting regularly with their counterparts in the House, notably committee and subcommittee chairmen working on the House proposal. The House Democratic proposal is likely to move "in the same direction" as the Senate Democratic plan, Mitchell said.

Industry Input

The majority leader said the Senate task force, over the past two years, has worked with a number of industry groups, including health care providers, insurance companies, and medical professional and hospital groups. Mitchell said the task force has developed "a remarkable consensus within the industry for reform.

The response of the health care industry to the Senate proposals generally has been positive, with a number of groups issuing press releases in support of the Democrats' effort. However, while many provider organizations support comprehensive health care reform, several associations expressed concern over the role the government would play in determining how much they would be paid under the Senate leadership's proposal.

Jack Owen, interim president of the American Hospital Association, said, "This legislation represents an important step forward in the process of health care reform, and the AHA is committed to working closely with the Democratic leadership to further refine the proposal."

Owen also said, however, the association supports the "pay-or-play" concept and the establishment of a broad public plan, but has "serious concerns about the broad regulatory authority" that would be given to both state and federal governments through state consortia and the Federal Expenditure Board.

American Medical Association President James Todd said in a press release that "the Democratic proposal is an interesting, first step toward exploring an issue of paramount importance to all Americans." Todd said, however, that the AMA did not endorse any particular legislation proposal and would work towards developing a package that would win the approval of both Congress and the president.

The American Protestant Health Association said that a system of all-payer rates also must address costs incurred by providers. If a federal or state commission limits price increases to hospitals, it is "only fair" that the same commission also limit wage and supply costs in the same amount, APHA said.

The Federation of American Health Systems, which represents investor-owned hospitals, expressed some concern about placing government "at the center of so many important spending decisions concerning health care. " It warned that "a health care system in which government, either directly or indirectly, controls prices and sets budgets will lead, inevitably, to serious shortfalls in quality and access."

The Blue Cross and Blue Shield Association said, "The proposal will serve as a catalyst for all of us. . .We will all borrow many ideas from the

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proposal and find substitutes for parts of it."

Meanwhile, the Association of Private Pension and Welfare Plans welcomed the proposed replacement of Medicaid with a new " AmeriCare" program because "Medicaid is just not doing its job." Howard Weitzman, APPWP executive director, said the group still has a "long lost of questions about many aspects of the leadership proposal, especially the minimum benefit package and the cost containment items" and added that "it is not clear that the rate-regulation path they have outlined is appropriate."

Other groups that came out in support of the proposal, at least in concept, included the American Association of Retired Persons, the Washington Business Group on Health, and Families USA.

The Democratic Governors Association also issued a release with endorsements for the plan from several governors, including New Jersey Gov. Jim Florio (D) and Maryland Gov. William Donald Schaefer (D).

The AFL-CIO came out behind the plan and expressed the hope that the proposal would "energize" the administration and others to enact health care reform legislation in the 102nd Congress.

As for business groups, the National Association of Manufacturers came out in support of the Democrats' effort but did express some reservations. "This bill opens the dialogue and helps us begin to address the problems of our ailing health care system. . .Though we can't support all the provisions of this bill, we comment its authors for taking a bold step and initiating this critical debate," NAM President Jerry Jasinowski said in a press release.

Small Business Concerns

According to National Small Business United, the proposal not only "stops short of actually limiting the growth of health care spending," but also "contains many elements which will be harmful to small business." NSBU Executive Vice President John Galles said actual limits and fee caps are needed to hold costs down.

Galles also said subsidizing businesses with tax credits takes the wrong approach. "It would be much more effective to focus tax subsidies on individuals, rather than on business entities," he said.

NSBU also argued the plan could become under-financed very quickly, resulting in increased payroll taxes for employers and adding greatly to the federal deficit. The plan would have the effect of steering small businesses away from private insurance into a public plan, Galles said, and create the need for either higher payroll taxes or higher income taxes to fund the program.

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Copyright (c) 1991 States News Service

June 5, 1991, Wednesday

LENGTH: 536 words

HEADLINE: Elements of Federal Health Plan Mirror Maine Pilot Health Programs

BYLINE: By Laurie Ledgard, States News Service

DATELINE: WASHINGTON

KEYWORD: health

BODY:

Some elements of the $6 billion, business-based health care plan introduced by Sen. George Mitchell on Wednesday are found in pilot health programs funded in part by the state of Maine.

"Access to affordable, quality health care should be a right for all Americans, not merely a luxury for those who have the economic means to purchase health insurance," Mitchell told reporters at a press conference in the Capitol.

The key to the Senate Democrats' plan is a requirement that employers either provide health insurance or pay into a new public program that will replace Medicaid.

Nationwide, 34 million Americans have no health insurance, Mitchell said. According to a 1986 University of Southern Maine study, 93,000 Mainers lack health coverage. More recent figures were not available.

Recognizing the health coverage problems in the state, particularly in rural areas, the Maine Department of Human Services (DHS) developed pilot programs combining state subsidies with employer or employee payments. One program, called MaineCare, ensures that small businesses and the self-employed have basic health coverage.

Mitchell's office has watched these programs carefully, a Mitchell staffer said, and last year found federal demonstration funds for the Maine Health Program. That program, run by the state DHS, extends Medicaid coverage and picks up employees' shares of insurance payments.

"There are a lot of ideas . . . that we've discussed with people in the state," the staff member said. "We think the states are doing a lot of innovative things."

Progressive forms of health care in Washington state and Hawaii also were studied as the basis for the federal plan, as was the German system. Operated by the former West German government, it is the closest business-based model to the Senate plan.

Beth Kilbreth, director of the medical insurance program at the Human Services Development Institute of the University of Southern Maine, said a recent study of small businesses found that half of them offer no coverage for their employees.

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Due to Maine's seasonal tourism industry, Kilbreth said, part-time and seasonal employees have a dramatically low rate of health coverage.

Kilbreth said it is difficult to determine if the results of the two-year study were affected by the regional economy.

"Rural areas are harder hit than urban areas," Kilbreth said. "There are a lot of desperate stories."

Mitchell joined fellow Democrats Sens. Edward Kennedy of Massachusetts, John D. Rockefeller IV of West Virginia, and Donald W. Reigle, Jr. of Michigan to introduce the plan.

Highlights of the proposal include federal-state public health coverage called " AmeriCare, " that would replace Medicaid, tax credits and insurance reform to assist small businesses -- which make up much of the business community in Maine -- and reductions in unnecessary care and administrative costs.

It also calls for the creation of a new Federal Health Expenditure Board (similar in nature to the Federal Reserve Board) that will maintain and analyze information about health care providers in all communities in order to compare costs and quality.

Similar legislation is pending in the House, Mitchell said.

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Copyright (c) 1991 Crain Communications, Inc.;
Business Insurance

June 10, 1991

SECTION: Pg. 1

LENGTH: 1008 words

HEADLINE: Democrats proposal includes cost control

BYLINE: By JERRY GEISEL

DATELINE: WASHINGTON

BODY:

Legislation introduced by Senate Democrats last week to widen access to the health care system also would create a new federal board that would attempt to hold down health care costs.

The measure also would give certain small employers tax breaks to encourage them to offer their employees health insurance.

And, in a provision that surprised many benefit experts, the secretary of health and human services would be given authority to set the size of the penalty -- in the form of a new payroll tax -- on employers that fail to offer a health care plan that meets the standards outlined in the legislation.

Benefit experts had thought the size of the payroll tax penalty would be specified in the bill, S. 1227.

But much of the bill, "HealthAmerica: Affordable Health Care for All Americans Act," is similar to earlier versions that had been widely distributed (BI, June 3). Those provisions include:

* Requiring employers, as part of a "play or pay" approach, to offer employees a health care plan or pay a new tax to help fund coverage for the uninsured.

* Creating a new federal program, known as AmeriCare, which would largely replace Medicaid to provide comprehensive coverage for individuals without employment-based health insurance.

Unlike Medicaid, though, AmeriCare would not restrict eligibility to the poor. Others also could obtain the coverage, though they would have to pay a much greater share of the cost.

* Eliminating state laws that mandate that certain types of services be covered by health care plans sold by commercial insurers.

The legislation was introduced last week at a jammed press conference by its sponsors: Senate Majority Leader George Mitchell, D-Maine, and Sens. Edward M. Kennedy, D-Mass.; Donald Riegle Jr., D-Mich.; and John D. Rockefeller IV, D-W.Va.

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Sen. Kennedy, the congressional champion of universal health care, proclaimed the introduction of the bill as a "historic day for the Senate and for the nation."

Indeed, as benefit experts earlier noted, the legislation marks the first time that Senate Democratic leaders have united on a single approach to improving health care access. Previously, Sen. Kennedy had worked pretty much alone -- without significant backing from party leaders -- in advocating that employers be required to offer health care plans.

Sen. Mitchell pledged that he will work to win passage of the legislation during the current congressional session; hearings by the Senate Labor and Human Resources Committee, chaired by Sen. Kennedy, are set to begin this week. A similar bill is expected to be introduced in the House within a few weeks.

Despite the strong push by Senate Democrats, benefits experts say congressional passage of the legislation is not likely anytime soon.

"The chances of passage are zero" because of a lack of concensus on improving access to health care, said Dallas Salisbury, president of the Employee Benefit Research Institute in Washington, D.C.

But the introduction of the bill will expand the debate on health care access, said Dr. Roger Taylor, national health care leader with The Wyatt Co. in Washington, D.C.

Unlike earlier bills introduced by Sen. Kennedy, which were criticized as paying only lip service to cost containment, the Senate Democrats' proposal does create a mechanism to try to control national health care spending.

A Federal Health Expenditure Board would be created to establish voluntary targets for annual health care spending in specified areas, like hospital care and physician services.

The board also would bring together health care providers, like hospital associations, and purchasers, like employers and insurers, to conduct negotiations on rates for services.

However, the board only would mandate rate levels if a majority of both providers and purchasers reach an agreement. If agreement is not reached, the board would only issue non-binding recommended rates.

Many benefit experts said last week they want to study this complex provision before commenting.

However, the proposal at least pays attention to the importance of cost containment, noted Frank McArdle, a consultant with Hewitt Associates in Washington, D.C.

"For the first time senior members of Congress are taking a step to control costs. That is a step forward," agreed Mark Ugoretz, executive director of the ERISA Industry Committee, a Washington, D.C.-based employer lobbying group.

The measure also would give new tax breaks to certain small employers that offer health plans meeting standards laid down in the measure.

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For example, employers with fewer than 60 workers would receive a tax credit equal to 25% of the cost of coverage for each full-time employee earning less than $ 20,000. The tax credit would not be available to certain highly profitable firms.

Meanwhile, as earlier reported, the measure would require employers to either offer a health care plan or pay a payroll tax, to be set annually by the secretary of health and human services.

Generally, the employer would have to pay 80% of the premium, while deductibles could not exceed $ 250 for individual coverage and $ 500 for family coverage. Employee coinsurance could not exceed 20%, with a maximum annual out-of-pocket limit of $ 3,000.

Employers, though, could offer a health plan with different cost-sharing requirements so long as its "actuarial value" was equal to that of the basic health plan.

Small employers -- those with fewer than 25 employees -- would have five years to comply. If, at the end of five years, fewer than 75% of workers at small firms do not have health insurance, the employers would either have to offer a health plan or be subject to the payroll tax.

This same requirement would apply to employers with between 25 and 99 employees, except they would have only four years to voluntarily provide coverage.

Newly established employers with fewer than 25 employees would be exempt from offering coverage or paying a tax during their first two years of operations.

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HEADLINE: Reforming health care

BYLINE: Kevin Anderson

KEYWORD: JOHN D. ROCKEFELLER IV:JAY ROCKEFELLER:AGE: HEALTH CARE REFORM:MEDICAL CARE:COST

BODY:

Sen. John D. Rockefeller IV says 'people don't like change,' but 'the health care system needs change' to give access to all Americans.

Q: You are a sponsor of the Democratic health-care reform bill that was the subject of a congressional hearing Wednesday. What are the key points of this plan?

A: You want that in three sentences? It keeps our present job-based system, which is uniquely important for Americans. And through incentives to small business and a publicly funded plan insures that every American has access to health insurance. It's all done within our present system, but we do it by radically reforming the present system.

Q: Why does health care reform seem so terribly difficult in this country?

A: I asked a very brilliant, experienced lobbyist for the health-care industry once publicly: ''How many people do you feel understand health-care public policy in the Congress to a substantial degree?'' And he very quickly answered 12. That's out of 535.

Q: What does that tell you?

A: If he's right, that says health care is very difficult. It is not approached lightly. It is a world of acronyms, of conflicts, of incredibly palpable interests. It's a hard subject.

Q: Two-thirds of the 37 million Americans with no insurance are in families headed by a full-time worker, most at very small companies. What will be the impact of this bill on small businesses?

A: Very positive because we pay 40% of their health insurance premiums for five years.

Q: Is it just for the very smallest of small employers?

A: It's 25 and down, and in the bill it's 25% of health insurance premiums forever.

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Q: Another concern is whether this will create a huge bureaucracy. Will it?

A: Everything is a catastrophe until it happens. People don't like change. The health care system needs change.

Q: But do we want AmeriCare to be a huge, vast federal bureaucracy that swallows Medicaid without curing some of Medicaid's failings?

A: Well, we would get rid of Medicaid.

Q: And replace it with a public program that has even more people in it?

A: Not necessarily. For example, Medicare, which most people think is a gigantic bureaucracy, its overhead, its administrative costs are 3%. No business in this country operates an on overhead cost of 3%. So it could happen, but it doesn't necessarily have to happen. What we're doing today, according to some, is wasting $ 100 billion dollars on health care in unnecessary bureaucratic costs. We can't do worse than that.

Q: Does the Democratic plan have a lot of wiggle room for experimentation and accommodation once it is up and running?

A: Hopefully that's what this encourages. What we're trying to do is to get away from a system which clearly doesn't work, where health-care costs are becoming unsustainable very rapidly. And we're trying to get to a point where health- care costs begin to be controlled.

Q: What is controlled? We're looking at annual national health expenditure growth of 13% to 15% a year.

A: I'm not sure I can answer that. A lot less than our present rate of growth. A number of things are controllable; the consumer's behavior is less controllable. The whole problem of Americans just latching on to every single new piece of technology as their birth right is a very expensive sort of sense of ownership. So Americans have to participate in the cost of their own health care and share in tougher decision-making about their own reaching out for health care.

Q: What are the chances for passage of this bill?

A: My official answer is we'll get it because in health care legislation, your only attitude can be full speed ahead. Assault on all fronts. If, on the other hand, we came out of this session of the Congress with full health insurance for pregnant women and children and insurance reform, that would not be sufficient to what I want, but it would be a gigantic step forward.

How the Democrats' plan would change the system

THE BILL:

The Senate Democrats' HealthAmerica bill proposes to guarantee insurance coverage to all Americans and trim the nation's health care bill by $ 78 billion over five years.

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THE PROVISIONS:

- Mandate basic benefits, including hospital and physician services, pre-natal and preventive care and limited mental health benefits.

- Require all employers, after a five-year phase-in, to either provide at least basic coverage for all employees working more than 17 1/2 hours a week through private insurance, or pay a percentage of their payroll to a new public insurance program, AmeriCare.

- Allow everyone without insurance to buy basic coverage through AmeriCare for a premium based on income.

- Insure all without income for free. (AmeriCare would replace Medicaid that covers the poor and unemployed.)

- Subsidize insurance premiums for the smallest, lowest-wage employers.

- Make working people responsible for up to 20% of their premiums and most medical bills, based on income.

- Bar health insurers from denying coverage or charging prohibitive rates based on health status.

- Set up state or regional authorities to negotiate fees with doctors and hospitals, establish standards and guidelines for effective and efficient medical care, and weigh costs and benefits of new technology.

- Require a standard electronic claims filing system nationwide to cut administrative costs.

GRAPHIC: GRAPHIC; b/w, Keith Carter, USA TODAY, Source: Employee Benefits Research Institute, Small Business Administration (Pie charts); PHOTO; b/w, USA TODAY

CUTLINE: Rockefeller

TYPE: Inquiry

SUBJECT: PROFILE; HEALTH; LEGISLATION; INTERVIEW

NOTES: Sen. John D. Rockefeller IV, D-W.Va., 54, is the principal architect of the Democrats' health-care plan,

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