Rostenkowski

# Clinton Presidential Records
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102D CONGRESS
1ST SESSION

# H. R. 3205

To amend the Internal Revenue Code of 1986 and the Social Security Act to provide for health insurance coverage for workers and the public in a manner that contains the costs of health care in the United States.

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IN THE HOUSE OF REPRESENTATIVES

AUGUST 2, 1991

Mr. ROSTENKOWSKI introduced the following bill; which was referred jointly to the Committees on Ways and Means, Energy and Commerce, and Education and Labor

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# A BILL

To amend the Internal Revenue Code of 1986 and the Social Security Act to provide for health insurance coverage for workers and the public in a manner that contains the costs of health care in the United States.

*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 "Health Insurance Coverage and Cost Containment Act of 1991".

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

# THE HEALTH INSURANCE COVERAGE AND COST CONTAINMENT ACT OF 1991

## H.R. 3205

August 2, 1991

1. **Health Insurance Coverage for Every American**

In general, universal health insurance coverage would be assured by requiring each employer to provide basic health insurance meeting certain minimum standards to all employees and dependents or to pay an excise tax assessed as a percentage of wages.

Employees of firms that chose to pay the tax would be covered under a public plan similar to the existing Medicare program. Individuals not connected to the work force would be covered under the public plan.

2. **Pay-or-Play Plan**

Employers could provide the basic benefit package through private health insurance or a self-insured employer plan. Employers could charge employees up to 20 percent of the premiums for the coverage. Firms choosing to pay the tax would pay 80 percent of the tax, with employees paying the remaining 20 percent.

3. **Pay-or-Play Trigger**

The pay-or-play trigger would be imposed as an excise tax assessed as a percentage of wages. It would be initially set at 9.0 percent of the Medicare wage base and would be indexed to the rate of growth in the health benefits covered by the program. At the initial rate, it is estimated that employers employing fifteen percent of the covered employment-related population would select the public plan.

4. **Establishment of the Public Plan**

A public plan similar to Medicare would be established. Benefit payments and direct provider relations would be operated, as is Medicare, through fiscal intermediaries at the state level. The plan would operate under the same rules [illegible] provider certification and quality [illegible]rance as Medicare. The program would be administered by the Department of Health and Human Services.

A Health Insurance Trust Fund would be established to receive funds from the excise tax and the other revenues dedicated to support of the program.

5. **Phased Implementation of Pay or Play Requirements**

The requirements of the legislation would be phased in beginning January 1, 1993. In 1993, employers with more than 100 employees would be required to provide health insurance coverage or pay the tax. Other employers could voluntarily join the public plan as of that date.

As of January 1, 1994, employers with 50 or more employees would be required to provide coverage or pay the tax.

As of January 1, 1995, employers with 25 or more employees would be required to provide coverage or pay the tax.

As of January 1, 1996, all employers would be required to provide coverage or pay the tax. In addition, all persons not connected to the work force would be enrolled in the public plan.

6. **Multiple Employer Rules**

In the case of families with more than one worker and where both employers offer a private plan, families would choose under which employer plan they would be enrolled. The non-enrolling employer(s) would pay a special premium to the public plan equal to 40 percent of the applicable premium for the public plan. The enrolling employer would receive a subsidy from the public plan equal to that amount for each enrolled employee of another firm.

Families with employees covered by both a private and the public plan would be required to choose coverage under the private plan, and the private plan would receive a subsidy equal to forty percent of the applicable public plan premium for each enrolled employee of another firm. The employer participating in the public plan and the firm's employees would pay the tax.

Families with all employees covered by the public plan would receive coverage from that plan and each employee and their employer would pay the tax.

Families with more than one employed person would not be liable for paying the extra employee share(s) of taxes.

7. **Treatment of Part-time and Temporary Employees**

An employer could opt for private or public coverage of part-time employees, and such employees could be treated differently from full-time employees. Full-time work is defined as more than 17.5 hours per week. Temporary employees would be covered under the public plan.

For these employees participating in the public plan, the employer would pay the tax on the wages paid to the part-time or temporary employee. This amount would be credited against the public plan premium which the employee would otherwise owe as an individual, described below.

8. **Health Benefits**

*Basic benefits*: Benefits would generally be the same as under the Medicare program except there would be a single deductible of $250 per individual/$500 per family and an out-of-pocket limit of $2,500 per individual /$3,000 per family. Certain new prevention benefits, also added to Medicare and described below, would be included in the basic benefit package.

*Children's benefits*: Benefits for children would include well-child care and preventive care as recommended by the American Academy of Pediatrics without co-payments or deductibles, and hospital care without co-payments or limits on days of care per spell of illness.

*Pregnancy benefits*: Benefits for pregnancy-related services would include pre-natal care, inpatient labor and delivery, postnatal care, and postnatal family planning services based upon the recommendations of the American College of Obstetrics and Gynecology, without co-payments or deductibles.

The Secretary of Health and Human Services would be required to establish a system for certifying that insurance plans and employer self-insured plans met the benefit requirements.

9. **Health Care Cost Containment**

A national limit would be set on the health expenditures of the public plan and of employer plans for services covered under the program. The limit would equal the rate of nominal growth in the gross national product (GNP) plus:

* Four percent in 1993 and 1994;
* Three percent in 1995 and 1996;
* Two percent in 1997 and 1998;
* One percent in 1999 and 2000.

In 2001 and thereafter the increase would be equal to the nominal growth in the GNP.

A Health Care Cost Containment Commission would be established consisting of eleven experts in health financing, health insurance, provider reimbursement, and related fields. Commissioners would be appointed by the President with the advice and consent of the Senate.

The Commission would negotiate with health care providers to allocate national expenditures under the limit among the various sectors of the health care delivery system.

The Commission would also develop a national capital budget for needed health care facilities and equipment.

The Secretary of Health and Human Services would establish payment rates for health care services on an annual basis which would result in aggregate expenditures equal to the amount available under the national expenditure limit.

The rates would be based on the methodologies established under the Medicare system, including the Prospective Payment System for hospitals and the Resource-Based Relative Scale (RB RVS). The rates would be used by the public plan to pay providers and would be ceilings for rates of payment by private insurers and by self-insured employer plans. The extra billing limits of Medicare would apply to the public plan and to all private plans.

10. **Individual Enrollment in Public Plan**

Individuals not connected to the workforce would be enrolled in the public plan. Premiums for individual would be based upon the actuarial cost of the benefits of the public plan. Individuals who did not enroll on a timely basis would be subject to a penalty of twice any premiums otherwise due.

11. **Low-income Assistance**

**Low-income persons and families would be eligible for assistance relating to premiums, deductibles, and coinsurance for which they would otherwise be responsible.**

For individuals or families with incomes below 100 percent of the Federal poverty level, the assistance would equal the total amount of all premiums, deductibles, and coinsurance. For individuals and families with incomes between 100 and 200 percent of the poverty level, the assistance would diminish on a sliding scale.

Both employed persons and persons not connected to the work force could receive assistance, but employers would still pay their share of the costs of coverage for employed persons and their dependents.

Persons eligible for aid to families with dependent children, supplemental security income, or the earned income tax credit would be deemed to be eligible for assistance. Other persons would have to apply for assistance. If family income changed during the year, any assistance received would be reconciled to those changes at the end of the year.

Medicare beneficiaries would be eligible for low-income assistance under the same terms, except that the assistance available would relate to the Part A and B premiums, deductibles, and coinsurance otherwise due.

12. **Expansion of Medicare to Age 60**

The age of eligibility for Medicare would be reduced one year of age in each year beginning January 1, 1993; eligibility would reach age 60 on January 1, 1997.

13. **Prevention Benefits**

Annual mammography screening, colorectal screening, various vaccinations, and well-child care would be required benefits for employer plans and the public plan and would be added to the Medicare program.

14. **Group Health Insurance Standards**

*General Standards*: All group health insurance plans would be required to meet certain standards. Plans not meeting these standards would be subject to a tax equal to fifty percent of the premiums collected and would lose their status as qualified employer plans for purposes of the pay-or-play requirements.

Under the standards, no group insurance plans could discriminate on the basis of health status, claims experience, receipt of health care, medical history, or evidence of insurability of an individual. Pre-existing condition exclusions could only apply for a six-month period and could not apply to newborns. No pre-existing condition exclusion could apply if an individual had been covered under another qualified plan or the public plan for more than six months prior to enrollment.

*Small Group Standards*: No employer with fewer than 100 employees would be allowed to self-insure.

Insurers offering insurance plans to small employers would be required to offer the plan to all small employers on a continuous, year-round basis. Insurers would be required to offer coverage for a full year. Premiums would be required to be community-rated for a given geographic area, but could be adjusted for age, gender, and type of family enrollment. Insurers would be required to offer a minimum benefit package which contained only the basic benefits required for all employers.

15. **COBRA Continuation Requirements**

The health insurance continuation requirements enacted as part of the Consolidated Omnibus Reconciliation Act of 1985 would be repealed.

16. **Medicaid**

Medicaid would continue for the currently eligible population for the benefits not covered under this program.

During the transition period, payments under State Medicaid programs to hospitals and physicians would be required to be increased. Payments would be required to equal the following specified percentages of Medicare payments, adjusted for differences in the covered populations: 70 percent in 1993; 80 percent in 1994; and, 90 percent in 1995. These payment levels could not be waived by the Secretary.

States would be subject to maintenance of effort rules that would require them to pay the amount they otherwise would have spent for Medicaid benefits into the Health Insurance Trust Fund.

17. **Deduction for Health Insurance Costs of Self-employed Individuals**

The bill extends the present-law 25 percent deduction for health insurance costs of self-employed individuals for 1992 and modifies this deduction for subsequent years to conform to the universal health coverage policies of the bill.

Until the universal coverage provisions of the bill are effective (i.e., for 1993 through 1996), self-employed individuals and owners of personal service corporations are entitled to deduct 100 percent of their health insurance costs if they provide to all their employees who work more than 20 hours per week health coverage that meets the requirements of a qualified employer health plan under the bill. If such coverage is not provided, then the deduction for health insurance expenses of such person is limited to 25 percent.

For years after 1996, the deduction is 100 percent of the costs of health insurance coverage.

18. **Financing**

To the extent that it is not paid for by the payroll taxes under the pay-or-play provisions, the program would be financed through a combination of a health surtax imposed on corporations and individuals and increases in the Hospital Insurance payroll tax imposed on both employers and employees.

*Universal health coverage surtax*: The bill imposes a health surtax under which the tax liability (before any tax credits) of individuals (computed without regard to the surtax) would be increased. The surtax would be applied for purposes of the regular income tax as well as the alternative minimum tax. For taxable years beginning in 1993, the surtax would be six percent, for 1995 seven percent, and for 1996 nine percent. For example, if a taxpayer's tax liability was $1,000 in 1996, the taxpayer would owe an additional $90.

This surtax would applied both to the regular income tax as well as the alternative minimum tax. The surtax also would apply to estates and trusts.

The bill would impose a similar health surtax on the tax liability (before tax credits) of corporations increased on the same schedule as the individual income tax. The surtax would apply for purposes of the regular income tax as well as the alternative minimum tax. For taxable years beginning in 1993 the surtax would be six percent, for 1995 seven percent, and for 1996 nine percent.

*Hospital insurance tax*: The Hospital Insurance payroll tax imposed on both employers and employees would be raised to pay for the improvements in Medicare benefits, including the reduction in age of eligibility.

Under the bill, the HI taxable wage base would be increased from $125,000 to $200,000 (indexed), effective January 1, 1993.

In addition, the HI tax rate on both employers and employees would be increased from 1.45 percent to 1.55 percent in 1993 and to 1.65 percent in 1996. Corresponding changes would be made to self-employment taxes.

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