Kassebaum, Nancy

PHOTOCOPY
PRESERVATION

THE WHITE HOUSE

July 1, 1993

Honorable Nancy Landon Kassebaum
United States Senate
Washington, D.C. 20515

Dear Senator Kassebaum:

Thank you for your letter in support of the invitation extended by the Wichita Association of Legal Administrators. Unfortunately, my schedule does not permit me to accept every request that I would like to honor. If I am able to participate in this worthwhile event, I will contact Ms. Pamela Downs directly.

Again, thank you for writing.

Sincerely,

Hillary

Hillary Rodham Clinton

NANCY LANDON KASSEBAUM
KANSAS

United States Senate

WASHINGTON, D. C.

June 14, 1993

Dear Mrs. Clinton:

Knowing of the many demands on your time, I hesitate to add yet another. Nevertheless...

Pamela Downs has asked you to speak at the Spring 1994 Wichita Association of Legal Administrators Managing Partners Appreciation Meeting. I am, at this early date, adding my endorsement to her invitation and hope you will be able to accept.

With all best wishes,

Warmest regards,

Nancy

Nancy Landon Kassebaum
United States Senator

Mrs. Hillary Rodham Clinton
The White House
Washington, D.C. 20500

FLEESON, GOOING, COULSON & KITCH

LAWYERS

CARL A. BELL
GERRIT H. WORMHOUDT
WILLARD B. THOMPSON
RICHARD I. STEPHENSON
THOMAS D. KITCH
J. ERIC ENGSTROM
STEPHEN M. JOSEPH
STEPHEN E. ROBISON
MARK F. ANDERSON
RON CAMPBELL
TIMOTHY P. O'SULLIVAN
GREGORY J. STUCKY
CHARLES E. MILLSAP
EDWARD J. HEALY
WILLIAM P. TRETBAR
SUSAN P. SELVIDGE

DIXIE F. MADDEN
THOMAS J. LASATER
DAVID G. SEELY
MARY E. MAY
STEPHEN M. STARK
LYNDON W. VIX
MARY RUTH BYERLEY
ALAN R. WELCH
JOHN T. STEERE
WILLIAM L. TOWNSLEY
SCOTT D. JENSEN
JORDAN E. CLAY
JOHN R. GERDES
RICHARD B. CHAMBERS
JOHN E. REES II

SIXTEENTH FLOOR · 125 NORTH MARKET
POST OFFICE BOX 997
WICHITA, KANSAS 67201-0997
(316) 267-7361
TELECOPIER
(316) 267-1754

DALE M. STUCKY
DONALD R. NEWKIRK
JAMES R. BOYD
OF COUNSEL

HOWARD T. FLEESON
(1895-1957)
HOMER V. GOOING
(1894-1986)
WAYNE COULSON
(1910-1985)
PAUL R. KITCH
(1911-1987)

May 26, 1993

The Honorable Nancy Landon Kassebaum
United States Senate
304 Russell Senate Office Building
Washington, D.C. 20510

Re: Invitation to Hillary Rodham Clinton

Dear Senator Kassebaum:

I am writing to inform you that I have invited Mrs. Hillary Rodham Clinton to speak at the Spring 1994 Wichita Association of Legal Administrators Managing Partners Appreciation meeting. I would appreciate your support in securing Mrs. Rodham Clinton, as well as your attendence at this event.

Thank you, in advance, for your support.

Very truly yours,

Pamela N. Downs

Pamela N. Downs
Legal Administrator and
WALA President

PND/jds

S. 325 and H.R. 834, "BasiCare Health Access and Cost Control"
Introduced by Sen. Nancy Kassebaum (KS)
& Rep. Dan Glickman (KS)
February 4, 1993

Overview: This bill would require all insurers to offer a single uniform benefits package (BasiCare), mandate all individuals to purchase this package, and provide income-based vouchers for low-income persons.

Coverage: The bill would provide universal coverage through the individual mandate. BasiCare would supplant Medicaid and after five years, a legislative proposal would be developed to assimilate the Medicare, FEHB, and CHAMPUS programs into Basicare. The bill would require community rating and establish premium bands across blocks of business.

Benefits: While the bill sets a foundation for the Basicare package, an independent Basicare commission would determine the specific benefits to be included in the minimum coverage package. The package would have uniform national premiums, deductibles, and copayments.

Quality: The commission would contract with States or private organizations to collect and disseminate information to consumers on quality and cost effectiveness of services in the States. Other elements of the plan include malpractice reforms, expansion of low-income community health centers, and measures to increase the number of health professionals in underserved areas.

Cost Containment: Cost control would be achieved through binding annual limits on the rate of increase in Basicare premiums, capping tax exclusions for health benefits at the cost of the Basicare plan, enacting tort reform, and implementing electronic billing and payment systems.

Financing: Sources of revenue for this bill would include a diversion of up to 1 percent of the Social Security payroll tax, taxes on health benefits above the tax cap, and the Federal and State funds that would have been used for Medicaid. (States have a maintenance-of-effort requirement.) No cost estimates are available at this time.

Status: As of 7/20/93, this bill had 1 cosponsor in the House and 2 in the Senate. Cosponsors are Rep. McCurdy (OK) and Sens. Danforth (MO) and Burns (MT). Groups were not solicited to endorse this bill.

	Clinton	S 325 Kassebaum
1. Goals/Coverage	Universal access achieved through expanded employer-based insurance and state administered regional health alliances.	Provides an individual mandate for basic coverage and income-based vouchers for low-income persons. Small group health insurance market reforms to ensure availability and affordability would be phased-in immediately. Commission would submit recommendations for national standardization of the "BasiCare" package to Congress for approval.
	Medicare remains in place and expanded. Medicaid incorporation phased-in; FEHB incorporated; VA incorporated for vets; CHAMPUS/DOD study; IHS remains in place and expanded.	Medicare is incorporated; Medicaid is replaced with a more extensive program; FEHB similar; VA is incorporated; CHAMPUS is incorporated; IHS is incorporated.
2. Benefits	Three (3) options available: fee-for-service, network & HMO.	Fee-for-service; managed care options to be developed by the Commission.
	Guaranteed benefits package include: hospital and physician services; preventive care services; mental health (w/ limits phased-in; vision and hearing for kids; preventive dental for kids (phased-in for adults); Rx drugs w/ separate cost-sharing; limited long-term home care services through separate program (with phase-in expansion).	At a minimum the "BasiCare" package would include: basic hospitalization/outpatient services; preventive services (if proven cost-effective) Small employer required to offer benefits as offered under existing Medicare Parts A & B.
	Fee for service cost sharing incl. $250 deductible & 20% copay, out-of-pocket limit $1,500 indiv./$3,000 family; No cost sharing for preventive services. Lower cost-sharing in managed care plans.	The Commission is directed to employ copayments rather than deductibles in providing for cost-sharing in the BasiCare plan. Out-of-pocket protection not defined. Coverage against extraordinary long-term care costs.
	No provision.	Small employers (less than 51 emplo) cost sharing: deductibles $500 indiv./$1,000 family; no deductibles for children up to age 23 or pregnant . No cost sharing for preventive services. Out-of-pocket limit $2,000 individual/$3,000 family.
3. State Role	Federal program administered by States. States given flexibility to meet Federal requirements. State options include establishment of a single payer system, an alternative delivery system w/ multiple plans, or an all payer system w/ multiple plans.	Federal program administered by the States.
	Within Federal guidelines States must:	
	▸ establish alliances;	▸ no provision;
	▸ assure enrollment & access to care for its residents;	▸ similar but only for low-income persons receiving vouchers;
	▸ regulate plans, incl. financial standards, risk adjustment system, & quality standards;	▸ State role not defined.
	▸ provide for data/information systems;	▸ Commission could contract w/ State to collect/disseminate information to consumers on quality and cost-effectiveness of services.
	▸enforce budgets after a transition.	▸ no provision.

	Clinton	S 325 Kassebaum
4. Cost Containment	The national health board will set a national per capita budget target for health care based on current health care spending.	The BasiCare Commission would set basic premium rates for all BasiCare plans with limited allowances for geographic and demographic variations.
	The Board will set annual allowable premium increases equal to CPI + POPULATION.	Commission would establish a maximum allowable rate of increase in premiums.
	No provision.	Employers/employees would only be permitted to take tax deductions/exclusions for "BasiCare" plans.
	The allowable increase will be adjusted for each alliance to reflect any changes in the demographics of the alliance during the previous year.	No provision.
	State budgets allocated according to geographic adjustment factors. Federal funds to States for low-income subsidies.	No provision.
	Payments to providers are negotiated by plans, except that provider payment limits are one tool available to States/Feds to enforce budget.	No provision.
	During years 1-3 the federal government assumes responsibility for enforcement of alliance budgets, thereafter the states will enforce the budgets.	No provision.
5. Employer Financing	Employer must contribute 80% of the cost of employees coverage (contribution not to exceed 7.6% of employee wages).	No provision.
	Small low-wage firms employer contribution capped at 3.2% (depending on size and average wage level).	No provision.
	No provision.	Employer tax deduction for health insurance expenses limited to cost of "BasiCare" plan.
	No provision.	Deduction for self-employed increased from 25% of health costs to 100%.
6. Other Financing	Employees pay up to 20% of avg. premium in regional health alliance	Redirecting 1% of the existing Social Security payroll tax on wages and self-employment income;
		Redirects existing Medicaid (State and Federal) funds, otherwise unobligated amounts in the Medicare Hospital and Medical Insurance Trust Funds;
		Federal funds otherwise appropriated for the VA health program, CHAMPUS, the Indian Health Service, the FEHB, and the funds necessary to provide assistance to authorized low-income persons.
	Cigarette tax.	

	Clinton	S 325 Kassebaum
7. Malpractice Reform	[To be determined.]	Limits non-economic damages to $250,000; Allows for periodic payments (awards > $100,000); Requires collateral source offset; Caps punitive damages at amount awarded for economic and noneconomic damages; Limits attorneys fees based on hourly rate or as percentage of total damages awarded (excl. punitives); Reduces statute of limitations to 2 years from date injury should have been found, but not later than 4 years after occurrence; Authorizes grants to States to develop ADR systems.

S. 1057 "The MediCORE National Health Act"
Introduced by Sen. James M. Jeffords
May 27, 1993

Overview: The bill would provide universal access to a set of "CORE" benefits to all citizens and legal residents. It would create a federal board to design the CORE benefits. States would have the responsibility of designing and administering the program. They would also assume some financial responsibility for the program.

Coverage: The bill would provide universal access to all citizens and residents. Coverage would be portable to other states and overseas. Medicare services would be folded into the CORE and expanded to cover long-term custodial or personal assistance care. Medicaid, FEHBP and certain CHAMPUS services would also be folded into the CORE. DOD and Veterans Affairs programs would remain in tact.

Benefits: The program would provide a national comprehensive package to be determined by a Federal board. The benefits would include: medically necessary services, prescription drugs, mental health services, long-term care, primary and preventive care services. The Board would have to design the CORE services within the financing constraints predetermined by the current national health care expenditures and institute funding controls to limit budgeting deficits.

Quality: States would be required to have proper quality assurances mechanisms to receive accreditation to operate from the Board.

Cost Containment: Cost containment mechanisms include: limiting the scope and content of CORE services to that which can be financed by the MediCORE Trust Fund; State and regional level budgeting and fee schedules; outcomes reviews and malpractice reform.

Financing: Roughly 70 percent of the costs of the program would be federally financed. A MediCORE Trust Fund would be established and funded principally by a 6 percent payroll tax, where 4 percent is the employer's responsibility and 2 percent that of the employee. Other Federal funds would included a new health premium of 6 percent that would be applied to each taxpayer's adjusted gross income as well as funds which would otherwise have been appropriated to carry out specific Federal health programs (Medicare, Medicaid, FEHBP, etc.). States would responsible for the remaining 30 percent of the program funding. Cost estimates are not available at this time.

Status: As of 07/15/93, there were no cosponsors for S. 1057.

	Clinton	S 1057 Jeffords
1. Goals/Coverage	Universal access achieved through expanded employer-based insurance and state administered regional health alliances.	Universal access provided by a federal system of state-run and state-designed health care programs.
	Medicare remains in place and expanded.	Medicare folded into program and expanded.
	Medicaid incorporation phased-in; FEHB incorporated; VA incorporated for vets; CHAMPUS /DOD study; IHS remains in place and expanded.	Medicaid incorporated; FEHB incorporated; Certain CHAMPUS services incorporated; DOD and VA remain intact and studied; IHS remains in place.
2. Benefits	Three (3) options available: fee-for-service, network & HMO.	States must include at least one delivery plan offering significant freedom of choice of providers.
	Guaranteed benefits package include: hospital and physician services; preventive care services; mental health (w/ limits phased-in; vision and hearing for kids; preventive dental for kids (phased-in for adults); Rx drugs w/ separate cost-sharing; limited long-term home care services through separate program (with phase-in expansion).	A basic, comprehensive benefit package determined by a Federal board would include: medically necessary services, prescription drugs, mental health services, long-term care, primary and preventive care services.
	Fee for service cost sharing incl. $250 deductible & 20% copay, $3000 out-of-pocket limit; **No cost sharing for preventive services.** Lower cost-sharing in managed care plans.	No provision
3. State Role	Federal program administered by States. States given flexibility to meet Federal requirements. State options include establishment of a single payer system, an alternative delivery system w/ multiple plans, or an all payer system w/ multiple plans.	Federal program designed and administered by the States. States given flexibility to meet Federal requirements. States given wide latitude in designing program and they could establish single payer systems.
	Within Federal guidelines States must:	Within Federal guidelines States must:
	▸ establish alliances;	▸ does not have to establish alliances;
	▸ assure enrollment & access to care for its residents;	▸ Similar
	▸ regulate plans, incl. financial standards, risk adjustment system, & quality standards;	▸ Similar
	▸ provide for data/information systems;	▸ Similar;
	▸enforce budgets after a transition.	▸ States enforce budget.

	Clinton	S 1057 Jeffords
4. Cost Containment	The national health board will set a national per capita budget target for health care based on current health care spending.	The Federal board shall prepare an annual budget containing estimates of total national expenditures and the total amount it expects to be available from the Trust Fund.
	The Board will set annual allowable premium increases equal to CPI + POPULATION.	The Board shall compute the national average per capita costs for each category of CORE services and develop adjustment factors for risk groups.
	The allowable increase will be adjusted for each alliance to reflect any changes in the demographics of the alliance during the previous year.	No provision
	State budgets allocated according to geographic adjustment factors. Federal funds to States for low-income subsidies.	State budgets adjusted according to differing state circumstances.
	Payments to providers are negotiated by plans, except that provider payment limits are one tool available to States/Feds to enforce budget.	No provision
	During years 1-3 the federal government assumes responsibility for enforcement of alliance budgets, thereafter the states will enforce the budgets.	The Board must design the CORE services within the financing constraints predetermined by current national health care expenditures and institute funding controls to limit budgeting deficits.
5. Employer Financing	Employer must contribute 80% of the cost of employees coverage (contribution not to exceed 7.6% of employee wages).	Federal financing would be derived in part by employers contributing a tax equal to 4 percent of wages paid during each calendar year. Employers would not be permitted to deduct amounts paid for program coverage.
	Small low-wage firms employer contribution capped at 3.2% (depending on size and average wage level).	No provision
6. Other Financing	Employees pay up to 20% of avg. premium in regional health alliance wages).	Remaining Federal financing would be raised as follows: Employees must contribute a tax equal to 2 percent of wages received up to $100,000.
		Self-employed individuals must contribute a tax equal to 6 percent on the first $100,000 of income, and at 4 percent on amounts in excess of $100,000.
		No provision
		No provision
	Cigarette tax.	No provision
	No provision	Individuals would also pay a new tax on adjusted gross income with a maximum of 6 percent.
	No provision.	The Federal government would provide approximately 70 percent of the financing, with states responsible for the remaining 30 percent.

H.R. 1200 and S. 491 "American Health Security Act"
Introduced by Rep. Jim McDermott (WA)
& Sen. Paul Wellstone (MN)
March 3, 1993

Program: The bill would establish a universal access health program that would be paid for by the federal government as the single payor and administered by the states. States would be allowed to establish their own health care delivery system and patients would be able to chose their own providers. The bill would preserve the current fee-for-service system and give the states the option to enroll their residents, through capitated managed care, in comprehensive health service organizations.

Coverage: The bill would provide universal coverage, ensure portability of benefits between states. Medicare, Medicaid, FEHBP, and CHAMPUS programs would be replaced by the health security program and the VA and IHS programs would remain intact.

Benefits: The program would provide a national comprehensive benefit package.

Quality: Quality assessments would be directed through a Quality Council, state review programs, and a required State electronic database. The program would emphasize primary care by increasing the number of primary care physicians and primary care mid-level practitioners.

Cost Containment: Cost control mechanisms include health care expenditure budgets, national fee schedules, and streamlined administration. Overall health care spending increases would be limited to no more than the annual percentage increase in the gross domestic product.

Financing: A Trust Fund would be established and financed with funds from payroll and income taxes and funds which would otherwise have been appropriated to carry out specific Federal health programs (Medicare, Medicaid, FEHBP, etc.). Cost estimates are not available at this time.

Status: As of 7/20/93, this bill had 85 cosponsors in the House and 3 in the Senate. Key cosponsors include Reps. Stark (CA), Moakley (MA), Studds (MA), Mfume (MD), Collins (IL), Rangel (NY), Stokes (OH), Lewis (GA), Reynolds (IL) and Sens. Metzenbaum (OH) and Simon (IL). Key endorsing groups include Citizen Action, National Association of Social Workers, and Physicians for a National Health Program (PNHP), Gray Panthers, United Church of Christ, Teamsters, and the National Farmers Union.

	Clinton	HR 1200 McDermott
1. Goals/Coverage	Universal access achieved through expanded employer-based insurance and state administered regional health alliances.	Universal access would be achieved through a State-based/administered national health insurance program.
	Medicare remains in place and expanded. Medicaid incorporation phased-in; FEHB incorporated; VA incorporated for vets; CHAMPUS/DOD study; IHS remains in place and expanded.	Medicare replaced; Medicaid replaced; FEHB replaced; VA remains; CHAMPUS replaced; IHS remains.
2. Benefits	Three (3) options available: fee-for-service, network & HMO.	Multiple plan types not guaranteed.
	Guaranteed benefits package include: hospital and physician services; preventive care services; mental health (w/ limits phased-in; vision and hearing for kids; preventive dental for kids (phased-in for adults); Rx drugs w/ separate cost-sharing;	Comprehensive benefit pkg. similar plus includes full coverage for mental health. full coverage for prescription drugs
	limited long-term home care services through separate program (with phase-in expansion).	long-term care (age 65 and older pay monthly premium);
	Fee for service cost sharing incl. $250 deductible & 20% copay, out-of-pocket limit $1500 indiv./$3,000 family; No cost sharing for preventive services. Lower cost-sharing in managed care plans.	No cost-sharing for acute care services.
3. State Role	Federal program administered by States. States given flexibility to meet Federal requirements. State option includes the establishment of a single payer system, an alternative delivery system w/ multiple plans or all payer system w/ multiple plans.	Similar but States given greater flexibility in meeting Federal requirements.
	Within Federal guidelines States must:	
	▸ establish alliances;	▸ no provision
	▸ assure enrollment & access to care for its residents;	▸ similar provision
	▸ regulate plans, incl. financial standards, risk adjustment system, & quality standards;	▸ similar except private health insurance plans for basic benefits no longer exist. States would provide these functions directly;
	▸ provide for data/information systems;	▸ similar provision;
	▸enforce budgets after a transition.	▸ similar provision. ▸ establish health planning programs; ▸ establish fraud and abuse programs.

	Clinton	HR 1200 McDermott
4. Cost Containment	The national health budget is established.	A national health security budget established annually.
	Statute will set annual allowable premium increases equal to CPI + POPULATION	Increases in the budget would be based on prior year health expenditures plus growth in GDP.
	No provision.	The national budget would be divided into quality assessment, professional education, administrative, and operating components.
	The allowable increase will be adjusted for each alliance to reflect any changes in the demographics of the alliance during the previous year.	Similar provision, adjusted for differences among States in costs and health status of populations.
	No provision.	States could spend no more than 3% of budget on administrative costs.
	State budgets allocated according to geographic adjustment factors. Federal funds to States for low-income subsidies.	States would receive federal funds b l on the national avg. per capita cost of all covered services, factoring in a state adjustment factor and a risk adjustment factor.
	Payments to providers are negotiated by plans, except that provider payment limits are one tool available to States/Feds to enforce budget.	Payments to institutions would be made based on annual prospective global budgets approved by the State. Global budgets would be developed through State/institution negotiations.
	During years 1-3 the federal government assumes responsibility for enforcement of alliance budgets, thereafter the states will enforce the budgets.	State enforcement.
5. Employer Financing	Employer must contribute 80% of the cost of employees coverage (contribution not to exceed 7.6% of employee wages).	The dollar limitation on the amount of wages subject to the Medicare Hospital Insurance (HI) tax would be repealed. The employer portion of HI tax would be increased from 1.45% to 7.9%.
	Small low-wage firms employer contribution capped at 3.2% (depending on size and average wage level).	No provision
	No provision	The self-employed tax is increased from 2.9% to 8.35% of income.
	No provision	State and local government employees would be subject to 1.45% HI tax.
	No provision	The top corporate tax rates would be increased from 34 to 37%. Deductions for business-related meals would be abolished.

	Clinton	HR 1200 McDermott
6. Other Financing	Employees pay up to 20% of avg. premium in regional health alliance	Individual income tax rates increased to 28%, 31% & 34%; adds new top rate of 38% for families with incomes over $200,000; A health security premium equal to 7.5% of taxes paid would apply to the income taxes paid by each taxpayer. A 10% surtax would be applied to income taxes paid by persons with taxable inc over $1 million. The deductibility of moving expenses would be limited to $5,000. The deduction for club membership i would be eliminated. The portion of Social Security benefits subject to taxation is increased from 50 to 85%. All individuals age 65 or older eligible for health security benefits would pay a monthly premium of $65 for long-term health care (adjusted annually based on cost-of-living).
	Cigarette tax.	

H.R. 5936 "Managed Competition Act of 1992"
Introduced by Reps. Cooper (TN), Andrews (TX) and Stenholm (TX)

Overview: This bill would guarantee universal access to affordable health care coverage, relying on a system of managed competition. Through tax incentives, providers and insurance companies would be encouraged to form health partnerships to deliver quality, cost-effective health care. Each State would be required to have at least one Health Plan Purchasing Cooperative (HPPC) which would enter into agreements with Accountable Health Plans to offer a uniform benefit package. A uniform package of effective benefits would be offered to small employers and individuals through HPPCs. Unlike other managed competition models, there is no employer or individual mandate.

Coverage: Universal access to affordable health care coverage would be attained by allowing small employers and individuals to purchase a health care policy through a HPPC. The Medicaid program would be repealed. All individuals below 200% of poverty would be enrolled in a HPPC. Premiums, copayments and deductibles would be paid for under the new federal program for all individuals below 100% of poverty. A Federal subsidy would be provided to individuals between 100% and 200% of poverty to help pay their premiums and copayments.

Benefits: The National Health Board would develop a uniform set of effective treatment benefits, including preventive services which must be approved by Congress. The Board could exclude treatments that have not been proven effective. An enhanced benefit package including prescription drugs, eyeglasses and hearing aids would be available for low-income individuals. Copayments and deductibles would be required.

Quality: The National Board would be required to establish minimum quality standards. Providers would be required to report medical outcomes and consumers would be provided information on the quality of care provided in a plan.

Cost Containment: Cost restraint is built into the system through cost conscious consumer choice, competition between health plans, reduced administrative overhead, limitations imposed on the tax treatment of employer provided health benefits, and specification of effective treatment benefits.

Financing: The bill would eliminate the limit on income which is subject to the Medicare HI tax, cap deductibility of health plan expenses at the price of the lowest health plan, impose a 34% excise tax on employers or individuals who purchase an enhanced benefit package and redirect Federal Medicaid spending.

Status: HR 5936 was introduced in the 102nd Congress and had 19 cosponsors. It has not been reintroduced in this Congress. Blue Cross/Blue Shield, the American Hospital Association and American Healthcare Systems were strong supporters of Mr. Cooper's bill.

	Clinton	HR 5936 Cooper
1. Goals/Coverage	Universal access achieved through expanded employer-based insurance and state administered regional health alliances.	Access improved through State Health Purchasing Cooperatives, but universal access not guaranteed.
	Medicare remains in place and expanded.	Similar
	Medicaid incorporation phased-in;	Similar
	FEHB incorporated;	No provision
	VA incorporated for vets;	No Provision
	CHAMPUS /DOD study;	No Provision
	IHS remains in place and expanded.	No Provision
2. Benefits	Three (3) options available: fee-for-service, network & HMO.	Similar
	Guaranteed benefits package include: hospital and physician services; preventive care services; mental health (w/ limits phased-in; vision and hearing for kids; preventive dental for kids (phased-in for adults); Rx drugs w/ separate cost-sharing; limited long-term home care services through separate program (with phase-in expansion).	Benefit package to be determined by Natl.Health Bd. to include at min. hospital, physician and prevention services
	Fee for service cost sharing incl. $250 deductible & 20% copay, $3000 out-of-pocket limit; **No cost sharing for preventive services.** Lower cost-sharing in managed care plans.	Cost sharing required of all individuals. Natl. Bd. determines copays and deductibles. No cost sharing for individuals under 100% of poverty; 100%-200% of poverty cost sharing subsidized.
3. State Role	Federal program administered by States. States given flexibility to meet Federal requirements. State option includes establishment of a single payer system, an alternative delivery system w/ multiple plans or an all payer system w/ multiple plans.	Federal program administered by States. States have no authority to set rates or adopt a single payer system.
	Within Federal guidelines States must:	
	▸ establish alliances;	same
	▸ assure enrollment & access to care for its residents;	same
	▸ regulate plans, incl. financial standards, risk adjustment system, & quality standards;	similar requirement for Natl.Bd.
	▸ provide for data/information systems;	same
	▸enforce budgets after a transition.	No provision

	Clinton	HR 5936 Cooper
4. Cost Containment	The national health board will set a national per capita budget target for health care based on current health care spending.	No provision
	The Board will set annual allowable premium increases equal to GDP -1%.	No provision
	The allowable increase will be adjusted for each alliance to reflect any changes in the demographics of the alliance during the previous year.	No provision
	State budgets allocated according to geographic adjustment factors. Federal funds to States for low-income subsidies.	No provision
	Payments to providers are negotiated by plans, except that provider payment limits are one tool available to States/Feds to enforce budget.	Payments to providers are negotiated by plans.
	During years 1-3 the federal government assumes responsibility for enforcement of alliance budgets, thereafter the states will enforce the budgets.	No provision
	Tax deductibility for basic benefit plan.	Limits tax deductibility for employers and individuals to 100% of lowest cost plan.
5. Employer Financing	Employer must contribute 80% of the cost of employees coverage (contribution not to exceed 7.6% of employee wages).	No provision
	Small low-wage firms employer contribution capped at 3.2% (depending on size and average wage level).	No provision
6. Other Financing	Employees pay up to 20% of avg. premium in regional health alliance	Individuals pay full premium with subsidy for low-income.
		No provision
		No provision
		No provision
	Cigarette tax.	No provision
	No Provision	Eliminates limit on income subject to Medicare HI tax; caps employer, employee deductibility to 100% of lowest health plan; imposes 34% excise tax for excessive benefit pkg; redirects Medicaid spending

H.R. 101 "Action Now Health Care Reform Act of 1993"
Introduced by Rep. Bob Michel (IL)
January 5, 1993

Overview: The product of the Minority Leader's Task Force on Health Care, this bill would establish incremental reforms in the current health care system with the main objective of cost containment. These various incremental reforms reflect where a broad spectrum of Members were in the last Congress when comprehensive health care reform was not thought possible.

Coverage: The bill would expand the availability and affordability of health insurance to small employers. The plan would ensure portability, restrict the use of preexisting condition limitations, and place limits on premium increases. For self-employed persons who purchase their own insurance, the existing deduction for these expenses would be increased from 25 to 100 percent. The bill would also increase funds for the community health centers program.

Benefits: Insurers would have to offer small employers at least two plans, one providing only essential medical and preventive benefits and the other a more generous package.

Quality: To improve rural health care, the bill would authorize a series of grants to train emergency medical personnel, develop air transport systems, and improve telecommunication links between rural and urban hospitals. It would also extend the special treatment rules for Medicare dependent, small rural hospitals.

Cost Containment: In an attempt to include consumers in health care cost containment, the bill would authorize individual medical savings accounts similar to IRAs. Employers could make tax-deductible contributions to employee accounts and workers could use the money to purchase insurance and pay other medical costs.

Also, the bill proposes malpractice reforms including mandated use of alternative dispute resolution, caps on non-economic damages, elimination of joint and several liability, and limits on attorneys' fees.

Likewise, the bill would seek to reduce administrative costs by streamlining the insurance billing system and utilizing electronic data cards for Medicare beneficiaries.

Financing: No specific financing is provided for in this bill. Cost estimates are not available at this time.

Status: As of 7/20/93, this bill had 69 Republican cosponsors. Key cosponsors include: Reps. Archer (TX), Bilirakis (FL), Bliley (VA), Gingrich (GA), Grandy (IA), Hastert (IL), Johnson (CT), Kasich (OH), McMillan (NC), and Moorhead (CA).

	Clinton	HR 101 Michel
1. Goals/Coverage	Universal access achieved through expanded employer-based insurance and state administered regional health alliances. Medicare remains in place and expanded. Medicaid incorporation phased-in; FEHB incorporated; VA incorporated for vets; CHAMPUS/DOD study; IHS remains in place and expanded.	Establishes incremental reforms in the current health care system with the main objective of cost containment. Federal programs remain in place; Community health centers expanded.
2. Benefits	Three (3) options available: fee-for-service, network & HMO. Guaranteed benefits package include: hospital and physician services; preventive care services; mental health (w/ limits phased-in; vision and hearing for kids; preventive dental for kids (phased-in for adults); Rx drugs w/ separate cost-sharing; limited long-term home care services through separate program (with phase-in expansion). Fee for service cost sharing incl. $250 deductible & 20% copay, out-of-pocket limit $1,500 /$3000 family; No cost sharing for preventive services. Lower cost-sharing in managed care plans.	No provision Insurers would have to offer small employers 2 alternative MedAccess benefit plans: a "basic" plan with essential medical and preventive benefits, and a "standard" plan more comparable to coverage now generally available. The HHS Secretary would request that the National Association of Insurance commissioners to specify the benefit standards. No provision
3. State Role	Federal program administered by States. States given flexibility to meet Federal requirements. State option includes establishment of a single payer system, an alternative delivery system w/ multiple plans or an all payer system w/ multiple plans. Within Federal guidelines States must: ▸ establish alliances; ▸ assure enrollment & access to care for its residents; ▸ regulate plans, incl. financial standards, risk adjustment system, & quality standards; ▸ provide for data/information systems; ▸enforce budgets after a transition.	States have increased regulatory authority due to insurance market reforms and increased responsibilities due to alternative dispute resolution systems (see malpractice reform section) No provision

	Clinton	HR 101 Michel
4. Cost Containment	The national health board will set a national per capita budget target for health care based on current health care spending.	No provision
	The Board will set annual allowable premium increases equal to CPI + POPULATION.	No provision
	The allowable increase will be adjusted for each alliance to reflect any changes in the demographics of the alliance during the previous year.	No provision
	State budgets allocated according to geographic adjustment factors. Federal funds to States for low-income subsidies.	No provision
	Payments to providers are negotiated by plans, except that provider payment limits are one tool available to States/Feds to enforce budget.	No provision
	During years 1-3 the federal government assumes responsibility for enforcement of alliance budgets, thereafter the states will enforce the budgets.	No provision
	Alternative delivery systems are available in each alliance for all citizens, not just Medicaid.	States are allowed to provide coverage to Medicaid recipients through alternative delivery systems such as HMOs or PPOs.
	Certain physician referrals to facilities in which the physician holds an ownership or investment interest are prohibited.	Similar provision
	Administrative costs reforms are implemented.	Administrative cost reforms include requiring States to develop comparative value information programs and requiring the adoption of uniform standards for electronic collection and transmission of health insurance information.
	No provision	Employees/Employers have option to contribute to a tax fee medical savings account. Funds to be used for medical or long term care services/insurance.
5. Employer Financing	Employer must contribute 80% of the cost of employees coverage (contribution not to exceed 7.6% of employee wages).	No provision
	Small low-wage firms employer contribution capped at 3.2% (depending on size and average wage level).	No provision
6. Other Financing	Employees pay up to 20% of avg. premium in regional health alliance	No provision
		No provision
	Cigarette tax.	

	Clinton	HR 101 Michel
7. Malpractice Reform	[To be determined]	Requirement that all medical liability disputes would be handled through an alternative dispute resolution process (ADR) before plaintiffs could go to court. A state's ADR would have to apply to all medical malpractice claims in the state, would require the written opinions be issued that contain findings of fact, and would have to be approved by state or local governments. Non-economic damages would be limited to $250,000. Attorneys' fees could not exceed 25% of the first $150,000 of an award or settlement and 15% of any additional amount. The liability of each defendant in a medical malpractice action would be several and not joint. Punitive damages would be capped at 2 times the total damage award and these payments must go to the States to defray malpractice-related expenses.

SUMMARY OF SEN. CHAFEE'S HEALTH CARE REFORM PLAN (UNDER DEVELOPMENT)

OVERVIEW - SEN. CHAFEE IS DEVELOPING A HEALTH CARE REFORM BILL WITH A TASK FORCE OF OTHER MODERATE REPUBLICANS AND SEN. DOLE. THE CHAFEE BILL WOULD BE SIMILAR IN SOME RESPECTS TO REP. COOPER'S APPROACH TO MANAGED COMPETITION. THE CHAFEE BILL WILL PROPOSE INSURANCE MARKET REFORMS, A HIPC STRUCTURE AND OTHER COMPETITIVE INCENTIVES TO ENHANCE PURCHASING CLOUT FOR INDIVIDUALS AND SMALL EMPLOYERS. CHAFEE WILL PROPOSE AN INDIVIDUAL MANDATE IN AN EFFORT TO BRING ALL AMERICANS INTO THE REFORMED HEALTH CARE SYSTEM. THERE WILL BE SIGNIFICANT STATE FLEXIBILITY TO SET UP HIPCs AS THEY SEE FIT.

COVERAGE - THE PLAN WILL REQUIRE ALL INDIVIDUALS TO ENROLL IN BASIC HEALTH INSURANCE COVERAGE. EMPLOYERS WOULD BE PERMITTED TO CONTRIBUTE TOWARD THIS COVERAGE, BUT WOULD NOT BE REQUIRED TO DO SO. A WAIVER BOARD MAY BE ESTABLISHED TO PERMIT STATE EXPERIMENTATION WITH MEDICAID AND MEDICARE INTEGRATION. SUBSIDIES TO LOW INCOME PERSONS WILL BE AVAILABLE AS COST CONTAINMENT SAVINGS ARE REALIZED.

BENEFITS - THE PLAN WILL PROVIDE FOR A GUARANTEED LEVEL OF HEALTH COVERAGE WHICH ALL PLANS MUST OFFER. COVERAGE OF PREVENTIVE HEALTH SERVICES AND PRIMARY CARE WILL BE EMPHASIZED.

QUALITY - INDIVIDUALS WOULD BE PROVIDED INFORMATION ON QUALITY OF CARE TO INFORM THEIR CHOICE OF PLANS, THEREBY PROVIDING INCENTIVES FOR HEALTH PLANS TO MAINTAIN QUALITY.

SUMMARY OF SEN. CHAFEE'S HEALTH CARE REFORM PLAN (UNDER DEVELOPMENT) (CONTINUED)

COST CONTAINMENT - SMALL EMPLOYERS (UNDER 125 WORKERS) WISHING TO PURCHASE COVERAGE WOULD DO SO THROUGH PURCHASING COOPERATIVES. INDIVIDUALS NOT OTHERWISE COVERED WOULD ALSO PURCHASE INSURANCE THROUGH THESE COOPERATIVES. MARKET PRESSURES COMBINED WITH MALPRACTICE REFORMS AND ADMINISTRATIVE SIMPLIFICATIONS ARE THE PRIMARY COST CONTAINMENT TOOLS AT THIS TIME.

FINANCING - MEDICARE AND MEDICAID SAVINGS PLUS SOME FORM OF TAX CAP.

STATUS - CHAFEE IS WORKING WITH 23 OTHER REPUBLICAN SENATORS ON A TASK FORCE TO DRAFT THIS PLAN WHICH WILL BE INTRODUCED AROUND THE TIME THAT THE PRESIDENT INTRODUCES HIS PLAN.

SUMMARY OF THE NICKLES/McCAIN BILL
(UNDER DEVELOPMENT)

OVERVIEW - CONSERVATIVE REPUBLICANS WILL INTRODUCE A BILL BASED ON THE HERITAGE FOUNDATION PROPOSALS. THEY ARE DEBATING WHETHER IT SHOULD BE VOLUNTARY OR INCLUDE AN INDIVIDUAL MANDATE. IT WOULD END EMPLOYER-BASED COVERAGE AND CONVERT CURRENT BENEFITS INTO WAGES FOR EMPLOYEES WHICH THEY COULD USE TO PURCHASE HEALTH INSURANCE.

COVERAGE AND BENEFITS - IF A MANDATE IS CHOSEN, IT WILL BE FOR A "CATASTROPHIC" LEVEL POLICY.

QUALITY - THERE WILL BE NO FORMAL NEW QUALITY SYSTEM.

COST CONTAINMENT - INDIVIDUAL RESPONSIBILITY FOR PAYMENT OF HEALTH COSTS AND THE LARGE OUT-OF-POCKET CONSEQUENCES FOR A CATASTROPHIC PLAN WILL CONTROL COSTS ALONG WITH MALPRACTICE REFORM AND ADMINISTRATIVE SIMPLIFICATION.

FINANCING - WILL ELIMINATE ALL TAX DEDUCTIBILITY FOR EMPLOYER PAID HEALTH CARE AND PROBABLY CAP THE BASE OF GROWTH OF MEDICARE AND MEDICAID.

STATUS - WILL PROBABLY BE INTRODUCED SHORTLY AFTER THE PRESIDENT'S BILL BY A COALITION OF HOUSE AND SENATE CONSERVATIVE REPUBLICANS.

H.R. 2610, "MediPlan Health Care Act of 1993"
Introduced by Rep. Pete Stark (CA)
July 1, 1993

Overview: Of the various bills introduced by Mr. Stark, this one is most representative of his health care reform agenda. Mr. Stark believes that the Medicare program has been a success and logically should be extended to everyone. Therefore, H.R. 2610 would create a publicly financed federally administered Medicare-for-all program. States would be granted substantial flexibility; they could elect to receive their MediPlan share in the form of a block grant to use in their own health reform system so long as Federal standards of access, cost containment and quality were satisfied.

Coverage: The bill provides for universal health care coverage through a newly created MediPlan program. All residents would be enrolled in MediPlan. Medicaid, FEHB and CHAMPUS remain only for services not covered by MediPlan.

Benefits: The benefit package would be that which is currently offered under Medicare plus a new prescription drug benefit (with cost-sharing), preventive services and pregnancy-related services (incl. pre- and post-natal care, well-baby and well-child services).

Quality: Quality programs currently utilized under Medicare would remain in place. The bill includes administrative simplification provisions for electronic claims processing of all claims, uniform billing, eligibility determination, and the reporting and coordination of benefits.

Cost Containment: Cost control mechanisms include a national health budget system, a single rate of payment for all providers (after phase-in), and streamlined administration.

Financing: A MediPlan Trust fund would be established and financed from a 10% tax on health care providers based on the amount of benefits provided during the prior year, payroll taxes, and MediPlan premiums. A State maintenance-of-effort is also required with regard to Medicaid. No cost estimates are available at this time.

Status: As of 7/20/93, there were no cosponsors for HR 2610. The bill has been referred jointly to the House Ways and Means and Energy and Commerce Committees. No committee action has been taken on the bill. The single payer groups have bypassed supporting Stark in favor of McDermott.

	Clinton	HR 2610 Stark
1. Goals/Coverage	Universal access achieved through expanded employer-based insurance and state administered regional health alliances.	Universal access achieved through publicly financed Federally administered Medicare-for-all program.
	Medicare remains in place and expanded.	Incorporated.
	Medicaid incorporation phased-in;	Medicaid remains, but only for services not covered in MediPlan.
	FEHB incorporated;	FEHB remains but, only for services not covered in MediPlan.
	VA incorporated for vets;	No provision.
	CHAMPUS/DOD study;	CHAMPUS remains but, only for services not covered in MediPlan.
	IHS remains in place and expanded.	Not specified.
2. Benefits	Three (3) options available: fee-for-service, network & HMO.	No provision.
	Guaranteed benefits package include:	Existing Medicare benefits w/addition of Medicaid acute care services.
	hospital and physician services;	Medicare spell of illness limits. No stay limits or cost-sharing for kids.
	preventive care services;	Similar.
	mental health (w/ limits phased-in); vision and hearing for kids;	More extensive.
	preventive dental for kids (phased-in for adults);	Similar.
	Rx drugs w/ separate cost-sharing;	No provision.
	limited long-term home care services through separate program (with phase-in expansion).	Similar but cost-sharing $800 deduct./20% copay.
	Fee for service cost sharing incl. $250 deductible & 20% copay, out-of-pocket limit $1,500 indiv./$3000 family; No cost sharing for preventive services. Lower cost-sharing in managed care plans.	No provision.
		Cost-sharing: single deductible of $350 indiv./$500 family; $2,500/$3,000 out-of-pocket limits. No cost-sharing for child preventive services or pregnancy-related services. Low-income persons have sliding-scale deductibles.
3. State Role	Federal program administered by States. States given flexibility to meet Federal requirements.	Federal program administered Federally. States would certify/regulate supplemental health plans.
	State options include establishment of a single payer system, an alternative delivery system w/ multiple plans, or an all payer system w/ multiple plans.	State option broader; State may elect to develop its own program subject to meeting federal requirements for universal access, cost-sharing, cost containment, etc.
	Within Federal guidelines States must: ▸ establish alliances; ▸ assure enrollment & access to care for its residents; ▸ regulate plans, incl. financial standards, risk adjustment system, & quality standards; ▸ provide for data/information systems; ▸enforce budgets after a transition.	

	Clinton	HR 2610 Stark
4. Cost Containment	Similar; Board apportions to States.	A MediPlan budget would be set statutorily; and equal to the amount spent for MediPlan benefits now provided under Medicare, Medicaid and private health insurance plans.
	Statute will set annual allowable premium increases equal to CPI + POPULATION.	Growth in MediPlan would be set at (approx.) current trend minus 1% and phase down to the increase in the GDP over 5 years.
	The allowable increase will be adjusted for each alliance to reflect any changes in the demographics of the alliance during the previous year.	No provision.
	State budgets allocated according to geographic adjustment factors. Federal funds to States for low-income subsidies.	N/A
	Payments to providers are negotiated by plans, except that provider payment limits are one tool available to States/Feds to enforce budget.	HHS would set MediPlan rates of payment for providers at levels estimated to the MediPlan budget limit. Payments to providers would be made based on existing Medicare reimbursement methodologies.
	No provision.	Expenditures relating to qualified group and staff model HMOs would not be included under the budget to encourage and support these plans.
	During years 1-3 the federal government assumes responsibility for enforcement of alliance budgets, thereafter the states will enforce the budgets.	Federal enforcement.
5. Employer Financing	Employer must contribute 80% of the cost of employees coverage (contribution not to exceed 7.6% of employee wages).	Employer must contribute 80% of cost of MediPlan benefits through payroll tax (approx. .60/hr). Employer contribution is credited against employees' MediPlan premium paid through income tax (reduces adult liability to approx. $300).
	Benefits beyond guaranteed level may be offered for 3 years or duration of contract & receive tax favored status.	Employers currently providing benefits in excess of MediPlan benefits required to continue for current employees and dependents.
	Small low-wage firms employer contribution capped at 3.2% (depending on size and average wage level).	No provision.
6. Other Financing	Employees pay up to 20% of avg. premium in regional health alliance	All individuals (except low-income) pay MediPlan premium ($1,500/indiv.; $3,000/working couples) through income tax system. Children and Medicare beneficiaries exempt from tax.
		States maintenance of effort required portion of Medicaid.
		A 10% tax on providers of health care benefits under MediPlan.
	Cigarette tax.	